LETTERS TO THE EDITOR

The paper by Fox, Lynch, and Brookshire, "Selected Developmental Factors of Cleft Palate Children Between Two and Thirty-three Months of Age" (CPJ, July 1978, pp. 239–245) showed that the "deficits documented in older cleft palate children and adults can be identified during the first three years of life."

Language abilities of children with palatal clefts have been described by several investigators. However, the question of whether they are delayed in language development is not yet resolved. Another problem is that only limited information is available about the language abilities of adults with cleft palate. Early reports suggest that there may be differences between the language skills of children with clefts and normals. However, recent reports indicate that if differences exist, they are minimal (Bradley, 1977; Morris, 1975). Bradley (1977, p. 326) suggested that these decreasing differences were "likely the result of more emphasis in the early treatment years on language stimulation in the home and early intervention."

Data also exist which suggest that there are differences during the early and later preschool years although the evidence has not been consistent regarding the direction of the differences. Philips and Harrison (1969), and Smith and McWilliams (1968a, 1968b) indicate there is a tendency for language skills in cleft palate children to become progressively poorer with increased age. Musgrave, McWilliams, and Matthews (1975) found that cleft palate children were somewhat below average on the ITPA but near the time of school entrance, approximately two years later showed considerable gains in language skills. Other studies (Shames et al., 1966, 1968, 1971; Faircloth and Faircloth, 1972; Zimmerman and Canfield, 1968; Zimmerman and Sheldon, 1975) suggest that cleft palate children catch up to noncleft children by about five years of age. This would tend to indicate that the major difference between cleft palate and normal children is in the onset and acquisition time necessary for learning language.

There are very little data about language skills of adult cleft palate speakers. Fox, Lynch, and Brookshire (1978, p. 239) cite the work of Pannbacker (1975) as evidence of "language deviations persisting in a group of cleft palate adults." Pannbacker (1975) reported that: (1) cleft palate speakers used shorter sentences than noncleft adults; (2) there were no significant differences between cleft palate and noncleft speakers in sentence structure and vocabulary skills; (3) cleft palate speakers were more consistent in their language usage than noncleft speakers, and (4) for cleft palate speakers there was a relationship between intelligibility and other spoken language measures. More recently, Pannbacker, Leeper, and Roginski (1977) reported poorer receptive and expressive language skills in female cleft lip and palate and male cleft palate only adults.

Until systematic, well controlled research is done in the area of language skills of individuals with cleft palate, it should be expected that research findings will continue to be somewhat inconsistent and perhaps even misleading. Yet the evidence reported at this time clearly demonstrates that there is need for further research. Several writers have also suggested that need for further study (Bradley, 1977; McWilliams, 1966, 1970, 1973; Morris, 1975; Spriestersbach et al., 1973). That research will need to be both cross-sectional and longitudinal and for a large group of subjects. With controlled research generalizations concerning the language skills of individuals with cleft palate may facilitate more accurate description, assessment, and management. At the same time such research can aid in the definition of significant variables influencing language acquisition and development.

The intent is not to criticize Fox, Lynch, and Brookshire (1978). Rather it is to facilitate further work regarding the language skills of individuals with cleft palate. It is obvious that further information is needed about language skills throughout life.

Mary Pannbacker, Ph.D.
New Orleans, LA 70119

References

BRADLEY, D., Speech and language aspects. *Cleft Palate J. 14,* 321–328, 1977.

FAIRCLOTH, S., and FAIRCLOTH, M., Delayed language and linguistic variations. In K. Bzoch (Ed.), *Communicative Disorders Related to Cleft Lip and Palate.* Boston: Little Brown, 130–135.

MCWILLIAMS, B., Speech and language problems in children with cleft palate. *J. Amer. Med. Woman's Assn., 21,* 1005–1015, 1966.

MCWILLIAMS, B., Psychosocial development and modification in Proceedings of the Workshop: Speech and Dentofacial Complex: The State of the Art, *Amer. Sp. Hear. Assn., Report #5,* 165–187, 1970.

