BOOK REVIEWS

MACHIDA, JUNJI, *Cleft Lip and Cleft Palate: Bibliography.* Osaka, Japan: Nagai Shoten, 1973. Pp. 284. $15.00.

It is no understatement that these days the major problem faced by a clinician/scientist working in the field of cleft palate-orofacial disorders is in not being able to keep abreast with the literature. Like the weather, everybody talks about this problem but few do anything about it! Dr. Machida (a Japanese dentist-speech scientist) has done something about it.

This is a masterful job of preparation. It contains a very large number of references (about 10,000!) which have been categorized into 13 sections. Some examples of the section headings: development, statistics and genetics, cleft lip surgery, cleft palate surgery, anesthesia, and so forth. In each section, references are listed in alphabetical order by first named author.

Coverage appears to be rather comprehensive. In leafing through the text, I noted references published in journals and text books from Japan, Europe, North and South America, India and the Philippines. In addition, I noticed a few theses and dissertations. In general, the reference is presented in the original language although some titles (apparently mostly European ones) have been translated to English. Japanese titles are not translated to any other language and so, even though the compilation of Japanese literature is now available to the world-wide community, the listings will not be useful without translation. I hope that Dr. Machida will attempt to provide some translations in the next edition of the volume.

A genuine concern with bibliography sources such as this is the accuracy with which the material appears to have been collected. It's difficult to estimate that but, as a very superficial check, I compared 10 listings from this volume with original publications. Of the 10, I found one error in year of publication and one error in the reading of the title. Both errors could have occurred by chance, of course, but the finding suggests that users may want to check original source carefully for accuracy of listing before including a listing in another bibliography.

In summary, this is a very useful volume and I commend it to clinicians/researchers in the area of cleft palate and associated problems.

(Note: presumably, orders for this volume could be placed with Dr. Machida as well as with the publisher. Dr. Machida's address: Depart-

ment of Oral and Maxillo-facial Surgery, Osaka University Dental School, Joan-cho, Kita-ku, Osaka, Japan.)

HUGHLETT L. MORRIS, PH.D.

The University of Iowa

SPRIESTERSBACH, D. C., POWERS, GENE R., and associates, *Psychosocial Aspects of the "Cleft Palate Problem."* Vol. I, by D. C. Spriestersbach, pages. Vol. II, by D. C. Spriestersbach, Gene R. Powers and associates, 320 pages. University of Iowa Press, Iowa City, Iowa, 1973. Hardback. Price $12.50.

Volume I first identifies the "Cleft Palate Problem" and the related psychosocial problems. Personal attitudes and evaluations are obtained from 175 sets of families with children with clefts and their matched controls. The children varied in age through 15 years.

Perceptions considered were immediate reactions, etiology, feeding, general health, physical management of the cleft, social development, school history, speech aspects, and others.

The studies make available new data on the psychosocial aspects of the "Cleft Palate Problem" and identify areas for additional research.

Volume II contains all the data which supports the material in Volume I. These two volumes contain carefully gathered information which will be of value to all interested in the "Cleft Palate Problem".

EDITOR

WEINER, FLORENCE, *Help for the Handicapped Child.* New York: McGraw-Hill, 1973, Pp. 211, $7.95.

Sources of help for handicapped children are listed by condition from allergies/asthma, through venereal disease.

Among the conditions covered are: Arthritis and Related Rheumatic Diseases, Birth Defects, Blindness and Partial Sightedness, Cancer/Leukemia, Cerebral Palsy, Cooley's Anemia, Cystic Fibrosis, Deafness/Partial Hearing, Dental Problems, Diabetes, Drug Addiction, Epilepsy, Heart Disease, Hemophilia, Kidney Disease, Learning Disabilities/Minimal Brain Dysfunction, Mental Illness/Autism, Muscular Dystrophy, Orthopedic and Physically Handicapping Conditions, Retardation, Sickle-Cell Anemia, Tay-Sachs Disease, Tuberculosis, and Venereal Disease.

Community resources, state health services, voluntary health associations, and National Institute of Health agencies are enumerated.

A description of each condition and its treatment is appended for lay-readers.

This book is directed toward the parents of the child with a handicap, but it can also be useful to professional workers who must make recom-

mendations and referrals. Its organization leaves a little to be desired, but the information is good.

While it covers more problems than cleft palate and craniofacial anomalies, it would be of interest to those who deal with this general category of conditions.

