LETTERS TO THE EDITOR

Dear Sir:

In evaluating models of different genetic theories, pedigrees of families in which two individuals with clefts have married and had offspring could prove of great help. For example, with data presently available one currently popular genetic model predicts that two affected parents will produce ½–¾ cleft offspring. An equally feasible alternate model which also fits current data predicts a risk of less than ¼ in these matings. Even a relatively small sample of pedigrees would help decide between these alternatives and would help provide a basis for better genetic counseling in the future.

Queries to a number of agencies and institutions for habilitating cleft palate children have produced insufficient information. Therefore, if any readers of this journal have knowledge of such families that they are willing to share, I would very much appreciate being contacted by letter or phone.

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Dear Sir:

Recently I found in my files the material presented below. Someone sent it to me in about 1965. I had always meant to publish it in *CPJ* but somehow never got around to it. I still think it's funny and so I wanted to share it with the readers of *CPJ* now.

The point of the material, of course, is that professional and scientific writers tend sometimes to overstate the case!

WHAT THEY SAY . . . what they mean

IT HAS LONG BEEN KNOWN THAT . . . I haven't bothered to look up the original reference.

OF GREAT THEORETICAL AND PRACTICAL IMPORTANCE . . . interesting to me.

WHILE IT HAS NOT BEEN POSSIBLE TO PROVIDE DEFINITE ANSWERS TO THESE QUESTIONS . . . the project didn't work out, but I figured I could at least get a publication out of it.

SAMPLING PROCEDURE AND RESULTS: THREE OF THE SAMPLES WERE CHOSEN FOR DETAILED STUDY . . . the results on the others didn't make sense and were ignored.

TYPICAL RESULTS ARE SHOWN . . . the best results are shown.

THE AGREEMENT WITH THE PREDICTED CURVE IS EXCELLENT . . . fair; GOOD . . . poor; SATISFACTORY . . . doubtful; FAIR . . . imaginary.

IT IS SUGGESTED THAT . . . IT IS BELIEVED THAT . . . IT MAY BE THAT . . . I think.

IT IS GENERALLY BELIEVED THAT . . . a couple other guys think so too.

IT IS CLEAR THAT MUCH ADDITIONAL WORK WILL BE REQUIRED BEFORE A COMPLETE UNDERSTANDING . . . I don't understand it.

UNFORTUNATELY, A QUANTITATIVE THEORY TO ACCOUNT FOR THESE EFFECTS HAS NOT BEEN FORMULATED . . . neither does anybody else's.

CORRECT WITHIN AN ORDER OF MAGNITUDE . . . wrong.

WE ARE MAKING A SURVEY . . . we need more time to think of an answer.

WILL ADVISE IN DUE COURSE . . . if we ever figure it out, we'll let you know.

A STUDY IS BEING MADE . . . haven't done anything about it yet.

NOTE AND INITIAL . . . let's spread the responsibility.

UNDER CONSIDERATION . . . never heard of it.

UNDER ACTIVE CONSIDERATION . . . we are looking in the files for it.

The original reference apparently is *News of the Sanitary Engineering Division,* American Society of Civil Engineers, August, 1964.

In short, then, and to borrow some of the above terminology, we are making a survey to find out whether writers in our field show typical results or whether in actuality the findings are correct within an order of magnitude. It is clear that much additional work will be required before a complete understanding of the problem is achieved and a study is being made. We will advise readers in due course but right now it's under active consideration!

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BOOK REVIEWS

BOONE, DANIEL, *The Voice and Voice Therapy*. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1971. Pp. 241. $7.95.

Possibly no other speech pathology has associated with it the air of mystery, the dearth of scientific evidence, and the number of old wives' tales as do disorders of the voice. Voice problems and voice therapy have been an interest of many kinds of professional workers: from the psychiatrist, to the marriage counselor; from the laryngologist, to the singing teacher. Traditionally, the speech pathologist has used techniques from all these diverse sources and, although it's difficult to generalize, has been more or less successful in helping people change the way they generate the voice—the source of sound used in speech. Clinical success has seemed to be more highly related to variables which smack more of the arts, however, than of the sciences, and that is somewhat bothersome.

It's bothersome, of course, because we all need to be able to share experiences about patients in order to teach each other, and to be able to ask appropriate questions and to formulate hypotheses to gain additional information about the voice, voice disorders, and voice therapy.

It's also very bothersome when one has the responsibility for teaching clinicians in training about voice therapy because, if such therapy is considered an art, then methods of clinical practice must be related to a very great degree to the personality of the specific clinician, and no generalization to the problem is really possible. Personally I do not believe that.

And neither does Dr. Boone, the author of this text.

He has written an excellent text which will be of particularly great value in training programs. His thesis is that, "Most voice disorders are related to the misuse and abuse of the voice . . . " and that direct symptom modification can be used to eliminate and reduce those disorders. He does a detailed and remarkably clear job of describing the methods for modification and, more importantly, the rationales for those methods. (152 of the 233 pages in the text are devoted to diagnosis and therapy procedures!)