MCWILLIAMS, B., Language problems in speech, language and psychosocial aspects of cleft lip and cleft palate: the state of the art. *Amer. Sp. Hear. Assn., Report #9,* 41–42, 1973.

PANNBACKER, M., Oral language skills of adult cleft palate speakers. *Cleft Palate J., 12,* 19–106, 1975.

PANNBACKER, M., LEEPER, A., and ROGINSKI, J., Oral language characteristics of adult cleft palate speakers compared on the basis of cleft type and sex. Poster session presented at 3rd International Congress on Cleft Palate, Toronto, 1977.

PHILIPS, B., and HARRISON, R., Language skills of preschool cleft palate children. *Cleft Palate J., 6,* 108–119, 1969.

MUSGRAVE, R., MCWILLIAMS, B., AND MATTHEWS, H., A review of the results of two different surgical procedures for the repair of clefts of the soft palate only. *Cleft Palate J., 12,* 281–290, 1975.

SHAMES, G., and RUBIN, H., Psycholinguistic measures of language and speech. In W. Grabb, S. Rosenstein, and K. Bzoch (Eds.), *Cleft Lip and Palate.* Boston, Little Brown, 805–824, 1971.

SHAMES, G., RUBIN, H., and KRAMER, J., The development of verbal behavior in cleft palate and non-cleft palate children. Paper presented at Annual Meeting of American Cleft Palate Association, Mexico City, 1966.

SHAMES, G., RUBIN, H., and SHAMES, J., Correlates to language development in cleft palate children. Paper presented at Annual Meeting of American Cleft Palate Association, Miami Beach, 1968.

SMITH, R., and MCWILLIAMS, B., Psycholinguistic abilities of children with clefts. *Cleft Palate J., 5,* 238–249, 1968a.

SMITH, R., and MCWILLIAMS, B., Psycholinguistic considerations in the management of children with cleft palate. *J. Speech Hearing Dis., 33,* 26–33, 1968b.

SPRIESTERSBACH, D., DICKSON, D., FRASER, P., HOROWITZ, S., MCWILLIAMS, B., PARADISE, J., and RANDALL, P. Clinical research in cleft lip and cleft palate: the state of the art. *Cleft Palate J., 10,* 113–165, 1973.

ZIMMERMAN, J., and CANFIELD, W., Language and speech development. In R. Stark (Ed.), *Cleft Palate: A Multidiscipline Approach.* N.Y.: Harper and Row, 220–242, 1968.

ZIMMERMAN, K., and SHELDON, N., Language development in children with cleft palate and associated disorders: a preliminary investigation. Paper presented at Annual Meeting of the American Speech and Hearing Association, Washington, D.C., 1975.

Dear Dr. McWilliams: August 22, 1978

I would like to draw attention to the less than acceptable speech results following staphylorrhaphy. Schweckendiek, whose father was an early proponent of the procedure (Schweckendiek, W., Primary veloplasty: long term results without maxillary deformity. A twenty-five year report, Cleft Palate Journal, July, 1978) concludes that "the results (of primary veloplasty) may be regarded as good in terms of... normal speech and very good in terms of enabling the jaw and face to develop normally." These long-term speech results in 266 patients were 57.2 per cent normal speech, 37.6 per cent intelligible speech (I have trouble with knowing what that means), 4.5 per cent moderate speech, and 0.7 per cent poor speech. I do not believe that 57 per cent normal speech is good enough.

The strongest evidence to support my opinion is that the only other papers which I have been able to find which provide speech results following staphylorrhaphy reported that the speech was so poor after this operation that most of the patients subsequently required pharyngoplasty or palatal pushback and the *authors no longer perform staphylorrhaphys* (Fara and Brousilova, 1969; Schröder 1966). Schweckendiek did not refer to either of these papers in his article, nor even include them in his references.

William C. Grabb, M.D.
Section of Plastic Surgery
University of Michigan Medical Center
Ann Arbor, Michigan 48109

References

FARA, M. and BROUSILOVÁ, M.: Experiences with early closure of velum and later closure of hard palate. Plast. & Reconstr. Surg., 44: 134, 1969.