MAXINE SCHURTER, M.D.

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ABSTRACTS

Bartels, R. J. and R. C. Howard, Congenital midline sinus of the upper lip: Case report. *Plast. reconstr. Surg. 52,* 665–668, 1973.

Only six previously reported cases of midline sinus have been found by the author in a search of the literature and his case represents the seventh reported. The possibilities of the embryologic origin of this defect are presented and discussed together with a brief presentation of the method of its repair. (Cosman)

Bundey, S., Importance of genetic counseling. *Mod. Med., 41,* 32A–32C, 1973.

This is a general article relating to genetic counseling aimed primarily toward the general practitioner of medicine. The author stressed some of the common problems seen in the practice of medicine, their incidence and the likelihood of recurrence of the problem in subsequent pregnancies. (Gregg)

Bundey, S., Typical problems encountered in genetic counseling. *Mod. Med., 41,* 32B–32D, 1973.

The author has presented a discussion of problems relating to genetic counseling which might be presented to the general practitioner of medicine. Appropriate answers to the questions presented are supplied. (Gregg)

Chaudhry, A. P. and R. M. Shah, Estimation of hydrocortisone dose and optimal gestation period for cleft palate induction in golden hamsters. *Teratology, 8,* 139–142, 1973.

Thirty milligrams of hydrocortisone administered into pregnant golden hamsters at gestation day 10:20 (i.e., 10 days, 20 h postconception), 11:00, or 11:04 produced 91, 100, and 100% cleft palate, respectively. Smaller doses (15, 20, or 25 mg) produced higher incidences of cleft palate at day 11:00 than 10:20 or 11:04, indicating that day 11:00 is the optimal time for yield of cleft palate with this system. (Authors' Summary: Lass)

Chernoff, N., Teratogenic effects of cadmium in rats. *Teratology, 8,* 29–32, 1973.

The teratogenic effects of subcutaneous injections of cadmium in CD rats were investigated. Injections of 4–12 mg/kg $CdCl_2$ on 4 consecutive days beginning on days 13–16 of gestation resulted in a dose-related rise in the fetal death rate, decrease in fetal weight, and increase in the rate of anomalies. The anomalies included micrognathia, cleft palate, clubfoot, and small lungs. The lung/body weight ratios were significantly reduced in fetuses of animals injected with 8 mg/kg $CdCl_2$ on days 14–17 of gestation. The data indicate that this was a specific retardation and not merely a reflection of differential organ growth rates and overall fetal growth retardation. (Author's Summary: Lass)

Converse, J. M., S. L. Horowitz, P. J. Coccaro, and D. Wood-Smith, The corrective treatment of the skeletal asymmetry in hemifacial microsomia. *Plast. reconstr. Surg., 52,* 221–231, 1973.

The rationale for surgical intervention in patients with the first and second branchial arch syndrome is presented together with details of the procedures worked out in the course of several years of study. At 8 to 9 years of age a bilateral osteotomy through the ramus is performed permitting forward lateral and downward movement to the mandibular body on the affected side toward the unaffected side. The rotation and displacement result in a bony gap requiring iliac bone graft. Second stage of the corrective treatment is undertaken after the eruption of permanent dentition and a variety of procedures are involved. Multiple operative interventions may be required in this second stage. Onlay bone grafts over the defective mandible or maxilla, horizontal advancement osteotomy of the anterior inferior portion of the body of the mandible, varying shaped osteotomies through the mandible for elongation of the lower jaw, as well as dermal fat grafts placed subcutaneously to alleviate the soft tissue deficiency over the parotid masseteric region have all been employed. (Cosman)

Dey, D. L., Oblique facial clefts. *Plast. reconstr. Surg., 52,* 258–263, 1973.

Five more cases of complex oblique facial clefts including oro-ocular and naso-ocular clefts are presented by the author who has the impression that these rare lesions are increasing in frequency in the Australian area. (Cosman)

Diewert, V. M., The course of the palatine arteries during secondary palate development in the rat. *J. Dent. Research, 52,* 1273–1280, 1973.

India ink-injected rat fetuses 13–20 days of age were studied. The arteries were a

major blood supply to the incisive area of the primary palate. As the palatal shelves were elevated, the arteries became positioned more mesially and formed a V-shaped pattern. (Luban)

Edwards, L. and S. Levin, Complications from hip replacement with use of acrylic cement. *Health Services Reports, 88,* 857–867, 1973.