The division of material is as follows. Chapters One through Three include the general introduction; the philosophy of the approach; a review of the vocal mechanisms (respiration, phonation, resonance); and a description of the various disorders (dysphonias). Chapter Four deals with evaluation. Chapters Five through Eight contain detailed material for the clinical management of dysphonias; among them are vocal hyperfunction, functional aphonia, ventricular phonation, spastic dysphonia,

vocal cord paralysis, laryngectomy, and some other special problems (such as voice therapy for the deaf).

Of special interest to *CPJ* readers is Chapter Seven, which is written about what he calls *resonance* disorders. In general, the material in Chapter Seven is in accordance with current clinical practice. Boone differentiates clearly between the phenomenon of nasal resonance and that of nasal emission, and is of the opinion that nasal emission is really a phenomenon of articulation. His position about the management of physiological velopharyngeal incompetence is clear: physical management is needed if oral speech is to be achieved. His description of diagnostic observations is good and, as in other sections of the book, he outlines some procedures for behavioral modification.

I have a few small quarrels with the material in this Chapter: the section on oral-pharyngeal resonance problems seems a little far-fetched to me; I have always considered stridency to be a vibratory phenomenon, not a resonance trait; and so forth.

My major objection, however, is that he gives too much emphasis to the possibility of "functional" hypernasality (he frequently puts quotation marks around the word *functional*). It seems clear to me that "excessive" nasal resonance can be a trait of a specific dialect and, therefore, *learned* behavior. In my opinion, however, it is a mistake to assume that a phenomenon such as assimilated nasality is usually of functional (behavioral) origin or that some problems of functional nasality may be related to inappropriate tongue size or lingual innervation problems. Although the data are not all in, by any means, the preponderance of what data we have suggests (at least to me) that many of the nasality problems which were considered to be functional prior to 1960 may in reality be related to marginal or minimal deficits of palatal length or palatal mobility. If that is true, and I believe it is, then such "functional" nasality problems are not functional but physiological in nature.

The danger here is in creating a psychological set in the beginning speech clinician (or other kinds of clinicians in cleft palate work) that these marginal nasality problems really can be treated successfully by voice therapy. Granted that some of these patients can be taught to compensate for marginal velopharyngeal problems so effectively that at specific times they can demonstrate pretty good oral speech. But, in my experience, they cannot be taught to have *normally* oral speech all the time. The demands on the mechanism are simply too great.

In my opinion, then, Dr. Boone does not make clear enough the fact that, if speech therapy over a period of time is not optimally successful, the clinician must infer that the etiology of the problem is physiological and then proceed accordingly. She may assist the patient to compensate for the physiological deficit as best he can or she may refer the patient for physical management, but she certainly does not continue to regard the problem as functional. He says something to this effect on page 189,

but, in my opinion, the point does not emerge strongly enough against the background of functional nasality which he has described.

In summary, this text is a significant addition to the literature about voice and voice therapy. Dr. Boone writes very well and obviously speaks with considerable authority about his subject. Certainly, an outstanding contribution is made in those sections of the text in which he discusses therapy. Nowhere else, to my knowledge, is such material available in printed form. My chief complaint is his discussion about functional nasality and that may be a problem of semantics.

I recommend the book without reservation.

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VAN RIPER, CHARLES, *The Nature of Stuttering*. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1971. Pp. 454. $11.95.

This is an extraordinary book. It reflects an enormous amount of scholarly activity and insight. The author discusses other points of view besides his own, but clearly lets you know where he stands. The material is comprehensive and current. And the whole thing reads, for the most part, like a well-written adventure story!

Dr. Van Riper is of course very well known to speech pathologists for his prodigious contributions to the field of speech pathology in general and especially to the area of stuttering. He has all the professional and scholarly credentials for writing such an ambitious text (who indeed knows the nature of stuttering?) and he deploys them with great skill.

In this volume, he sought to assemble and organize most of the information concerning the nature of stuttering. (Apparently, there is to be a sequel to this text, called *Stuttering: Its Treatment*.) He has written about many aspects of stuttering in this text: the definition of stuttering, prevalence and incidence of the problem, the onset and development, phenomenology, severity, stuttering as a neurosis and as learned behavior, the organicity of stuttering, and, finally, and importantly, he has made an attempted synthesis of the available information about the problem.

His synthesis is important, because it represents the current thinking of a clinician-teacher-researcher who has spent many years with the problem of stuttering. His synthesis is fascinating ("a disorder of timing") because it seems to incorporate aspects of several theories of stuttering any one of which he is disinclined to accept. It is, then, an eclectic synthesis, in many ways. He speaks of "motoric facility"' (organicity), variability in the adult stutterer (learned behavior), and the effect of masking to reduce stuttering (auditory feedback).

He concludes by saying that his attempt at a synthesis is far from adequate, but I don't think that many readers of his volume will agree.

To the contrary, his synthesis seems so right, in light of the evidence, that I predict it will become a major theoretical statement about the nature of stuttering in current speech pathology literature.

Anyone interested in the problem of stuttering, from either the layman's or the professional's point of view, will find this new text interesting and informative. Certainly, no clinical speech pathologist's library will be complete without it.

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ABSTRACTS

Aduss, H., S. Pruzansky, & Marilyn Miller, Interorbital distance in cleft lip and palate. *Teratology, 4,* 171–181, 1971.

