

BOOK REVIEWS

Betty J. McWilliams, Ph.D., Editor

WESTLAKE, HAROLD, AND RUTHERFORD, DAVID, *Cleft Palate*. Englewood Cliffs: Prentice-Hall, Inc. 1966. Pp. 137. \$4.95.

This book is written by Harold Westlake, Professor of Speech Pathology, and David Rutherford, Professor and Chairman, Department of Communicative Disorders, both of Northwestern University. The authors are recognized authorities in their fields with an extensive background in research and clinical experience. This book is one in a set of fourteen volumes, which constitutes the Foundations of Speech Pathology Series, each designed to give a core of information to students and professional workers.

The opening chapter of the book defines the problem and the second chapter, entitled "Personal Adjustment," explores various social problems related to the cleft palate patient. The next two sections deal with speech and hearing problems. Throughout each chapter there are search items which serve as a guide to further reading on the subject. Information basic to the cleft palate problem is included in sections on nasal resonance and nasality, embryology, and normal velopharyngeal closure.

The next chapter, entitled "Cleft Palate Habilitation," stresses the team approach and the effects of treatment by the related disciplines upon the speech of the cleft palate patient. The authors conclude the book by presenting a method for evaluating and improving cleft palate speech.

This book is recommended for the library of those interested in the cleft palate problem.

ROBERT L. HARDING, M.D.

Harrisburg, Pennsylvania

ABSTRACTS

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Bernstein, L., Treatment of velopharyngeal incompetence. *Arch. Otolaryng.*, 85, 89-96, 1967.

The evaluation of treatment for velopharyngeal inadequacy is outlined. The preoperative selection of patients is discussed and details are given of the surgical techniques for the creation of the superiorly based velopharyngeal flap and the pharyngeal pad. The results of a series of 190 pharyngeal flap operations are presented and analyzed. (author's summary)

Kushnick, T., The D₁ syndrome with unusual cleft lip. *J. Newark City Hospital*, 3, 113-192, 1966.

A patient with the phenotype of D₁ trisomy has been described. The chromosomal aberration was confirmed by chromosome analysis. The clinical features of the syndrome have been reviewed. An unusual aspect of this patient was that the cleft lip simulated a post-operative repair rather than the usual widely cleft lip and palate. (author's summary)

Pruzansky, S., Ruess, A., and Buzdygan, Danuta, Oral-facial-digital syndrome in a Negro female. *Plastic reconstr. Surg.*, 37, 221-226, 1966.

It is generally recognized that the incidence of various malformations may vary widely in specific populations. Cleft lip/cleft palate, for example, is encountered more frequently in American Indians and Japanese than in Caucasians in Europe and in the United States, and is even less frequent in American Negroes. To date, approximately 53 cases of the oro-facial-digital syndrome have been reported in white females. The present report is the first description of the syndrome in a Negro female. On the basis of the identified cases, the differences between the races seems greater with respect to this condition than for cleft lip/cleft palate. It may be that with the increasing identification of this syndrome, this ratio may be altered. (authors' summary)

Bjork, L., and Nylén, B., Studies on velopharyngeal closure. *Acta Chir. Scand.*, 131, 226-229, 1966.

Studies on velopharyngeal closure have been performed using lateral cineradiograms, synchronized with sound spectrograms and colour cinefilms of the soft movements seen from above through a facial defect following cancer surgery of the maxilla. The pattern of movements of the soft palate as seen on the cineradiograms in lateral projection and on the colour cinefilms corresponded well and there was practically 100% correlation in the assessment of closure or non closure on the two types of films. In cleft palate patients, operated with velopharyngeal closure corresponding well to the closure found on lateral cineradiography. The area of the coupling gate between the naso- and oropharynx was found to be a simple linear function of the sagittal diameter of the openings, which means that variations

in the area can well be studied by lateral cineradiography. (authors' summary)

Bjork, L., and Nylén, B., The function of the soft palate during connected speech. *Acta Chir. Scand.*, 126, 434-444, 1963.