Experiences are reported here in hip replacement where acrylics are used. Self-curing acrylic cement is a mixture of powder and liquid which hardens into a polymer with marked heat reaction that may create temperatures up to 80–90 degrees C. The use of acrylics leads to two possible reactions: (1) an allergic reaction to the material itself, and (2) local destruction of tissue which may provide a necrotic focus for the development of an infection. (Goldenberg)

Farkas, L. G. and W. K. Lindsay, Morphology of the adult face following repair of unilateral cleft lip and palate in childhood. *Plast. reconstr. Surg., 52,* 652–655, 1973.

Seventy-four patients with 57 complete and 17 incomplete unilateral cleft lip and palate defects were studied. Lip repair was by the LeMesurier quadrangular flap operation. The palate was repaired by a modified Dorrance pushback operation at about two years of age. Seventy-three of the 74 patients had had orthodontic treatment. In general, there was a longer facial profile, a horizontally narrower face and a narrower labial fissure in this group than in a matched control, normal group. The authors did not find the excessive length of lip usually ascribed to the quadrangular flap repairs. (Cosman)

Frolova, L. E., Early preventive measures in children with inherent lip and palate clefts. *Internat. Dent. J., 23,* 286–288, 1973.

The Soviet public health authorities place great emphasis on preventive dental services for children. Provision is made for early treatment of congenital facial deformities. Special teams have been established who are available to travel at once to the maternity hospital where the case is examined and assessed as to course of treatment to be followed. Early treatment with acrylic expansion plates is the accepted treatment prior to surgery, and early surgical procedures are carried out followed by routine orthodontic care. (Goldenberg)

Gath, Ann, The mental health of siblings of congenitally abnormal children. *J. Child Psychol. Psychiatry Allied Discip., 13*(3), 211–218, 1972.

An index group of 36 school-age siblings of children with Down's Syndrome and another index group of 35 school-age siblings of children with cleft lip/palate were compared with 71 individually matched school children. Behavioral questionnaires (Rutter Scales A2 and B2) were completed by parents and teacher for all index siblings and controls. No significant difference in behavioral rating was found between either index group and their controls. At parental interview, it was found that families of children with Down's Syndrome were experiencing more problems of management than families of children with cleft lip/palate deformities. (Abstract from *BioResearch Today—Birth Defects, 2,* 133, Nov. 1973.)

Gorlin, R. J. and H. Sedano, Lenz microphthalmia syndrome. *Mod. Med., 41,* 98A, 1973.

This is a short didactic article aimed primarily toward the general practitioner of medicine, describing the syndrome reported by Lenz in 1955, consisting of microphthalmia, skeletal anomalies of the hands and clavicles, renal and genital anomalies and defects of dentition. It is probably an X-linked recessive trait. The ears may be asymmetric, dysplastic, hypo-

plastic and protuberant. Various anomalies may be present in the fingers and toes, hands and feet, vertebrae, hips and fibulae. Congenital heart defects, atresia of the ileum, umbilical hernia, unusual dermatoglyphics and defective speech may be present. Also there can be high arched palate, crooked anterior teeth, agenesis of the permanent maxillary lateral incisors and mental retradation. (Gregg)

Gorlin, R. J. and A. Sedano, Multiple pterygium syndrome, *Mod. Med., 41,* 92, 1973.

This is a short discusion of the syndrome which consists of growth retardation, multiple pterygia involving the neck and fingers and the antecubital, popliteal and intercrural areas and cleft palate. An illustrative photograph is presented. (Gregg)

Green, R. M. and D. M. Kochhar, Spatial relations in the oral cavity of cortisone-treated mouse fetuses during the time of secondary palate closure. *Teratology, 8,* 153–162, 1973.

The authors investigated the effects of cortisone on the spatial relations in the oral cavity of mouse fetuses. Maternally administered cortisone resulted in 95% cleft palate in ICR/DUB mouse fetuses who were observed at days 15–18 of gestation. From observation of frozen, cryostat-cut sections of fetal heads during the time of palate closure, it was found that shelf elevation in experimental mice was delayed by as much as 12–14 hours. However, it was found that when the shelves finally reached the horizontal plane, they made contact with both the nasal septum and with each other. Thus, the authors concluded that, in addition to causing delay in shelf movement, cortisone may also interfere with the processes that occur after horizontalization leading to fusion of the palatine shelves. (Lass)

Grocott, J., Maxillary osteotomies in cleft palate repairs. *Brit. J. Plast. Surg., 26,* 261–265, 1973.