The bony interorbital distance (BIOD), as a measure of orbital hypertelorism, was determined for 285 children representing the major categories of cleft lip and/or cleft palate. The BIOD was measured on longitudinal postero-anterior roentgencephalograms from 6 months to 16 years. There were no significant differences in BIOD between the males and females with complete unilateral and complete bilateral cleft lip and palate or between the combined cleft samples. The BIOD was increased more in those with cleft lip and cleft lip-cleft palate than in those with only cleft palate. Although patients with clefts had an increased BIOD, in most cases the increase did not exceed 1 SD of that reported for a control group. In unoperated infants no association was found between increased BIOD and the width of the cleft or palate at the level of the maxillary tuberosities. This finding suggested that the BIOD may reflect abnormal development in the nasofrontal process,

which also affects the lip but does not include the palatal shelves. Finally, it is suggested that the BIOD is a relevant developmental variable with a threshold character in the etiopathogenesis of cleft lip and cleft lip-cleft palate. (Authors' Summary: Lass)

Bakamjian, V. Y., M. Long, & B. Rigg, Experience with the medially based deltopectoral flap in reconstructive surgery of the head and neck. *Brit. J. of Plas. Surg., 24,* 174–183, 1971.

The medially based deltopectoral skin flap is described in detail. Uses of the flap are discussed. Included is a description of the high reach of the flap into the nasopharynx to reconstruct the posterior oropharyngeal wall after removal of a carcinoma. (Lass)

Beasley, J. W., & J. B. Gregg, Single stage repair of a median cleft lip in an infant with premaxillary agenesis. *South Dakota J. of Med., 24,* 15–23, 1971.

The authors have described a case with premaxillary agenesis which lived causing a nursing problem. To expedite feeding, a single stage surgical repair of the defect was devised so as to close the lip defect and at the same time reconstruct the columellar portion of the nose. The operation was a success, but the patient died. The surgical technique outline may have potential in the future for reconstruction of nasal columellar defects. (Gregg)

Bell, R. C., A child with two tongues (oral-facial-digital syndrome). *Brit. J. of Plas. Surg., 24,* 193–196, 1971.

This paper describes a case of a male born with two tongues and a cleft palate. A description of the surgical procedures employed is also included. (Lass)

Black, F. O., I. Sando, J. A. Wagner, & W. G. Hemenway, Middle and inner ear abnormalities, 13–15 (D_1) Trisomy. *Arch. of Oto., 93,* 615–619, 1971.

The authors have reported a case and discussed primarily the ear findings in an instance of Trisomy D_1 or Patau's syndrome. In this instance there were bilateral cleft lip and palate, a shortened but otherwise well formed organ of Corti which was situated in a distorted and incompletely developed bony cochlea, frontal hemangioma, arrhinencephalic profile, low set pinnae, loud systolic cardiac murmur, bilateral undescended testes, supernumerary digits, and bilateral simian palmar creases. (Gregg)

Blakeley, R. W., & D. R. Porter, Unexpected reduction and removal of an obturator in a patient with cleft palate paralysis. *Brit. J. of Dis. of Comm., 6,* 33–36, 1971.

A 9.9 year old boy having palatal paralysis and pharyngeal weakness with accompanying hypernasality and misarticulation, successfully wore a speech obturator (prosthesis). Subsequently, this was systematically reduced in size and removed from the mouth in three and one-half years without detrimental effect on voice or articulation. The pharyngeal muscles apparently compensated enough with the help of the obturator to make up virtually all of the original palatopharyngeal gap. This case report emphasizes the need for further study of obturator reduction, not only in post-surgical cleft palate, but in a variety of cases of palatal insufficiency. Some limitations for obturator use are lack of parental cooperation, poor oral hygiene, and grave limitations of the patient to cooperate. (Authors' Summary: Lass)

Calnan, J. S., Permanent nasal escape in speech after adenoidectomy. *Brit. J. of Plas. Surg., 24,* 197–204, 1971.

The author reviews the case histories of 19 patients in whom adenoidectomy had

produced disturbances in speech due to the permanent nasal escape of air. He provides clinical histories, results of cephalometric investigation, intelligence of the patients, and surgical treatment to improve their speech. (Lass)

Carroll, D. B., R. A. Peterson, E. W. Worton, & L. M. Birnbaum, Hereditary factors in the Pierre Robin syndrome. *Brit. J. of Plas. Surg., 24,* 43–47, 1971.

Nine family histories of children with the Pierre Robin syndrome have been presented, demonstrating a hereditary background present in these families. These hereditary patterns do not follow the patterns for cleft lip (with or without cleft palate) and solitary cleft palate. (Authors' Summary: Lass)

Chong, J. K., & R. B. Winslow, Simple technique for correction of "whistling" deformity in repaired cleft lips. *Plastic and Reconstructive Surgery, 48,* 84–85, 1971.

The use of free composite submucosal-muscle grafts taken from the redundant lateral segments of a bilateral cleft lip with central whistle tip deformity for the bolstering of the whistle area is presented. Satisfactory improvement in contour from both the frontal and profile view is claimed. (Cosman)

Dieffenbach, J. F., Contributions on suture of the palate and on the soft palate of human beings and of mammals. *Plastic and Reconstructive Surgery, 47,* 588–591, 591–593, 1971.