Cineradiography synchronized with sound spectrography was used to study in detail the movements of the soft palate during connected speech. The palate showed a very constant pattern of movement which was but little influenced by different experimental conditions. This applied both to normal persons and to cleft palate patients with normal postoperative speech. The clinical application of the experimental results is discussed. (authors' summary)

Aduss, H., and Pruzansky, S., The nasal cavity in complete unilateral cleft lip and palate. *Arch. Otolaryng.*, 85, 53-61, 1967.

Serial frontal cephalometric radiographs and serial maxillary casts of complete unilateral cleft lip and palate obtained from 32 patients prior to and following lip repair, and prior to and following palatal repair, were analyzed to determine the interrelation between the shape of the nasal chambers and the form of the maxillary arch. In all patients, prior to lip repair, the nasal septum was displaced to the non-cleft side, in varying degrees, and the greatest degree of septal deviation recorded. Following lip repair, medial approximation of the palatal segments was observed in all patients. The limitations on such medial movement and the subsequent form of the arch were dependent on the size and shape of the alveolar process adjacent to the cleft and on the configuration of the nasal septum and turbinates on the cleft side. Thus, the degree of medial approximation of the maxillary segments and the presence and severity of arch collapse were shown to be related

to intrinsic anatomical variants. As the children with clefts grew older, the degree of deviation of the septum did not differ markedly from that observed in children without clefts; however, the septum consistently deviated toward the non-cleft side. (authors' summary)

Adamson, J. M., Horton, C. E., Crawford, H. H., and Wertz, Mildred, A practical method of judging cleft palate speech. *Plastic reconstr. Surg.*, 38, 544-551, 1966.

The authors have developed a method of testing for velopharyngeal competence which they believe can be administered and interpreted by a general practitioner or his office nurse. It was first determined by trained speech pathologists that cleft palate speech errors occurred in only 16 consonant sounds. Simple picture recognition cards were prepared so that each picture could be identified by a single word in each of which one of the 16 consonants was used. After testing a number of cleft palate subjects a standard for judgement was arbitrarily selected as follows. No errors: speech was classified as excellent. One to four errors: good. Five to nine errors: fair. Ten to sixteen errors: poor. The authors believe that their method of judging cleft palate speech can be applied easily and the standards easily interpreted. (Huffman)

Gruber, H., Harvin, J. S., and Hull, D., The role of the orthodontist on the cleft palate team in a military hospital. *Plastic reconstr. Surg.*, 38, 560-566, 1966.

An orthodontist can offer considerable service to cleft patients before surgery, immediately following surgery, or later in life. The malaligned maxilla can be brought into more nearly normal shape by preoperative maxillary splinting, by the use of extraoral appliances, or both. After lip repair and after palatal repair, maxil-

lary splinting can prevent contraction of the maxilla by pressure of perioral soft tissues. Cleft palate patients who have their permanent dentition and varying degrees of malocclusion before being treated by orthodontic means can be improved considerably, but the results are seldom as gratifying as they are in patients who are treated early in life. (Huffman)

Longacre, J. J., Halak, D. B., Munick, L. H., Johnson, H. A., and Chune-kamrai, D., A new approach to the correction of the nasal deformity following cleft lip repair. *Plastic reconstr. Surg.*, 38, 555-559, 1966.

The authors take note of the fact that the unilateral cleft lip nasal deformity is apt to become more noticeable as the patient matures. In the belief that the deformity was due to underdevelopment of the maxilla on the side of the cleft rather than to nasal soft tissues, they applied split rib grafts as correction of the maxillary hypoplasia. They believe that if the maxillary segments are properly aligned and the hypoplastic maxillary defect is corrected prior to the age of five years, the nose will assume a more nearly normal contour and appearance. (Huffman)

Lynch, J. B., Lewis, S. R., and Blocker, T. G., Cleft palate not explained by embryology. *Plastic reconstr. Surg.*, 38, 552-554, 1966.

