

BOOK REVIEWS

BEDER, OSCAR EDWARD, *Surgical and Maxillofacial Prostheses* (Rev. ed.).
Seattle, Washington: University of Washington Press, 1959. Pp. 90.
\$4.00.

This book, consisting of 90 pages, attempts to explain the different types of prosthetic appliances and the approach to the cleft palate problem with illustrations and descriptions. There is not, however, enough technical information to teach the dentist the construction of those appliances.

The individual patient's emotional problems are considered as well as the corrective measures. Radiation therapy and the use of protective shields are explained. Of noted interest is the information on radiosensitivity and the absorption of gamma rays by lead, including consideration of the handling of patients with radon seed implants. Appliances for osteotomized patients or ones with surgically removed mandibles are discussed. There are also a few pages dealing with extraoral impressions for the construction of somatoprotheses as well as the materials necessary for the construction of these prostheses.

A sizable portion of the book is devoted to cleft palate and the construction of both fixed and mobile types of obturators, for congenital as well as acquired clefts. The seven-part classification of clefts appears to be too much in detail in one direction (Classes I and II differentiate notched and bifid uvulas), but is missing a category for isolated alveolar process and lip clefts.

Speech pathology is a field closely allied with dentistry and/or maxillofacial surgery for the complete habilitation of the cleft palate patient. It is, therefore, entirely appropriate that the last section, written by Dr. James Carrell, is a review of speech and problems related to oral deformities. This chapter, as the rest of the book, appears to be an overview written for the dental specialist.

The publication is a brief compendium of information rather than a text. There is no index or bibliography. The book was originally published in 1949 and revised in 1959, but the material on cleft palate particularly appears somewhat out-dated.

WILLIAM R. HARKINS, D.D.S.

*Osceola Mills,
Pennsylvania*

MORLEY, MURIEL E., *Cleft Palate and Speech*. (5th ed.) Baltimore, Maryland: The Williams & Wilkins Company, 1962. Pp. 279. \$6.50.

It seems appropriate to point out specifically that this is the fifth edition of the volume *Cleft Palate and Speech* by Dr. Morley. Previous editions

have appeared in 1945, 1951, 1954, and 1958. The author is a well-known British speech pathologist; her book presumably is for those professional people with interests in the speech problems of individuals with clefts. For purposes of review, material in each of the eight chapters will be described, differences between this and the fourth edition will be considered, and a general critique of the book offered.

For those familiar with the fourth edition of the volume (1958), the major revisions in this edition occur in Chapters IV and V and, in general, consist of either inserted material about the Newcastle investigation of 360 children with clefts or are revisions of material about the development of articulation and language skills in children both with and without clefts. The revisions are relatively minor and do not involve entire sections of material in any instance. The photographs and drawings appear also to be essentially the same as those in the fourth edition. A more serious comment is made about the fact that the bibliography is also unchanged from the fourth edition. One wonders whether Dr. Morley considered such revision not important or whether she felt that no significant research in this area had been reported between the years of 1958 and 1962.

Chapter I includes a general description of congenital clefts of lip and palate. Dr. Morley presents the classical theory of maldevelopment of the embryo in which the frontonasal, maxillary, and mandibular processes are said to fail to unite in the first trimester of pregnancy. The classification system which she uses in this and subsequent portions of the book is that first described by Davis, Staige, and Ritchie in 1922 and is based on the position of the cleft relative to the alveolar process. For information about incidence of clefts, incidence of various types of clefts, and distribution of clefts according to sex, she draws heavily from material reported by Fogh-Anderson as well as several other investigators. Although she mentions various other causative variables, she quite apparently considers heredity to be a major if not *the* major factor in the etiology of clefts.

In Chapter II, the anatomy and physiology of the normal palatopharyngeal complex are described in some detail. Some attention is also given to blood supply and innervation of the palate. Of particular interest is a small section in that chapter in which the function of the palatopharyngeal valve is described not only for speech production but during respiration and blowing as well. Her bases for these observations are not cited. Strangely enough, this chapter also contains material which is entitled "Treatment for cleft palate" and which includes the only description of prosthetic management of cleft palates in the entire book.