These are classic reprints of two of Dieffenbach's contributions to cleft palate surgery as translated and commented upon by Dr. Eduard Schmid. The reprints contain Dieffenbach's proposal for uranoplasty and the description of relaxing incisions. (Cosman)

Dishotsky, N. I., W. D. Loughman, R. E. Mogar, & W. R. Lipscomb, LSD and genetic damage. *Science, 172,* 431–440,

The authors have presented a lengthy discussion accompanied by a generous bibliography relating to the subject of LSD and its chromosome damaging properties, carcinogenetic aspects, mutagenicity, and teratogenecity. After a review of all of the evidence available they concluded that from their work and the review of the literature, "pure LSD ingested in moderate doses does not damage chromosomes in vivo, does not cause detectable genetic damage, and is not a teratogen or carcinogen in man." They suggest that other than during pregnancy there is no present contraindication to the continued use of pure LSD in controlled experimental situations. (Gregg)

Duffy, M. M., Restoration of orbicularis oris muscle continuity in the repair of bilateral cleft lip. *Brit. J. of Plas. Surg., 24,* 48–56, 1971.

The author emphasizes the importance of the restoration of orbicularis oris muscle continuity in the repair of cases of bilateral cleft lip. He discusses the cosmetic and functional defect of failure to restore the continuity of this muscle, anatomy and morphogenesis of this muscle, previous approaches to repair of bilateral clefts, and his suggested approach to restoring continuity of the orbicularis oris muscle. (Lass)

Fara, M. D., Congenital defects in the hard palate. Observation of five cases. *Plastic and Reconstructive Surgery, 48,* 44–47, 1971.

Five cases are presented with defects of the hard palate without overt clefts of the soft palate. All cases proved on close inspection to represent submucous clefts of the uncleft portion. Accordingly, the author concurs with Veau in feeling that

these cases represent the antenatal rupture of the anterior portion of the submucous cleft palate. (Cosman)

Furnas, D. W., & G. W. Fischer, The Z-plasty: biomechanics and mathematics. *Brit. J. of Plas. Surg., 24,* 144–160, 1971.

The biomechanics and mathematics of many different Z-plasties constructed on flat surfaces in dogs are discussed. The observations included the following: (1) Z-plasties of different sizes; (2) serial Z-plasties differing in number and size of flaps but equal in length; (3) Z-plasties with differing tip angles; (4) asymmetrical Z-plasties; (5) field strain; (6) distortion of tip angles and limb lengths; (7) Z-plasties on webs; (8) single vs. serial Z-plasties on a web; (9) measured lengthening vs. predicted lengthening; (10) tension related curves; and (11) Z-plasty mathematics. (Lass)

Hook, E. B., Monitoring human birth defects and mutations to detect environmental effects, Report of a meeting, *Science, 172,* 1363–1366, 1971.

This is the report of the first annual symposium of the Birth Defects Institute of the New York State Health Department, held in October 1970. The main concern at the conference was methods for detecting increases in background rates of birth defects or mutations. The main thrust was to attempt to find methods for systematically monitoring rates in human populations so that the effect of new occult teratogens or mutagens in the environment can be detected more quickly. Various methods for accumulating these data which were discussed included: study of human embryos; evaluation of major common malformations in liveborns; the use of fresh dominant cases of multiple congenital malformations (syndromes such as Apert's syndrome or achondroplasia as sentinel phenotypes); death certificates; the use of surveillance programs utilizing birth, stillbirth and death certificates on a provincial basis; computerized hospital records; systematic review of hospital records; biochemical approach to monitoring mutations; large scale monitoring of chromosomal breakage in human population; and histochemical methods to monitor somatic cell variants. (Gregg)

Hsu, L. Y. F., M. Barcinski, L. R. Shapiro, E. Valderrama, M. Gertner, & K. Hirschorn, Parental chromosomal aberrations associated with multiple abortions and an abnormal infant. *Obstet. Gynec., 36*(5), 723–730, Nov. 1970.

A cytogenetic study revealed a number of chromosomal aberrations in a family with a history of fetal wastage and a number of congenital anomalies in a female child. There had been three first trimester abortions and one stillbirth, all of which occurred within a three-year-period. The female infant of low birth weight was born to phenotypically normal parents after approximately 32 weeks of gestation. Librium had been taken during the third month of gestation. The mother and father were 25 and 27 years of age, respectively. Examination of the infant revealed bilateral cleft lip and palate, low-set ears, asymmetrical chest, a precordial systolic murmur, and minor dermatoglyphic abnormalities. Autopsy showed some gross visceral anomalies. The infant's sex chromatin was normal. The mother and infant had a pericentric inverstion of a No. 2 chromosome in all the metaphases and increased frequencies of chromatid and chromosome breaks. The father was a mosaic for trisomy D, 46, XY/47, XY, D+. The infant also had a B ring in some cells and partial deletion of the long arm of a B chromosome in other cells. While the ring B chromosome was not specifically identified, the clinical features of the infant appear to be more similar to the midline fusion defects seen with short arm

deletion of No. 4 than to the cri-du-chat syndrome associated with the short arm deletion of No. 5 (15 references) (This abstract is from *Birth Defects: Abstracts of Selected Articles*. The National Foundation-March of Dimes, 7(12), Dec. 1970, abstract number 70-1030).