The author describes two kinds of maxillary osteotomies which have been used for cleft palate repair. They include the bilateral posterior osteotomy and the premaxillary osteotomy. (Lass)

Holmes, L. B., Syndrome of ocular and facial anomalies, telecanthus and deafness. *J. Pediatr., 81*(3), 552–555, 1972.

A sister (12 years old) and brother (9 years old) are presented who had severe eye abnormalities, telecanthus, sensorineural deafness, and craniofacial anomalies. This is a new syndrome of multiple anomalies. (This abstract is from *BioResearch Today—Birth Defects, 2*(12), 139, Dec 1973.)

Idanpaan-Heikkila, J. and L. Saxen, Possible teratogenicity of Imipramine/Chlorpyramine. *Lancet, 2,* 282–284, 1973.

Finland has had mandatory registration with the National Board of Health of all congenital malformations detected in living and stillborn infants since 1963. The registry card upon these infants contains information about all non-prescription and prescription drugs known to have been used by the mothers during pregnancy. The maternity welfare centers cover about 98% of all mothers. To date about 8000 cases with malformations have been reported; 2784 of which were selected for this study. Matched controls were the mothers whose delivery preceded the delivery of the malformed infant in the same hospital. The incidence of malformations in Finland in 1964–71 was 1.25%. The authors found four children with soft tissue craniofacial defects or C.N.S. anomalies whose mothers had taken tricyclic antidepressant drugs during pregnancy; one with cleft lip only, one having cleft

palate only, one hydrocephalic, and one child which had micrognathia, anomalous right mandible, and left pes equinovarus. Also they found one mother who delivered a stillborn (3500 g.) baby with a meningocoele and renal cystic degeneration. The authors felt that the facts that 1) the number of cases found was small plus 2) the information that four of the five mothers having infants with craniofacial defects had taken several drugs, makes assessment of this information difficult. (Gregg)

Juberg, R. C. and Sue R. Chambers, An autosomal recessive form of craniofacial dysostosis (the Crouzon syndrome). *J. Med. Genet., 10*(1), 89–94, 1973.

This report is a description of two similarly affected Negro sibs, a male and a female, in a sibship of nine, with manifestations of the Crouzon syndrome: cranial synostoses, bilateral exophthalmos with external strabismus, psitticorhina, and maxillary underdevelopment with relative mandibular prognathism and a drooping lower lip. By history there were no similarly affected persons on either side of the family, and by examination neither the parents nor two younger sibs had either cranial or facial anomalies. Characteristically, most observers consider the Crouzon syndrome to be monogenically determined as autosomal dominant, and they attribute sporadic cases to spontaneous mutation, with the frequent variability in manifestation to irregular expression rather than to an anomaly of penetrance. However, after excluding other genetic and environmental explanations in the present case, the authors conclude that the craniofacial disorder is monogenically determined as autosomal recessive. (Noll)

Kapetansky, D. I., Bilateral transverse pharyngeal flaps for repair of cleft palate. *Plast. reconstr. Surg., 52,* 52–54, 1973.

A technique of transverse elevation of nasopharyngeal-posterior pharyngeal wall tissue to create a double flap for pharyngeal flap development is depicted. Twenty-one patients have had the procedure without obvious difficulty but further study is necessary to evaluate the long term speech results. (Cosman)

Kemble, J. H. V., Underdevelopment of the maxilla related to absence of the cartilaginous nasal septum. *Brit. J. Plast. Surg., 26,* 266–270, 1973.

The author reviews eight cases of patients having the absence of the cartilaginous nasal septum, and concludes that the growth of the nasal septum expands the maxilla and other facial bones out from the cranial base and separates them from one another. Therefore, normal growth of the cartilaginous nasal septum is necessary for full maxillary development. (Lass)

Kvinnsland, S., Growth potential of autografts of cartilage from the nasal septum in the rat. *Plast. reconstr. Surg., 52,* 557–561, 1973.