Chapter III contains a rather detailed description of various primary and secondary surgical techniques which have been employed for the management of clefts. There is also a two-part discussion of speech results following the various surgical techniques. The first part relates reported results from some of the early (1915-1933) surgical procedures. Later in that chapter, Dr. Morley reports results of speech evaluations of 360 chil-

dren all of whom had palate surgery at Newcastle. The reporting of that investigation is one of the several unique aspects of the fifth edition of the volume and various aspects of the study are referred to throughout the book.

Chapter IV presents discussions of several diverse topics: feeding the infant who has a cleft, or facial growth, orthodontics, patterns of normal speech development, and considerations for selecting the age for surgery. The description of development of speech in a child with cleft palate and the discussion of the effects of age of surgery on the acquisition of speech skills are presented in detail and provide the rationale for Dr. Morley's viewpoint that if at all feasible, cleft palate surgery should be performed before the child begins to talk.

Chapters V, VI, and VII include the bulk of the technical material in the book for the speech pathologist. Chapter V has to do primarily with diagnosis. Consideration is made of the various aspects of the speech problems of cleft palate speakers, notably intraoral pressure, vocal tone and resonance, and articulation. Also described under the heading of other disorders of speech are the factors of dyslalia or articulatory dyspraxia, and peculiarly enough, hearing defect, mental retardation, and persistence of abnormal habits. Clearly Dr. Morley is now describing what she considers etiological factors but has not labelled them such. Much more lucid is the section of that chapter regarding techniques for assessing speech both before and after surgical repair of the palate. Examination procedures are described in relatively great detail. Generally these techniques pertain to assessing competence of the palatopharyngeal sphincter, general articulation skills, and resonance characteristics. Various types of possible findings and their interpretation are discussed.

Chapter VI includes discussions of a general nature which consider the conduct of speech therapy for patients with clefts. Specifically, seven conditions are named which in her opinion will influence the result of treatment (therapy): a) the anatomical and physiological result of surgical treatment; b) intelligence; c) hearing acuity; d) level and type of speech development at the time of surgery; e) degree of stabilization of the faulty neuromuscular patterns of speech and the patient's ability to inhibit these and incorporate normal articulation in fluent speech; f) age at which speech therapy commences; and g) the environment and personality of the patient.

Chapter VII continues the discussion about therapy with some rather detailed suggestions for treatment. And furthermore, the suggestions for treatment are presented by classification from Dr. Morley's scheme of typical defects which was described previously in Chapter V. For patients, then, with certain kinds of errors, she describes (prescribes?) certain kinds of treatment techniques. These techniques involve direction of air stream, blowing and sucking techniques (which she says are now rarely necessary), coordinating the palatopharyngeal sphincter and the muscles of articula-

tion, lip and tongue exercises, and treatment of glottal stops or pharyngeal fricatives. Treatment techniques are also described for patients of various age levels.

The final section of the book, Chapter VIII, is composed of case history material which, in Dr. Morley's opinion, illustrates specific points.

Basically, the major criticism which may be made of Dr. Morley's book is about organization of material. For example, methods of physical management of the cleft palate are described in Chapters II, III, and IV. Speech results following surgical repair are discussed in Chapters III, IV, and V. Techniques for assessing speech are described in Chapters III, IV, and V. Clearly, material such as this is not easily divided in neat discrete sections, but greater effort in organization would make reading the book much easier.

Another comment to be made, and it may not necessarily be a criticism, is that in general Dr. Morley presents in this volume her own philosophies and frequently does not document her bases for them. And indeed, those references cited are, in the majority, British, and do not refer to recently published material (only two of 70 articles were published in 1956 or later). Again, one need not necessarily be critical of the book because of these considerations, but they should be remembered in evaluating the material.

A final criticism relates to the air of cook-bookish-ness which pervades some parts of the book, particularly those which have to do with therapy. The efforts which are made to be practical are to be commended but oversimplification has its dangers, too.