Hurley, Lucille S., Jean Gowan, & Helene Swenerton, Teratogenic effects of short-term and transitory zinc deficiency in rats. *Teratology, 4,* 199–204, 1971.

When female rats were fed a zinc-deficient diet during pregnancy (days 0 to 21), impaired reproduction and a high incidence of congenitally malformed offspring resulted. One of the malformations observed in some of the offspring was cleft palate. (Lass)

Kasirsky, G., & M. F. Tansy, Teratogenic effects of methamphetamine in mice and rabbits. *Teratology, 4,* 131–134, 1971.

The authors report the results of studies on the teratogenic effect of methamphetamine hydrochloride, an analogue of dexamphetamine sulfate. This agent was studied because of its current use as an "abuse" drug, commonly referred to as "speed." Among the anomalies occurring in the offspring of rabbits and mice who were given methamphetamine hydrochloride was cleft palate. (Lass)

Kernahan, D. A., The striped Y-A symbolic classification for cleft lip and palate. *Plas. reconstr. Surg., 47,* 469–470, 1971.

The author describes his method of conveniently classifying cleft deformities by considering the crossing of the Y to represent the incisive foramen with a right and left limb divided each into 3 portions representing respectively lip, alveolus and area between alveolus and incisive foramen and with the stem of the Y similarly divided into 3 portions. Each individual patient can be diagrammatically represented by stippling appropriate areas of clefting. By assigning numbers to the striped Y's segment, classification and retrieval of information can be achieved with ease. (Cosman)

Khoo Boo-Chai, Three surgical instruments for cleft lip/palate repair. *Brit. J. of Plas. Surg., 24,* 216–217, 1971.

Three surgical tools for use in the cleft lip/palate repair are described. They include: (1) double-angled scissors; (2) pen-holder grip needle holder; and (3) the combined elevator and bow-knife. (Lass)

Kirchner, F. R., & G. O. Proud, Speech problems in children. *Mod. Med., 39,* 109–114, May 17, 1971.

This article is a brief overview of some of the characteristics of disordered speech development. Emphasis is given to a few of the pulmonic and laryngeal defects which may account for certain dysphonias. The authors mention possible organic and functional causes of articulatory defects, and they refer to the importance of good velopharyngeal function. The role of normal hearing on speech development and the consequence of impaired hearing is described. There are several colored illustrations included. (Noll)

Kriens, O. B., Traumatic cleft lip. *Brit. J. of Plas. Surg., 24,* 69–70, 1971.

A case report of a cleft lip resulting from a trauma in a 12-year-old male is described. (Lass)

Lewis, Ruth, Survey of the intelligence of cleft-lip and cleft-palate children in Ontario. *Brit. J. of Dis. of Comm., 6,* 17–25, 1971.

The intelligence of a total of 558 children with cleft lip and/or palate in Ontario was examined. It was found that: (1) the cleft lip and/or palate group dif-

fered from the general population in intelligence; (2) the children with clefts differed in intelligence from their siblings; and (3) multiple causes, rather than one single cause, may account for these differences in intelligence. (Lass)

Massengill, R., Viola Willis, Linda Fertner, & Judy Fetterolf, Documentation of syndactyly and Treacher Collins syndrome for possible concomitant speech disorders. *Brit. J. of Dis. of Comm., 6,* 45–51, 1971.

The speech characteristics of four syndactyly patients and five Treacher Collins patients are described. Each patient was given a battery of tests including X-ray analysis, articulation tests, a diadochokinetic rate analysis, to evaluate the speech proficiency and the functioning of the peripheral speech mechanism. Because of the wide range of associated defects, many involving the speech mechanism, often accompanying these two congenital anomalies, this study does indicate that such cases should be seen and studied by the speech pathologist. (Authors' Summary: Lass)

McEvitt, W. G., Conversion of an inferiorly-based pharyngeal flap to a superiorly-based position. *Plastic and Reconstructive Surgery, 48,* 36–39, 1971.

The author reports on his personal performance of pharyngeal flaps in 207 patients including 117 with previously repaired cleft palates and 90 on patients with submucous clefts. His impression is strong that superiorly-based flaps are better than inferiorly-based flaps and he actually had instances of inferiorly-based flaps which resulted in poorer speech than that preoperatively. A technique for the revision of an inferiorly-based flap recreating it as a superiorly-based flap is presented and diagrammed. (Cosman)

McWilliams, Betty J., & R. H. Musgrave, Diagnosis of speech problems in patients with cleft palate. *Brit. J. of Dis. of Comm., 6,* 26–32, 1971.

The authors consider diagnostic procedures of utmost importance in cases where acceptable speech is not attained through surgery alone. They discuss some of the problems encountered in diagnosis of the causes of speech problems in cleft palate cases. Their discussion includes assessment of language function, consonant articulation skills, and voice quality and its relationship to the velopharyngeal valving mechanism. (Lass)

Medical News Section, Lively debate breaks out over plastic surgery techniques. *J. of Amer. Med. Assn., 216,* 2075–2082, 1971.