It is generally believed that oral clefts are due either to lack of fusion of embryologic processes or to failure of mesodermal penetration after fusion. The authors present an instance of a cleft that involved the hard palate from the incisive foramen to the junction of the hard and soft palates and believe that this type of cleft cannot be explained by either of the generally accepted beliefs concerning the mechanics of oral clefts. (Huffman)

Cocke, W., Experimental production of

micrognathia and glossoptosis associated with cleft palate (Pierre Robin syndrome). *Plastic reconstr. Surg.*, 38, 395-403, 1966.

The author presents a short historical and literature review of micrognathia. Fertile white Leghorn eggs were injected with purine deoxyguanosine on the fourth day of incubation. Among other defects in the embryos that survived, cleft palate and micrognathia with glossoptosis were found in twelve. It is postulated that the alteration of a normal physiologic substance may explain the anatomic malformations in the Pierre Robin syndrome. (Huffman)

McDowell, F., Late results in cleft lip repairs. *Plastic reconstr. Surg.*, 38, 444-476, 1966.

Very few surgeons have studied the long term results of any particular type of cleft lip repair. The many procedures that have been used for repair of the unilateral cleft lip are described and their advantages and disadvantages are discussed. The overall late results after early cleft lip repair by use of the small triangular flap are encouraging. Partial single cleft lips require just as much care in repair as do total single cleft lips; however, final results are generally better in the former. Double cleft lips were closed by the same design as were single clefts and both sides were repaired at one operation, the premaxilla being set back surgically whenever needed. Cleft palate repair by the simple von Langenbeck operation produced excellent

speech in a high percentage of cases. Overall late results in the repair of double cleft lips are not as good as those in unilateral clefts. It may be that much of the difference is due to the fact that the bilateral clefts nearly always need a great deal more dental care than do the single clefts, and this care is often unavailable. (Huffman)

Von Schule, H., Histologic and electrophysiologic examination of prolabium in bilateral cleft lips. *Deutsche Zahnärztliche Zeitschrift*, 21, 752-761, 1966.

The neuromuscular supply of the prolabium was studied in 41 patients with cleft lips (alveolus and palate), treated during the period 1963-65. Histological examination of the prolabium in bilateral clefts showed either very little or no muscle fibers. Electromyographically, no action potentials were found in either galvanic or faradic stimulation; thus no visible motor reactions were established. In most incomplete bilateral clefts of the lips, muscles were histologically demonstrated. There was a certain dependence between the quantity of the muscles as well as the orientation to functional units and the tissue on the incomplete side, however, which was always less than in normal lips or in unilateral clefts of lips. With two exceptions, action potentials were found in the prolabium of incomplete bilateral clefts of the lips, however the intensity and frequency was less than in normal lips. (Schmid)

ANNOUNCEMENTS

1969 International Congress . . . The Secretary-General, Dr. D. C. Spriestersbach, has announced the appointment of the Secretariat and the Advisory Committee to the Secretary-General. The seven members of the Secretariat are: three Assistant Secretaries-General—Peter Randall, M.D. (Congress Program), Donald W. Warren, D.D.S. (Convention Affairs), and Betty Jane McWilliams, Ph.D. (Public Relations and Liason); the Assistant to the Secretary-General—Duane R. VanDemark, Ph.D.; and three officers of the Association—the President, the President-Elect, and the Secretary. The six members of the Advisory Committee are: Stephen P. Forrest, D.D.S., Robert L. Harding, M.D., Herbert Koepp-Baker, Ph. D., Herold S. Lillywhite, Ph. D., Mohammad Mazaheri, D.D.S., and Ross H. Musgrave, M.D.

Dr. Spriestersbach and the Secretariat held a first meeting in December, 1966, for the purpose of preliminary planning. ACPA members will be notified of developments as the planning proceeds.