Undoubtedly, Dr. Morley is one of the best informed speech pathologists in the world on the subject of cleft palate. Her book reflects this competence and is highly recommended to all professional people interested in that specialty area.

HUGHLETT L. MORRIS, PH.D.

*State University of Iowa
Iowa City, Iowa*

ABSTRACTS

Editor

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Okayama, Japan

Stark, D. B., Nasal lining in partial cleft palate repair. *Plastic reconstr. Surg.*, 32, 75-81, 1963.

A procedure for complete closure of the nasal side of a Wardill push-back type palate procedure is described by the author. Long term follow-up is not yet available. The technique consists of the intra-oral elevation of nasal mucoperiosteal flaps with the aid of a dental curette, flap rotation in a Z-shaped closure and suture to the bony palatal shelves via catgut passed through drill holes. The author notes the inapplicability of his procedure to soft palate clefts where little nasal mucosa can be mobilized by this method and suggests Cronin's method for these cases. In discussion, Cronin questioned the technical feasibility of the method while approving the goal of nasal side coverage. (Crikelair)

Coccaro, P. J., Subtelny, J. D., and Pruzansky, S., Growth of soft palate in cleft palate children: A serial cephalometric study. *Plastic reconstr. Surg.*, 30, 43-55, 1962.

This study was designed to answer the questions: Is the soft palate in newborns

with clefts shorter than that in the normal? and How does the growth of the cleft soft palate compare with that of the normal soft palate? Lateral serial cephalometric roentgenograms obtained for 57 children with clefts of the lip and/or palate from infancy to seven years of age were studied. Comparisons were made with normative data on the growth of the soft palate. The increase in length of the soft palate was evaluated by two different measurements: the linear distance from the posterior border of the hard palate (posterior nasal spine or its equivalent) to the tip of the uvula of the resting soft palate (PNS-U); and the linear distance from the point of intersection of the palatal plane of the resting soft palate (PTM-U). The analysis showed that velar growth patterns are essentially the same for cleft palate and control groups regardless of the anterior skeletal landmark (PTM or PNS) used as a reference for measurement. Periods of active and less active growth were apparent during the same age intervals. The most rapid growth in length was noted from birth to two and a half years of age. Averaged measurements of velar length showed that the

cleft palate group, at the earliest age level and consistently thereafter, showed shorter velar dimensions than the normal and the cleft lip control groups. From three months to one and a half years of age cleft palate and control groups were found to have attained about half of the respective total increment in velar length to be achieved by seven years of age, demonstrating a striking similarity in early growth characteristic. The tendency for averaged velar length measurements to be similar, regardless of cleft types, was observed to be rather consistent for most of the age levels studied. The bilateral cleft palate group tended to consistently show a slightly shorter velum at most of the age levels when compared to the other two cleft palate groups. The unilateral cleft palate group was found to show a percentage increment in velar length during the period between three months and one and half years of age which was proportionately greater than the percentage increment observed in the bilateral or posterior cleft palate groups during analogous stages of development. (Authors Abstract)

Hadley, R. C., and Johnson, J. B., Utilization of the Kirschner wire in Pierre Robin syndrome. *Plastic reconstr. Surg.*, 31, 587-596, 1963.

A brief description is given of the history and possible physiology of the Pierre Robin syndrome of micrognathia, usually incomplete cleft palate, and respiratory obstruction. Surgical intervention is recommended in those cases in which respiratory crises are frequent or home management is difficult. Treatment by external traction is condemned as based on the false premise that such traction stimulates mandibular growth. The technical difficulties and post-operative complications of the Douglas tongue-lip traction procedure are described. An alternative treatment method is presented and its successful use in a patient is illustrated. Under general endotracheal anesthesia with the tongue

protracted, an 0.045 Kirschner wire is directed through the lower half of the body of the mandible just anterior to the angle. It is guided to transfix the tongue at the junction of its middle and posterior thirds and to emerge through the corresponding point of the contralateral mandibular body. Operating time is 10 minutes, and post-operative care is minimal. Early nipple feeding is possible. No secondary operation is required. In the case described, the wire was removed on the 29th post-operative day without recurrence of respiratory distress. (Ashley)

Blackfield, H. M., Owsley, J. Q., Jr., Miller, E. R., and Lawson, Lucie I., Cinefluorographic analysis of the surgical treatment of cleft palate speech. A preliminary report. *Plastic reconstr. Surg.*, 31, 542-553, 1963.