This is a report of two papers and the discussion which followed their presentation at the meeting of The American Association of Plastic Surgeons. Under discussion were two techniques for the construction of posterior pharyngeal palatal flaps to correct the speech of cleft palate patients. The first paper which was presented by V. M. Hogan, M.D., of New York University Medical Center was a discussion of a technique to eliminate velopharyngeal incompetence using lateral port control flaps. The second presentation was by C. L. Zahorsky, M.D., from the Children's Mercy Hospital, Kansas City, Mo., and was a discussion of a bipedicle, chevron-shaped pharyngeal flap. The Editor of the Journal reports that the discussion of these two papers was spirited. Excellent schematic diagrams illustrate this report. (Gregg)

O'Driscoll, P. M., Ostectomy at the midline of the mandible. *Brit. J. of Plas. Surg., 24,* 71–77, 1971.

Treatment of an individual with gross Class III malocclusion is described. Ostectomy at the midline of the mandible com-

bined with dento-alveolar surgery is discussed. (Lass)

Pannbacker, Mary, Language skills of cleft palate children: a review. *Brit. J. of Dis. of Comm., 6,* 37–44, 1971.

This paper reviews the literature on language skills and the etiology of delayed language development in cleft palate children, and provides some theoretical speculations concerning these findings. (Lass)

Robertson, N. R. E., & R. Hilton, The changes produced by pre-surgical oral orthopedics. *Brit. J. of Plas. Surg., 24,* 57–68, 1971.

Pre-surgical oral orthopedic preparation of the mouth of newborn infants with orofacial clefts is discussed in detail. The instrumentation and current procedures are described. The authors also present summaries of five cases involving treatment of the cleft by means of oral orthopedics. (Lass)

Schrudde, J., The influence of primary osteoplasty on the treatment of patients with clefts of the lip, palate and jaw. *Brit. J. of Plas. Surg., 24,* 189–192, 1971.

The authors offer evidence for their belief that primary bone grafting has a stimulating influence on the future development of the upper jaw. (Lass)

Shirley, W. L., & W. M. Cocke, A nursing device for use in cleft palate care. *Plastic and Reconstructive Surgery, 48,* 83, 1971.

A nursing bottle with ball valve opening has been shown to be advantageous in the nursing of a child with cleft palate. It has the advantage of allowing the infant to self regulate the flow of milk. (Cosman)

Singh, R. P., N. T. Jaco, & V. Vigna, Pierre Robin syndrome in siblings. *Amer. J. Dis. Child., 120(6),* 560–561, Dec. 1970.

A study is presented of a family in which two brothers who are the only children, exhibited the Pierre Robin syndrome. The older brother and the father, also carried a chromosome anomaly. The proband, the younger sib, was born at term after an uneventful pregnancy. The mother and father were 34 and 35 years of age, respectively. The infant experienced marked respiratory distress immediately after birth. He had a cleft posterior two-thirds of the hard palate, and a small jaw typical of the Pierre Robin syndrome. The palate was repaired at one year of age. The eight-year-old brother had surgical repair of the palate at one year. Both brothers are of normal intelligence. The proband and the mother were found to have normal karyotypes. The older brother and the phenotypically normal father had an unusual member of the A group, which was interpreted as a pericentric inversion in a No. 2 chromosome. The chromosome anomaly appears to be unrelated to the Pierre Robin syndrome. So far, the abnormal chromosome appears to have no deleterious effect on the son. There was no relevant family history; dermatoglyphics were normal. (4 references) (This abstract is from *Birth Defects: Abstracts of Selected Articles.* The National Foundation-March of Dimes, *7*(12), Dec. 1970, abstract number 70-1073).

Smith, N., Suture of the palate. *Plastic and Reconstructive Surgery, 48,* 61, 1971.

This is a classic reprint of the article by Nathan Smith, Professor of Surgery at Yale College relating the first or one of the first cleft palate procedures performed in the Americas. (Cosman)

Solomon, L. M., D. Fretzin, & S. Pruzansky, Pilosebaceous dysplasia in the oral-facial-digital syndrome. *Arch. Derm., 102,* 598–602, December, 1970.

The clinical features of eight female patients with the oral-facial-digital (OFD) syndrome, including a description of the skin and its histological and pharmacological characteristics are described. The OFD syndrome is characterized in part by a cutaneous dysplasia which includes a marked diminution in sebaceous glands, some decrease in hair follicles, and early keratinous cyst formation, which may represent maldevelopment of the pilosebaceous unit. (Authors' Summary)

Stevens, A. H., Staphyloraphe, or palate-suture, successfully performed. *Plastic and Reconstructive Surgery, 48,* 61, 1971.

This is a classic reprint of an article by Dr. Stevens who performed one of the first cleft palate closures in America approximately 8 years after Roux's paper had appeared in Paris. It is a model case report. (Cosman)

Sullivan, G. E., & Eva Takacs, Comparative teratogenicity of pyrimethamine in rats and hamsters. *Teratology, 4,* 205–210, 1971.