The Lancaster Cleft Palate Clinic is presenting a seminar entitled "Habilitation/Rehabilitation of Oral-Facial-Communicative Disorders" October 23-27, 1967. Graduate trainingship awards from the National Institute of Dental Research are available to qualified individuals in the fields of medicine, dentistry, speech, and audiology. The award pays registration and tuition fees, transportation, and per diem costs for the five days at the Lancaster Clinic. Address all inquiries to R. T. Millard, Program Director, Lancaster Cleft Palate Clinic, 24 N. Lime Street, Lancaster, Pennsylvania 17602.

The Cleft Palate Research Center of the University of Pittsburgh presented a seminar, entitled "The Church and the Handicapped Child" on November 8, 1966. Presented in cooperation with the Council of Churches of the Pittsburgh Area, the seminar consisted of lectures by representatives of the various disciplines involved in the treatment and care of handicapping conditions in childhood and the habilitation of the child in the program of the local church.

USPHS traineeships sponsored by the National Institute of Dental Research are available for qualified candidates seeking a Ph.D. degree

in Genetics. Predoctoral stipends begin at \$2,400 and postdoctoral stipends at \$5,000 per year plus \$500 dependency allowance. Areas of specialization offered are Molecular and Microbiological Genetics, Cytogenetics, Physiological and Developmental Genetics, Population and Quantitative Genetics, and Human Genetics. Special training in the genetic aspects of the orofacial area is available. For further information, write Carl J. Witkop, Jr., Chairman, Human and Oral Genetics Division, 516 Owre Hall, School of Dentistry, University of Minnesota, Minneapolis, Minnesota 55455.

The Epidemiology Branch at the Dental Health Center of the U.S. Public Health Service, located in San Francisco, announces two vacancies on its staff. One of these vacancies is for an Epidemiologist (Physician) to plan and direct the epidemiologic investigations of birth defects conducted by the Epidemiology Branch. A Doctor of Medicine degree and advanced training and experience in epidemiology are required for this position; a background of specialized training and experience in pediatrics and/or genetics is preferred but not mandatory. The other vacancy is for a Geneticist to design and conduct research dealing with the genetics of cleft lip and palate and related birth defects, and provide consultation to other investigators of the Epidemiology Branch. Salaries are open (to be based upon the qualifications of the individual as determined by the U.S. Civil Service Commission), with periodic increases. Both of these vacancies will be filled through Federal Civil Service appointments: relevant benefits and standards will apply, with non-discrimination in employment. An application form SF-57 (obtainable from any Post Office or federal agency) should be submitted to: Sylvia Hay, Dental Health Center, 14th Avenue and Lake Street, San Francisco, California 94118.

Because of limitations of space in *CPJ*, the Registry of Current Research Programs will no longer be published. Information of the type which was included in the Registry can be obtained by individuals or institutions from Chief, Dental Section, Medical Sciences Branch, Science Information Exchange, 1730 M Street, N.W., Washington, D.C.

Time and Place, ACPA

1967—April 13, 14, and 15.....	Chicago at the Palmer House
1968—April 25, 26, and 27.....	Miami Beach at the Deauville
1969—International Congress, April 14, 15, 16, and 17.....	Houston at the Shamrock
1970—April 16, 17, and 18.....	Portland at the Hilton

The Editors of *CPJ* announce the appointment of Dr. Betty Jane McWilliams as Editor for Book Reviews. Please correspond with Dr. McWilliams, Salk Hall, University of Pittsburgh, regarding either new books which should come to her attention or a willingness to assist her in this very important activity of *CPJ* and the Association.

As one of the host institutions for the annual meeting of The American Cleft Palate Association, the Cleft Palate Clinic of the University of Illinois will present a two-day short course on April 11, 12, 1967, the Tuesday and Wednesday preceding the annual meeting. The course will summarize the principal findings to emerge from the longitudinal growth studies on clefts as well as other craniofacial malformations. Interested applicants are invited to write to:

Short Course
Cleft Palate Clinic
University of Illinois at the Medical Center
808 S. Wood Street
Chicago, Illinois 60612

Because of limitations in space, it may be necessary to limit attendance. (The preceding announcement is in accord with the ACPA 1967 Convention Program Committee, Dr. John W. Curtin, chairman.)