On the basis of films taken of 300 patients, the authors recommend cinefluorography as the most reliable method for determining the presence and degree of velopharyngeal closure. After evaluating 23 patients with velopharyngeal inadequacy before and after speech therapy, they concluded that the consequent nasality is not appreciably improved by speech therapy. They performed a push-back procedure in four of these patients, three of whom had a satisfactory result, whereas one subsequently required a pharyngeal flap. Pharyngeal flaps were superiorly based with attachment to the posterior portion of the soft palate on 48 patients with velopharyngeal inadequacy, 21 of whom were evaluated thoroughly before and after operation. In the post-operative examination it appeared that velopharyngeal closure was effected chiefly by pharyngeal muscle action at the level of the attachment of the palate to the pharyngeal wall. Improved intelligibility ensued in 81% of the patients, reduced nasality in 84%, and acceptable amount of nasality or none at all was allowed in 42%. The authors described a modified pharyngeal

flap procedure in which the soft palate is split, almost the entire posterior width of the pharyngeal wall is elevated, and the resulting flap is based high at the cranial base. The margin of the flap is attached to a small flap elevated from a denuded area at the midpoint of the dorsum at the soft palate. The soft palate incision is then closed. It is hoped that the resultant flap will more closely approximate the normal physiological action of the soft palate. (Ashley)

Fogh-Anderson, P., Vital statistics of cleft lip and palate—Past, present, future. *Acta Chir. Plasticae*, 3, 169–174, 1963.

Cleft lip and palate belong to the most common of the congenital anomalies. During the first third of this century, cleft lip and palate occurrences were calculated at approximately 1% in most countries. Because of a higher mortality rate, the percentage of these individuals in the living population was somewhat less. In 1939, the incidence in Denmark and many other countries was 1.5% and has continued to increase to 1.8% among children born in the Scandinavian countries. In the coming decades, a frequency of 1.5% of cleft lip and palate occurrences in the living population must be presumed. This figure will double in approximately 50 years. This increase is the result of a lowered mortality rate and statistical evidence of a percentage increase in cleft lip and palate newborn. (Harding)

Poradowska, W., and Jaworska, M., Etiology of bilateral cleft lip and palate. *Acta Chir. Plasticae*, 3, 175–176, 1963.

The patients were divided into two categories. Group I had bilateral cleft lip and palate and Group II, all other types of clefts. The analysis covered all patients seen between 1953 to 1961 and was composed of 51 in Group I and Group II. The

familial incidence in Group I (bilateral) was 21.6% and in Group II, 8.8%. The psychological factors were impressive, 47.1% in Group I and 35.7% in Group II. Other factors were also evaluated. The authors concluded that the majority of hereditary deformities are the result of the mutual effect of both genetic and non-genetic factors. The greater the hereditary sensitivity of the embryo to irregular influences of the internal environments of the mother, the greater the probability of extensive damage to its development. (Harding)

Jaworska, M., and Poradowska, W., Cleft lip and cleft palate: A summarized statistical survey. *Acta Chir. Plasticae*, 3, 181–186, 1963.

A higher percentage of males have cleft lip and palate and more females have cleft palate only. Combined cases were more common than cleft palate only. Unilateral cleft lip occurs more often on the left side. The results were similar to other reported material. Only 10.7% of the cases studied had a positive family history. Children with an isolated cleft lip or palate are not likely to have relatives affected with a type of cleft other than theirs. In 9.8% other anomalies were present. There are many noxious factors which may directly produce clefts or provide an abnormal environment. The author's work confirmed some other studies on non-genetic factors. A statistically significant higher percentage of mothers over 35 years had offspring with a cleft. Conception during the winter season also showed a higher incidence, probably because of a diet deficient in fresh fruits and vegetables. The author's findings tended to confirm other reports on genetic and non-genetic etiological factors in clefts. (Harding)

Holdsworth, W. G., Later treatment of complete double cleft. *Brit. J. plastic Surg.*, 16, 27–33, 1963.