Nasal septum segments were removed and placed within the abdominal wall and recovered after 30 days. In all the rats the transplanted cartilage had increased considerably in size, both in height and in length. No shape change occurred except for rounding at the corners and a slight warping. There was little difference histologically between the removed transplants and septal cartilage removed from 30 day old rats. The findings are suggestive that the cartilaginous nasal septum in the very young rat has its own growth potential and that it increases in size in a normal manner after transplantation to a nonfunctional site. (Cosman)

Latham, R. A., G. R. Smiley, and J. M. Gregg, The problem of tissue deficiency in cleft palate: an experiment

in mobilising the palatine bones of cleft dogs. *Brit. J. Plast. Surg., 26,* 252–260, 1973.

This article describes an experiment which employed 10 five- to seven-week-old dogs, in which an attempt was made to reduce artificially created clefts in the palatine bone region by means of a pinned screw appliance. The experimenters hoped that the palatine bone region might provide sufficient additional palatal tissue to make wide clefts of the palate more amenable to surgery. They found that their appliance worked satisfactorily in providing a steady approximation of the cleft edges in the dogs on whom they experimented. (Lass)

LaValle, W. and G. Zach, The tissue bar and CEKA Anchor as aids in cleft palate rehabilitation, *J. Prosth. Dent., 30,* 321–325, 1973.

This is a technique, among others, as a functional aid for prosthesis support and retention. The tissue bar is efficient in forming a solid rest for the anterior segment of a prosthesis and as an indirect retainer for a speech aid obturator. The Ceka anchor is a semi-precision attachment consisting of a male and female portion. One part is imbedded in the acrylic plate, and soldered onto the tissue bar. One fits into the other thereby giving the retentive quality. (Goldenberg)

Long, Sally Y., K. Sune Larsson, and S. Lohmander, Cell proliferation in the cranial base of A/J mice with 6-AN-induced cleft palate. *Teratology, 8,* 127–138, 1973.

Midsagittal sections of the heads of day 14.5–15.0 control A/J mouse fetuses revealed three areas of rapidly growing cartilage in the cranial base: mesethmoid, presphenoid, and craniopharyngeal. There was a curvature in the presphenoid, which straightened by the time of palatine shelf movement. In fetuses of females treated with 6-aminonicotinamide (6-AN) on gestation day 13 the presphenoid had not straightened by day 15.5 and these fetuses all had cleft palate. In nontreated mice with spontaneous cleft lip and palate the presphenoid straightening was not impaired. Autoradiographs of [^{3}H]thymidine uptake in the cranial base of experimental fetuses revealed selective impairment of cell proliferation in the presphenoid as judged by a significant decrease in labeled nuclei. It is proposed that straightening of the presphenoid is necessary for palatine shelf movement and normal palate closure. (Authors' Summary: Lass)

McCabe, W. P., Experience with cleft lip and palate at the Henry Ford Hospital. *Henry Ford Hospital Med. J., 21,* 91–100, 1973.

A detailed analysis is presented of 321 patients with clefts of the lip and/or palate treated at Henry Ford Hospital. Comments are made on past and future trends in the management of these complex entities. (Author's abstract: Gregg)

McEvitt, W. G., Treatment of respiratory obstruction in micrognathia by use of a nasogastric tube. *Plast. reconstr. Surg., 52,* 138–140, 1973.

Simple passage of a nasogastric tube will often be adequate for the treatment of the respiratory obstruction of the Pierre Robin syndrome. Experience in 13 cases is presented and the need for surgery was eliminated by this technique. It is the author's thesis that when the tube is in place the tongue, though falling back, encounters the tube and is unable to wrap itself around the tube so that a small triangular space remains on each side of it. This space allows a column of air to move and is sufficient to relieve the obstruction. While the successful treatment of the patients presented is impressive, there is no

evidence directly bearing on this thesis. (Cosman)

O'Connor, G. B., M. W. McGregor, S. Murphy, and H. Tolleth, Advancement of soft tissues to correct mild midfacial retrusion. *Plast. reconstr. Surg., 52,* 42–46, 1973.

Mild retrusion in the infranasal region in patients following cleft lip repair has been ameliorated by advancement of buccal mucosa and soft tissue centrally in V-Y fashion after broad freeing of the upper lip from the maxilla. This has been carried out simultaneously with lip revisions. The results presented show distinct improvement. (Cosman)

Pap, C. S., First branchial cleft sinus and pouch: Case report. *Plast. reconstr. Surg., 52,* 583–585, 1973.