ACPA Members: Secretary-Treasurer Bzoch reports that the results of the mail ballot vote for the \$10 assessment for the 1969 International Congress is as follows:

Approve 44
Disapprove 94

Procedures for monitoring the payment of the assessment are being worked out.

The Fourth International Congress of Plastic Surgery, organized by the Italian Society of Plastic and Reconstructive Surgery, will be held at the Cavalieri Hilton Hotel, Rome, October 8 to 13, 1967. President: Prof. Gustavo Sanvernero-Rosselli; General-Secretary: Prof. Vittorio Bergonzelli. Full and Corresponding Members of the various Societies related to the International Confederation for Plastic Surgery and all Surgeons having a scientific or professional interest in the problems and progress of plastic and reconstructive surgery are cordially invited. All communications and inquiries of those who expect to attend the Congress should be addressed until February 1st, 1967 to the Secretary-General, Prof. Vittorio Bergonzelli, Via Lamarmora 10—Milano (Italy). Hotel registrations

should be made directly with the Wagon-Lits/Cook, Via Gradisca 29—Rome (Italy), the official travel Agent for the Congress.

Dr. William H. Stewart, Surgeon General of the Public Health Service, has announced a recent reorganization of the grant-supported research and educational programs of the National Institute of Dental Research. The reorganization, he said, will help to better define areas of needed research and spur studies on these problems. It will also help identify those research contributions which have promise for application in the community and hasten the availability of their benefits. The earlier structure dealt separately with the development of scientific manpower resources and the conduct and application of research. These elements are combined in the newly-established, four major program areas covering (a) dental caries and hard tissue studies, (b) periodontal disease and soft tissue studies, (c) oro-facial growth and development, and (d) biomaterials and special field projects. Emphasizing program breadth, each area will include a fundamental, undifferentiated research component, as well as basic, clinical, applied, and epidemiologic research directly concerned with the major oral diseases, according to Dr. Seymour J. Kreshover, Director of the Dental Institute. Similarly, each area will encompass training grants, fellowships, and career development awards. A small expert committee of advisers will be appointed for each area, and special ad hoc consultant groups will be called on as necessary.

The programs will function under the broad direction of Edward J. Driscoll, Associate Director for Extramural Programs of the Dental Institute.

Robert C. Likins, D.D.S., will serve as Chief of the area of Dental Caries and Hard Tissues. This program will encompass studies of the formation, calcification, composition, and fine structure of dental hard tissues as well as work directed at the causes, treatment, and prevention of tooth decay. Dental caries was found to be the number one health problem among children in Operation Head Start, and it affects more than 95 percent of the total population.

Thomas E. Malone, Ph.D., will administer the Periodontal Disease and Soft Tissue Study area. Periodontal disease, the chief cause of tooth loss after 35, affects an estimated 67 million American adults. In addition to studies of normal and diseased periodontal tissues, this program will include investigations of oral cancer, saliva and the salivary glands, oral microorganisms, and oral ulcerations, such as canker sores.

K. Kenneth Hisaoka, Ph.D., will direct the Oro-Facial Growth and Development Program, which will be concerned primarily with studies in cleft lip and palate and orthodontics. One out of every 750 children is born with a cleft lip or palate. Disciplines such as surgery, sociology, and speech therapy will be included as well as the basic sciences related to etiology and treatment.

Robert J. Nelsen, D.D.S., is in charge of Biomaterials and Special Projects. Investigations in the development and use of improved methods and materials for prosthetic, implant, restorative, and preventive dentistry will be concentrated in this program area. Included in this category will be appropriate field trials to assess the benefits to population groups of promising laboratory leads.