The inevitable problems of function and appearance of the bilateral clefts such as

the narrow lip, hypoplastic premaxilla, short columella, and flat nostrils are pointed out by the author. He favors the soft tissue initial closure, accepting some of the deformity which it might leave in favor of a better molded dental arch. Gentle traction by the soft tissues on the premaxilla is preferred over the surgical repositioning for reasons of growth. After the age of four years, the procedure described by the author, consisting of cutting down the lip on both sides, dissecting the prolabium, joining muscle in the mid-line, trimming the vermillion, and narrowing of the nostrils, is carried out. Further work on the nasal tip is deferred for later in life. (Benavent)

Demjen, S., Flap operations for unilateral hare-lip. *Acta Chir. Plasticae*, 5, 23-34, 1963.

On the basis of 140 cases of unilateral cleft lip repair the author makes a comparative study of the two most popular flap methods of closure. In 60 cases the LeMesurier type of repair was done, and in 80 cases the Tennyson method was employed. In the author's opinion, the flap methods are far superior to the V-excision methods, such as the Mirault type. The preservation of the cupid's bow, a better looking, pouting lip, minimal tissue loss, and wider lips are definite assets of the Tennyson procedure. (Benavent)

Jolleys, A., and Savage, J. P., Healing defects in cleft palate surgery—the role of infection. *Brit. J. plastic Surg.*, 16, 134-139, 1963.

A study of the incidence of breakdown in 158 cleft palate patients is reported. A 4% total failure compares with studies reported by Rayner, Ivy, and Oldfield. The role of infection as the cause of breakdown is carefully analyzed. The authors conclude that in the presence of hemolytic streptococcus a repair of the palate is almost always doomed to failure. The oc-

currence of upper respiratory tract infection, post-operatively, need not be cause for concern except in the presence of hemolytic streptococcus or other oral or pharyngeal pathogens. A significant finding stressed in this work reveals that in the presence of an upper respiratory tract infection, even the less virulent pathogens may determine a breakdown rate five times greater than normal. (Benavent)

Stenström, S. J., and Thilander, B. L., Bone grafting in secondary cases of cleft lip and palate. *Plastic reconstr. Surg.*, 32, 353-360, 1963.

Iliac bone grafts were used in 16 unilateral and three bilateral cleft lip cases whose ages ranged from 14 to 31 years. Orthodontic arch correction was undertaken prior to grafting. Palatal and gingivolabial flaps were used for soft tissue coverage. Failure of healing occurred in two patients who didn't wear the retaining labial arch bar and prosthetic devices used to prevent the early collapse of the expanded maxilla. Ten cases were tested with the author's stability measuring device. Stability in the region of the graft was excellent. Instability in the transverse direction of the maxilla was present, however, although less than that in unoperated controls. (Crikelair)

Ryan, R. F., Longenecker, C. G., Krust, L., and Vincent, R. W., Anterior fixation of the tongue—A modification of the Douglas and Routledge techniques. *Plastic reconstr. Surg.*, 32, 318-321, 1963.

The authors have used a modification of standard operative techniques in the care of two infants with Pierre Robin syndrome. The method consisted of the suturing of a vertical midline tongue incision in transverse manner to a transverse labio-alveolar sulcus incision. The method reduces the amount of raw bleeding surface exposed and the hazard to the submaxil-

lary ducts encountered in the Douglas operation. Good use is made of the firm fibrous tissue of the midline of the tongue. The method is coupled with a circum-mandibular retention suture passed through lip and tongue. (Crikelair)

Stenström, S. J., and Thilander, B. L.,

An instrument for determining stability of the maxilla in cases of cleft lip and palate. *Plastic reconstr. Surg.*, 32, 348-352, 1963.

An instrument is described for administering stress in various directions and for registering consequent maxillary displacements in cleft lip and palate cases. (Crikelair)

Edgerton, M. T., and DeVito, R. V.,

Closure of palate defect by means of a hinged nasal septum flap. *Plastic reconstr. Surg.*, 31, 537-541, 1963.