When single oral doses of 5 mg. pyrimethamine, a drug used in the treatment of toxoplasmosis, were given to pregnant rats, about 70 percent of the rat fetuses were killed or malformed. A very frequent anomaly observed in the fetuses was cleft palate. However, in hamsters, less than 10 percent of the fetuses died or were malformed after administration of single doses of 20 mg. of pyrimethamine to the mother. (Lass)

Swenerton, H. & L. S. Hurley, Teratogenic effects of a chelating agent and their prevention by zinc. *Science, 173,* 62–63, 1971.

If ethylenediaminetetraacetic acid was fed to female rats during the interval 6 to 21 days of gestation, all of the full-term offspring had gross congenital malformations, provided the mothers were fed a diet which was low in zinc (100 ppm). Severe brain malformations were found in 44%; 57% had cleft palate or malformed digits; and nearly all had clubbed feet or malformed tails. When the mothers were fed a diet containing 1000 ppm of zinc at the time of feeding EDTA, none of these abnormalities appeared. The authors feel that their studies have showed that Na_2EDTA ingested during pregnancy was teratogenic but that the teratogenicity was prevented by a diet supplemented by zinc. They feel that this is important because with the increases in environmental metal-binding substances, such as EDTA or zinc antagonists such as cadmium, both of which may induce zinc deficiency, there may be interference with fundamental processes in which trace elements play an essential role. (Gregg)

Swindler, D. R. & E. M. Merrill, Spontaneous cleft lip and palate in a living nonhuman primate, Macaca mulatta. *Amer. J. of Phy. Anth., 34,* 435–439, 1971.

Insofar as the authors have been able to determine, there have been reported three cases of cleft lip and palate in subhuman primates, all dead. They feel that this is the first instance of such defect in a living nonhuman primate. The defect extends from the uvula to the incisive foramen and on into the lip on the right side, similar to the complete unilateral cleft found in man. Photographs of the monkey and dental casts are presented. It is the authors' plan to breed this monkey and to study longitudinal growth and development of the cephalofacial, dental complex. (Gregg)

Uchida, J. I., A new approach to the correction of cleft lip nasal deformities. *Plas. reconstr. Surg., 47,* 454–458, 1971.

The author describes his technique of combining incisions within the cleft side

nasal cartilage together with Z-plasty within the vestibule skin and alar rotation together with suspension of the cleft side cartilage to the opposite side of the nose. These procedures are diagrammed and the results evaluated. (Cosman)

von Graefe, K. F., The palate suture. A newly discovered method to correct congenital speech defects. *Plas. reconstr. Surg., 47,* 488–492, 1971.

This is a partial translation and interpretation of the classic article by von Graefe in which he lay down principles of treatment which remain valid to this day. (Cosman)

Walden, R. H., R. D. Logosso, & L. Brennan, Pierre Robin syndrome in association with combined congenital lengthening and shortening of the long bones. *Plastic and Reconstructive Surgery, 48,* 80–82, 1971.

A case of Pierre Robin syndrome with unique association with congenital shortening of the humerus and femur and lengthening of the radius and tibia is presented and discussed. (Cosman)

Wright, T. L., L. H. Hoffman, & J. Davies, Teratogenic effects of lithium in rats. *Teratology, 4,* 151–156, 1971.

Lithium, a drug used for the treatment of mania and other states of psychomotor excitement in human beings, was administered intraperitoneally to pregnant rats. Upon examination of the fetuses, it was found that the malformations which resulted were almost exclusively cranial in location, primarily affecting the eye, external ear, and palate. The percentage of occurrence of cleft palate in the fetuses varied from 26 to 50 percent, depending on the day of initial injection of the drug. (Lass)

Zeitzer, L. D., & R. C. Lindeman, Multiple branchial arch anomalies. *Arch. of Oto., 93,* 562–567, 1971.

The authors have presented a single case, have described the anatomical-pathological findings in a case, and have concluded, "Multiple branchial arch anomalies consisting of bilateral microtia, external meatal atresia, complete cleft palate, and mandibular ankylosis may be explained by arrest in fetal development at six to eight weeks. Involvement of the distal branchial arches at this time in fetal development may result in malformations in the laryngeal cartilages. Failure of peripheral facial nerve formation of cochlear anomalies may be associated with these branchial arch anomalies, although they are of different embryologic origin." (Gregg)

ANNOUNCEMENTS

1972 ANNUAL MEETING AMERICAN CLEFT PALATE ASSOCIATION

TO MEMBERS OF THE AMERICAN CLEFT PALATE ASSOCIATION:

The 1972 Annual Meeting of the American Cleft Palate Association will be held April 13–15, 1972 in Phoenix, Arizona, at the Towne House. Therefore, please be advised that this is the formal request of your Program Committee for the submission of all abstracts of papers, motion pictures, table clinics and demonstrations to be considered for presentation at the Phoenix meeting. You are cordially invited to participate.

The following information is included for your use and careful consideration in preparing proposals for presentation.

PAPERS: Summaries of contributed papers must be between 300 and 600 words in length. Each summary must be accompanied by an abstract of not more than 75 words. The summary of 300–600 words will be used by the Program Committee in making the selection of papers. The 75 word abstract will appear in the printed Program of the Convention. Summaries of research should include, where appropriate, a statement of the problem, procedures, and results.