"While these four categories will serve to sharpen the focus of our support, as well as emphasize the breadth of responsibility in the dental and relevant sciences," Dr. Kreshover said, "they are by no means all inclusive. Meritorious grant applications that do not clearly fall within these areas will continue to be encouraged and supported. An essential additional consideration is that this new structure will have a built-in flexibility that will permit the development of new program areas as needs arise."

LETTERS TO THE EDITOR

Dear Dr. Morris:

The issue raised by Dr. Graber (Ed: in the January 1967 *CPJ*) regarding the safety of sedation is important enough to those interested in roentgencephalometry of infants to warrant dispassionate clarification. It should be clear at the outset that his views are not shared by experienced clinicians.

Until we are given clear evidence of alternative methods for producing equivalent films of high quality, we must assume that sedation is essential. Nevertheless, two questions should be asked at this time: (1) What are the hazards? (2) What are the benefits to the patient?

The safeguards employed at the Cleft Palate Clinic of the Research and Educational Hospitals of the University of Illinois are designed to anticipate and minimize risks. In recent years, we have averaged 128 sedations annually with a total of approximately 2,000 sedations since this clinic began. This does not include sedations performed in other parts of the hospital. With a pediatrician and registered nurse in attendance, and in the setting of a large hospital, the risks have been minimized and we have experienced no mortality or morbidity.

At one time, we regarded roentgencephalometric research as a matter of interest only to the academically oriented orthodontist. We now recognize that such serial films, made possible by sedation, are an essential part of our diagnostic armamentarium with demonstrable benefit to the patients involved.

In the final analysis, one must weigh the negligible risks in a setting such as ours, against the major contributions to the welfare of children that have emerged from such studies.

Sincerely yours,
D. BUZDYGAN, M.D.
Pediatrician-in-Charge
E. F. LIS, M.D.
Professor of Pediatrics and Director
Cleft Palate Clinic
University of Illinois Medical Center

Dear Dr. Morris:

T. M. Graber's letter to the Editor (January 1967 *CPJ*) requires rebuttal.

The debate, of interest to readers of this *Journal* who are concerned with cranio-facial growth, centers on my contention that it is impossible

to obtain serial cephalometric x-rays unless the infant is sedated. Bodily restraints may impede movement of the head within the headholding device, but cannot restrict movements of the mandible, tongue, velum, and hyoid bone or control head to neck to body relations. Any attempt to restrain movement of the mandible would only result in artifacts of posture.

The utilization of improved technologies which reduce exposure time will not solve this problem, for there is no assurance that the position is standardized or that the same posture will be captured in subsequent series—both conditions being crucial to serial roentgencephalometry. Therefore, sedation is unavoidable if we are to produce films of consistent quality.

As further evidence, reference is made to two dissertations completed at Northwestern University utilizing data obtained at Children's Memorial Hospital:

WILLIAMS, RALEIGH T.: A Cephalometric Study of the Growth and Development in Cleft Lip and Palate Individuals from Birth to Four Years. Northwestern University, 1953.

"The material for this investigation consisted of 31 series of lateral cephalometric radiographs.

The age span covered by the radiographs of each subject comprised various portions of the span between birth and four years. No series covered the entire age span.

...of an original 54 cases, 23 were discarded. This was due to the fact that a series of clear radiographs could not be secured from these subjects. The mandibular position varied from occlusion to wide open in some of the radiographs utilized, although the subject remained still long enough for a clear picture. Since this study was undertaken chiefly to find out about growth of the maxillary complex in cleft palate cases, the position of the mandible was immaterial and such cases were incorporated. Selection of cases, therefore, was based on the quality of radiographs."

KONISHI, HISAO: An Appraisal by Cephalometric Radiographs and Intra-Oral Models of Unoperated Cleft Plate and Non-Cleft Palate Infants. Northwestern University, 1957.

"Since this investigation was concerned primarily with growth of the maxillary complex and the adjacent cranial structures in the unoperated cleft and non-cleft palate infant, the varied positions of the image of the mandible obtained on the films were not considered significant."