The history of methods for the closure of hemipalatal defects resulting from maxillectomy which require an intact nasal septum and nasal crest articulation is reviewed. At the time of maxillectomy, the operative defect is dressed with a split thickness skin graft and the margins of the palatal defect are allowed to epithelize. Approximately three weeks following maxillectomy the cheek is reopened. The outline of the palatal defect is reproduced slightly oversized on the septum with the base of the proposed flap at the caudal septal margin. The full thickness of the septum is incised along this outline. The vertical septal flap is bent over to the side of the defect, appropriate buccal mucosal flaps are elevated about the defect's margin, and a double-layered closure per-

formed. A few mattress sutures are placed to incorporate septal bone and cartilage. The septum is stabilized by an antral pack for seven to 10 days and a nasogastric tube is left in place for one week. (Ashley)

Stellmach, R., Prosthetic replacement of

absent deciduous teeth for improvement of speech in children with cleft lip and palate. Preliminary report. *Deutsche Zeitschrift für Zahnheilkunde*, 18, 1000-1004, 1963.

In this preliminary report, the author calls attention to the fact that the absence or abnormal position of the incisors, as well as gaps in the anterior part of the dental arch—so frequently associated with cleft lip and palate—lead to incorrect positioning of the tongue and make the pronunciation of the tongue sounds difficult. These dental speech defects concern the consonants *f*, *v*, *d*, and *t*, but, primarily the various *s* sounds (*s*, *z*, *ch*), all of which are formed in the anterior part of the mouth. The most frequent dental articulation defects are, as was proven statistically, the disturbances in *s* sounds. They are usually considered as purely functional disturbances. However, organic changes, such as absence of incisors, do contribute to their development. This condition merits particular attention since it is present in children at the beginning of speech development. Therefore, the author has followed the suggestion of McNeill from Glasgow and has used prosthetic replacements in deciduous dentition specifically for improvement of speech. Large gaps in the anterior dental arch have been closed with removable dentures at about the age of five. (Schmid, translated by Lewin)

DISSERTATIONS AND THESES

Casso, T. F., Jr., An investigation of current therapeutic procedures in the speech rehabilitation of children with

cleft palate. M.S. Thesis, Southern Connecticut State College, 1962.

Foy, Margaret, Techniques and instru-

mentation for the assessment of velopharyngeal closure. M.A. Thesis, Stanford University, 1962.

Lyons, Theresa M., A comparative study of parents of cleft lip and physically normal children. M.A. Thesis, Northern Illinois University, 1962.

McDermott, R. P., A study of /s/ sound production by individuals with cleft palate. Ph.D. Thesis, State University of Iowa, 1962.

Meyerson, Marion, Pharyngeal flap and

its effect on cleft palate speech. M.A. Thesis, Brooklyn College, 1962.

Towey, Maureen, Methods for the evaluation of speech proficiency following secondary surgical procedures for cleft palate management. M.A. Thesis, Stanford University, 1962.

Van Denmark, D. R., Misarticulation and listener judgments of the speech of individuals with cleft palates. Ph.D. dissertation, State University of Iowa, 1962.

ANNOUNCEMENTS

The Program Committee announces that the 1964 Program is nearly complete. Time is still available, however, for films, exhibits, or table clinics. For information, write:

Ross H. Musgrave, M.D.
Suite 303
3600 Forbes Avenue
Pittsburgh, Pennsylvania 15213

The Nomenclature Committee announces that reprints of the article "A classification of cleft lip and cleft palate" (*Plastic reconstr. Surg.*, 29, 31, 1962) are still available. Requests for no more than 10 copies are filled at no charge; a rate of 10 cents per copy is assessed for numbers of copies in excess of 10. Orders should be sent to:

William R. Harkins, D.D.S.
Fulton Building
Osceola Mills, Pennsylvania

Copies of the paper-bound volumes reprinting the *Cleft Palate Newsletter* and *Bulletin* from Volumes I through VIII are available for \$7.50. Copies of Volumes IX, X, XI, and XII are \$4.00 per volume. Non-member subscriptions to Volume XIII are \$4.00. Orders should be sent to the Secretary-Treasurer, Dr. Charlotte G. Wells, 106 Parker Hall, University of Missouri, Columbia, Missouri 65202.