Each summary and its accompanying abstract must be in sextuplet, double spaced on 8½″ x 11″ typing paper. The purpose is to expedite the work of the Program Committee. Each submitted paper must include a cover page on each of the six copies submitted. The cover page must follow this form:

Title: (of paper)

Author's Name: (For multiple authors, list first the speaker who will present the paper.) Give the following information for each author: Institution (name, location, specific office address); home address (house number, street, city, state, zip code).

Degree: (Highest degree held)

Member or Non-Member of ACPA.

Time Required: (Requests for more than 10 minutes for a paper should be accompanied by justification. The final allotment of time will be made by the Program Committee.)

Equipment required: (Standard equipment available will consist of the following items: a blackboard, a pointer, a single microphone, a 2 x 2 slide projector and a 3¼ x 4 slide projector. If any specialized audio-visual equipment is needed, i.e., equipment other than the five items listed above, it must be identified and justified. The acceptance of your paper may depend, to some degree, upon the total rental cost to the Association of specialized audio-visual equipment requested. NOTE: This is the only request for audio-visual and other equipment needs you will receive.

MOTION PICTURES: A brief abstract with running time, size of film, and whether or not it has sound.

TABLE CLINICS AND DEMONSTRATIONS: A brief abstract, amount of floor

or table space required, number of chairs, electrical requirements, and other special needs. The Association will pay for the basic needs of setting up such materials. All other expenses must be underwritten by the clinician.

The *deadline* for the submission of all abstracts for presentations of any type is December 1, 1971. These should be sent to the Chairman of the Program Committee. Authors or clinicians whose papers, films, or clinics have been selected for inclusion by the Program Committee, will be notified in January, 1972.

At the time of presentation, all papers should be in final form for publication in the *Cleft Palate Journal* subject to acceptance by the Editorial Board.

The 1972 Program Committee:

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WILLIAM TRIER, M.D.
MALCOLM JOHNSON, D.D.S., Ph.D

Early Treatment of Cleft Lip and Palate

NOW AVAILABLE . . . are the proceedings of the Second International Symposium, Cleft Lip and Palate Institute, Northwestern University Dental School, April 19–20, 1969. The proceedings, edited by Richard M. Cole, Ph.D., present a follow-up to the first International Symposium, held in Zurich, Switzerland in 1964, by Dr. Rudolph Hotz. Among the topics discussed in the proceedings are: Early Infant Orthopedics, Primary Bone Grafting, Maxillary Rapid Expansion, and Standardized Record Keeping and Nomenclature.

Copies of "Early Treatment of Cleft Lip and Palate" are available at $6.00 per copy. Orders should be sent to Northwestern University, Cleft Lip and Palate Institute, 311 East Chicago Avenue, Chicago, Illinois 60611.

International Prosthodontic Congress Meets in Las Vegas, Nevada October 26–28, 1972

The International Prosthodontic Congress will be held October 26–28, 1972. The meeting place this year will be the Las Vegas Hilton, Las Vegas, Nevada. The host for the meeting is the American Prosthodontic Society in cooperation with the Federation of Prosthodontic Organizations.

Florida Cleft Palate Association Meeting to be held January 21–22, 1972

The Annual Convention of the Florida Cleft Palate Association will be held at the Manger Motor Inn at Tampa, Florida, on January 21 and 22, 1972. The theme of the meeting will be, "Changing Concepts in the Management of Cranio-Facial Anomalies".

Guest speakers will include John W. Curtin, M.D. of Chicago, Illinois and the Honorable Emmett Roberts, Secretary of the Department of Health and Rehabilitative Services for the State of Florida. The program also will feature demonstrations and contributed papers. Further information regarding the program can be secured by contacting Robert J. Harrison, Ph.D., 446 Alhambra Circle, Coral Gables, Florida 33134.

Two New Training Programs in Dentistry and Speech Science-Speech Pathology

The University of Iowa announces the initiation of two new training programs in dentistry and speech science-speech pathology. The program is supported, in part, by training grant awards from the National Institute of Dental Research, in the amount of $545,000.

One program of study will train students in a combined curriculum that will lead to a D.D.S. degree, a M.S. degree in a specialized dental field, and the Ph.D. degree in speech science. The program will require approximately seven years of study. Co-directors of the program are Dr. Donald J. Galagan, dean of the College of Dentistry, and Dr. Kenneth L. Moll, chairman of the Department of Speech Pathology and Audiology.

The second program of study provides for the preparation of predoctoral students in speech science-speech pathology and postdoctoral fellows in dentistry or speech science-speech pathology for academic careers in the two disciplines. The specific purpose is to acquaint students in each of the two disciplines with the other discipline, to encourage them to develop a research interest in the area of oral function, and to encourage them to pursue careers directed toward furthering a productive working relationship between dentistry and speech science-speech pathology. The director of the program is Dr. Hughlett L. Morris, professor of speech pathology.

Applications for admission to either program are being accepted now. Inquiries about either program should be addressed to Dean Donald J. Galagan, College of Dentistry, The University of Iowa, Iowa City, Iowa 52240.

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