A first branchial cleft sinus and pouch with exit on the cheek is reported and radiopaque injection into the fistulous tract demonstrated the course of the anomaly in better than ordinary clarity. The literature regarding this defect is reviewed. (Cosman)

Paunio, K., The role of malocclusion and crowding in the development of periodontal disease. *Internat. Dent. J., 88,* 470–473, 1973.

Most studies show some correlation between poor periodontal conditions and malposed teeth or other types of malocclusions. There seems to be a clear relationship between crowding, accumulation of plaque and gingivitis. Factors caused by malocclusion and crowding are: increased or decreased occlusal forces, alteration of the environment in such a way that it predisposes plaque and calculus formation and accumulation, food impaction, inadequacy of the alveolar bone. (Author's Summary: Goldenberg)

Rees, T. D., F. L. Ashley, and J. P. Delgado, Silicone fluid injections for facial atrophy. A ten-year study. *Plast. reconstr. Surg. 52,* 118–127, 1973.

This is an interim report on experience with a total of 73 patients with multiple facial deformities including progressive hemifacial atrophy as well as bilateral facial atrophy from lipodystrophy. The successes, cautions, and problems encountered with this still experimental technique are presented in detail. (Cosman)

Siegel, M., Congenital malformations following chickenpox, measles, mumps, and hepatitis. *J. Amer. Med. Assn., 226,* 1521–1524, 1973.

This is a study of 409 pregnancies, with 409 controls, during which chickenpox, mumps, measles, and hepatitis occurred, from which there were 372 live births (controls, 393). In the study group, eight (2.2%) and nine (2.3%) control children had congenital anomalies. The most common defects in both groups involved the central nervous system and consisted of mental retardation, microcephaly, hydrocephalus, anencephaly, and spinocerebellar degeneration. Multiple cases with deafness were found in both the study and the control groups. Single cases of cataract, cardiac defect, mongolism, and anencephaly were also found. There were no maxillo-facial defects recorded. The author concluded, "The incidence of major malformations following maternal chickenpox, mumps, measles, and viral hepatitis was observed in a controlled, cohort study of offspring followed up until five years of age. Major congenital defects occurred in each viral group, but the malformations were equal in frequency and often similar in type to those observed among comparable controls for the respective viral groups. Consequently, the malformations that occurred could not be attributed directly to the associated diseases under study." (Gregg)

Subtelny, D., To treat or not to treat. *Internat. Dent. J., 23,* 292–303, 1973.

Judgments in orthodontic problems on when to institute treatment is the crux of the matter rather than whether to treat or not. Most malocclusions do not self correct except in some cases of oral habits where inhibition of habits as tongue-thrust and thumb sucking will aid a malocclusion in self-correction. Functional problems, such as mandibular shifts caused by malposed teeth, should be treated early. Gross bites, posterior and anterior, may cause mandibular shifts, and should be treated as soon as possible. (Goldenberg)

Telage, K. and D. Fucci, Vibrotactile stimulation: A future clinical tool for speech pathologists. *J. Speech Hear. Dis., 38,* 442–447, 1973.

The authors discuss areas of research related to vibrotactile stimulation and measurement. They make certain speculations concerning the diagnostic and therapeutic value of vibrotactile stimulations in the assessment of oral-sensory deficits which may be contributing to speech disorders. It is suggested that prior to its clinical use as a diagnostic and therapeutic tool certain disadvantages must be eliminated. (Lerman)

Whitlow, D. R. and J. D. Constable, Crossed alar wing procedure for correction of late deformity in the unilateral cleft lip nose. *Plast. reconstr. Surg., 52,* 38–41, 1973.

The authors employ an external Y-shaped incision to expose the cartilages in the lower lateral positions and then use crossed over alar cartilage wings each tied over separate pullout bolsters on either side of the nose. A discussion of some of the other methods to which this bears a relation is presented. The single case depicted does not show a very impressive result. (Cosman)

Zwitman, D. H., M. T. Gyepes, and F. Sample, The submentovertical projection in the radiographic analysis of velopharyngeal dynamics. *J. Speech Hear. Dis., 38,* 473–477, 1973.