Sedation for roentgencephalometry has been practiced by us since 1950. In 1957, the American Association of Orthodontists awarded its first prize in research to Pruzansky and Lis for a paper entitled "Cephalometric Roentgenography of Infants: Sedation, Instrumentation and Research" *Am. J. Orthodontics*, 44, 159-186, 1958. Students of craniofacial growth recognized that this technic made possible for the first time the accumulation of accurate data during infancy.

In that report we carefully spelled out the indications and contraindications for sedation. The safeguards which we maintain were devised in consultation with anesthesiologists, pharmacologists, and pediatricians. A pediatrician and a registered nurse are in continuous attendance and the procedure is employed in the setting of a large hospital. To date, we have had no mortality or morbidity.

The increasing number of infants with a wide variety of craniofacial malformations referred to our clinic for roentgencephalometric evaluation, made possible by sedation, testifies to the diagnostic value of this procedure and its contribution to the welfare of the patients involved.

Sincerely yours,

SAMUEL PRUZANSKY, D.D.S.

*Professor of Dentistry and Associate
Director*

Cleft Palate Clinic

University of Illinois Medical Center

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Changes of address, subscriptions, and all correspondence pertaining to the Association should be addressed to the Secretary: Dr. Kenneth R. Bzoch, Department of Communicative Disorders, College of Health Related Professions, University of Florida, Gainesville, Florida 32601.

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Herold S. Lillywhite, Ph.D.
Betty Jane McWilliams, Ph.D.

Program

John W. Curtin, M.D. (Chairman)
Samuel Berkowitz, D.D.S.
Raymond O. Brauer, M.D.
Elise S. Hahn, Ph.D.
Robert Mason, Ph.D.
Robert T. Millard, M.A.
Morton S. Rosen, D.D.S.
Donald W. Warren, D.D.S., Ph.D.

Public Relations

Charles R. Elliott, Ph.D. (Chairman)
Hratch A. Abrahamian, D.D.S.
Robert W. Blakeley, Ph.D.
Richard Shultz, M.D.

Time and Place

I. Kenneth Adisman, D.D.S. (Chairman)
Eugene Gottlieb, M.D.
Gordon S. Letterman, M.D.
William H. Olin, D.D.S.
Harry Z. Roch, D.D.S.

Simplified Speech Classification (ad hoc)

Robert W. Blakeley, Ph.D. (Chairman)
Ralph O. Coleman, Ph.D.
Harry Z. Roch, D.D.S.
James W. Schweiger, D.D.S.
Richard B. Stark, M.D.

AMERICAN CLEFT PALATE ASSOCIATION

Information for Applying for Membership

The Association was organized in 1940 with the following objectives:

1. To encourage scientific research in the causes of cleft lip and palate.
2. To promote the science and art of rehabilitation of persons with cleft palate and associated deformities.
3. To encourage cooperation among, and stimulation of, those specialists interested in the rehabilitation of cleft palate persons.
4. To stimulate public interest in, and support of, the rehabilitation of cleft palate persons.

The Association publishes the *Cleft Palate Journal* quarterly. The Association's Annual Meeting includes sessions devoted to the presentation of papers in medicine, dentistry, speech, and related areas concerning the problems in individuals with cleft lips and palates.

To be qualified as a member of the Association, the applicant must be in good standing in the professional organization representing his major or clinical orientation. He must be accredited in his professional field, and he must have displayed an interest in the rehabilitation of cleft palate persons. The above statement has been interpreted to mean that those applicants trained in Speech Pathology and Audiology must hold at least basic certification from the American Speech and Hearing Association at the time of the application.

The person shown as sponsor on the application must be a member of the Association and must write a letter attesting to the fact that the applicant is eligible for membership.

Send applications or requests for further information to:

KENNETH R. BZOGH, PH.D.
American Cleft Palate Association
Department of Communicative Disorders
University of Florida
Gainesville, Florida 32603