The Abstracts Committee is having difficulty in providing comprehensive coverage of current literature. To assist the members in their efforts, au-

thors are invited to either send reprints of recent publications for abstracting purposes in the *Cleft Palate Journal* or to send an abstract already prepared. Either should be sent to the Abstracts Editor:

Dr. Kenneth R. Lutz
School of Dentistry
Loma Linda University
Loma Linda, California

The Second Latin American Congress of Audiology and Phoniatrics is announced. The Congress will be held August 9 to 13, 1964, in Mexico City, and will include discussions on medical, teaching, and psychological aspects of speech and hearing. Inquiries about the Congress should be sent to:

Dr. Lucia O. de Flores
Colegio Hispanoamericano
Para El Estudio de Los Problemas de
La Audicion, La Voz y el Lenguaje
Av. Progreso 141-A
Mexico 18, D. F.

The Northwestern University Dental School announces the program of postgraduate courses, memorial lectures, and conferences for the 1963-1964 academic year. The postgraduate courses are designed primarily to enable the registrant to learn the currently accepted procedures and developments in dentistry. Enrollment is limited. Address all communications to:

Director of Dental Postgraduate School
Northwestern University Dental School
311 East Chicago Avenue
Chicago, Illinois 60611

The Morrisania City Hospital announces the establishment of an Oral Surgery Residency program to supplement its surgical internship beginning July 1, 1964. For information and application write:

Dr. Bernard M. Cohen
Director of Dentistry
Morrisania City Hospital
Bronx, New York

The University of Alabama School of Dentistry announces a three-year training program in Dental Radiology leading to a Master of Science de-

gree. Support for two qualified applicants at a stipend of \$5,000 per annum plus tuition charges is available through a National Institute of Dental Research training grant. Applicants are not restricted to those having a dental degree. Inquiries and applications should be addressed to Dr. Arthur H. Wuehrmann, University of Alabama Medical Center, School of Dentistry, Birmingham 3, Alabama. Individuals accepted into the program must be approved by both the School of Dentistry and the Graduate School of the University.

The University of Pennsylvania and the Lancaster Cleft Palate Clinic have announced that graduate fellowships in cleft palate therapy and rehabilitation, supported by the United States Public Health Service, are available to qualified applicants. Clinical training is offered at the Lancaster Cleft Palate Clinic, Lancaster, Pennsylvania. Graduate work in a basic science in connection with the clinical training is encouraged. The annual stipend is \$5,000 with annual increments and dependency allowances, and is tax-free. Address all inquiries to: Chairman, Committee on Traineeships and Fellowships, University of Pennsylvania, School of Dentistry, 4001 Spruce Street, Philadelphia 4, Pennsylvania.

The following professional meetings are announced:
 American Academy of Pediatrics, Spring Session, April 20 to 22, 1964 at Philadelphia.
 The American Association of Orthodontists, May 3 to 7, 1964 at Chicago.
 American Psychiatric Association, May 4 to 8, 1964 at Los Angeles.
 Societas Oto-Rhino-Laryngologica Latina, April 1 to 5, 1964 at Bologna, Italy.
 West Virginia Academy of Ophthalmology and Otolaryngology, April 15 to 18, 1964 at White Sulphur Springs, West Virginia.

Time and Place for Future ACPA Meetings

1964—April 30, May 1, and 2 Los Angeles at the Statler Hilton
 1965—May 20, 21, and 22 New York City at the American
 1966—Date not yet available Tentatively Mexico City

(Please note the corrected dates for the 1964 meeting. The previously given dates of April 29, 30, and May 1 were incorrect.)

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:

CHARLOTTE G. WELLS, PH.D.

Secretary-Treasurer

American Cleft Palate Association

Parker Hall, University of Missouri

Columbia, Missouri 65202