In assessing lateral pharyngeal wall movement during routine cinefluorographic examination for velopharyngeal adequacy, the inclusion of submentovertical projection is important to the lateral projection of the velum. The main structures of the nasopharynx and surrounding areas are defined, and a method to obtain visualization of this area in normal subjects is described. The degree of lateral pharyngeal wall movement varies among normal individuals and may affect the success of the pharyngeal flap operations in patients with velopharyngeal inadequacy. (Authors' Summary: Lerman)

ANNOUNCEMENTS

Forums Appointed by President of American Cleft Palate Association

The following forums have been appointed by Hughlett Morris, Ph.D., President of the American Cleft Palate Association.

1. Assistance to Parents Forum

Betty J. McWilliams, Ph.D. (Co-chairman)
Mary Pannbacker, Ph.D. (Co-chairman)
George J. Chierici, D.D.S.
LaForrest D. Garner, D.D.S.
William E. LaVelle, D.D.S.
Michael L. Lewin, M.D.
Robert B. McCabe, M.S.
John O'Connor, M.D.
Eugene J. Sidoti, M.D.

2. New Members Forum

R. Michael Hogan, M.D., Chairman
Mary A. Carpenter, Ph.D.
Robert M. Davis, M.D.
Ogden N. Munroe, D.D.S.
Joe D. Peak, D.D.S.
Kenneth E. Salyer, M.D.
Carl Scott, Ph.D.
Carol C. Towne, Ph.D.
Robert B. Winslow, M.D.

3. Interdisciplinary Members Forum

Alphonse R. Burdi, Ph.D., Chairman, anatomy
Tague C. Chisholm, M.D., pediatric surgery
Edward Clifford, Ph.D., psychology
James W. Moore, D.D.S., pedodontics
Shirley M. Motzkin, Ph.D., teratology
Jack L. Paradise, M.D., pediatrics
Donna Pruzansky, R.N., nursing
Larry Severeid, M.D., otolaryngology
Joan Shames, M.S., audiology
Leon M. Skolnick, M.D., radiology
Rosemary Tharp, M.A., sociology

4. International Members Forum

Richard M. Cole, Ph.D., Chairman
Jose Barros-Saint-Pasteur, M.D. (Venezuela)
Walter J. Benavent, M.D. (Puerto Rico)
Benjamin B. Cantor, M.D. (Canada)

David Davies, M.D. (South Africa)
Bridgette K. Graf, D.D.S. (Switzerland)
Arnold G. Huddart, D.D.S. (Britain)
Boo-Chai Khoo, M.D. (Singapore)
R-Jan Meursinge-Reijnders, B.D.S. (The Netherlands)
Zvi H. Neuman, M.D. (Israel)
Christos T. Oeconomopoulos, M. D. (Greece)
Fernando G. Ortiz-Monasterio, M.D. (Mexico)
Claude H. Perpere, M.D. (France)
Elias D. Pires, M.D. (Portugal)
R. N. Sharma, M.S. (India)
Borje W. Sundell, M.D. (Finland)
Takuro Wada, D.D.S. (Japan)

Notice to Members of American Cleft Palate Association

The report of the Interdisciplinary Relations Committee (ad Hoc) Task Force for Association Development has been published and sent to all members. If you did not receive your copy please notify Morton Rosen, D.D.S., the Treasurer.

Annual Symposium of the Center for Cranio-Facial Disorders

The Center for Cranio-Facial Disorders at Montefiore Hospital and Medical Center, New York City, will hold its Anuual Symposium on Friday, May 10th, 1974, 10:00 A.M.–4:00 P.M. Those interested in attending the Symposium, please write or call: Center for Cranio-Facial Disorders, Montefiore Hospital, 111 E. 210th Street, Bronx, N. Y. 10467. *Telephone: 212-920-4781.*

University of Iowa Course in Cleft Lip and Palate

The annual course in cleft lip and palate will be held at the University of Iowa from June 5 to 8, 1974. The faculty will include a general plastic surgeon, an otolaryngologist, an orthodontist, a maxillofacial prosthodontist, a speech pathologist, a pediatrician, a psychologist, and a social worker. All listed specialties are members of the cleft palate team in the Center for Congenital Anomalies of the Face at the University of Iowa. All aspects of cleft lip and palate will be covered, with special emphasis upon pre- and postoperative orthodontics, surgical treatment of primary and secondary deformities associated with cleft lip and palate, facial growth, chronic ear disease, and speech pathology. Instruction will include both didactic and practical demonstrations of techniques.

Enrollment will be limited to 30 persons. Tuition is $100.

For further information contact: Charles J. Krause, M.D., University of Iowa Hospitals, Iowa City, Iowa 52242.