SCHRÖDER, F.: Operation der Spalte in harten Gaumen im Anschluss an Velumplastik nach Schweckendiek. Acta chir. plast., 8: 257, 1966.

BOOK REVIEWS

KAUFMAN, ALAN S., and KAUFMAN, NADEEN L., *Clinical Evaluation of Young Children with the McCarthy Scales.* New York: Grune & Stratton, 1977, 301 pages, $16.50.

In our quest for more accurate psychological information on children, we are constantly striving for better tests and better interpretations of the results they yield. This book attempts to provide the diagnostician in behavioral sciences with a better understanding and interpretation of one such test battery, the McCarthy Scales. Although the purpose of the book is to clarify and define the role of the McCarthy Scales in clinical and psychoeducational assessment of young children, it also examines its use as a clinical tool for evaluating preschool and primary-grade minority children.

The book is divided into three parts: (1) practical considerations, (2) interpretation of the McCarthy Scales, and (3) integration of the McCarthy Scales with other tests. Discussions in these sections are not only helpful for clinical psychologists but also for other behavioral scientists concerned with the evaluation of children. The authors discuss both the advantages and limitations of the Scales in an objective, well written manner. Since they have been involved in development, research, and clinical use of the Scales since 1969, they were able to discuss thoroughly the intricacies of them.

Some of the practical considerations included are: the difficulties encountered in testing young children, standardization of the eighteen tests, length of test, comparison of McCarthy's General Cognitive Index (GCI) with intelligence quotient, administration and scoring of the tests along with special considerations and helpful hints, and computing prorated indexes when a test is "spoiled" or not given. The authors state frankly that more research is needed before many facets of GCI are well understood and that prorating is not easy with the McCarthy because test scores are not in equal units.

In Part II they raise three important questions in regard to interpretation: (1) What specific skills are required for successful performance in each area? (2) Do the obtained scores correspond to "real" abilities in the child? (3) Is the meaning of the scores the same across the age range, or do important developmental changes occur? They also suggest ways of evaluating the scatter in a profile, interpreting specific areas of strength and weakness, and ways of interpreting the McCarthy Scales qualitatively.

In Part III, the authors discuss ways of integrating the McCarthy with other tests, such as the Bender-Gestalt, ITPA, Goodenough-Harris Drawing Test, WPPSI, WISC-R, and Stanford-Binet. They recommend the McCarthy for screening learning problems and for educational planning. Finally, they recommend using the McCarthy as part of a larger test battery including some of the tests previously mentioned. The book is concluded with illustrative case reports that include summaries and recommendations.

This book, probably the only one available of its kind, is recommended for professionals who deal with evaluating and planning appropriate management of children and, particularly, for those who desire clinical interpretation of the McCarthy Scales. Its contents will provide a greater insight into these tests and perhaps into psychological testing in general.

CURTIS E. WEISS, Ph.D.
Coordinator of Speech and Language Pathology
Department of Communicative Disorders
University of New Mexico
Albuquerque

KROTH, ROGER, *Communicating with Parents of Exceptional Children: Improving Parent-Teacher Relationships,* Denver, Colorado, Love Publishing Company, 1975, 187 pages, $4.95.

The purpose of this book, which is one in a series of special education paperbacks, is to provide teachers with techniques to improve their skills in communicating with parents. The ten chapters are organized into three major sections: (1) understanding the child and his family, (2) providing parents with information, and (3) problem solving with parents. Section 1 describes techniques for preparing for parent conferences, listening to parents, and the Q-Sort technique for assessing individual perceptions of behavior. Section 2 deals with various techniques for reporting and presenting information including parent groups. Section 3 is concerned with strategies for defining problems and intervention techniques.

Each chapter includes two or more activities. References follow each chapter. There is no composite list for the seven tables and 14 figures. There are five appendixes: (1) case history information about four children followed by a series of review questions about each child, (2) an annotated bibliography of 95 references for parents of exceptional children, (3) a reinforcer survey, (4) forms for work and reinforcers, and (5) suggestions for working with parents of exceptional children based on experience and research.

Communicating with Parents of Exceptional Children should be useful to anyone interested in basic information and practical suggestions about interviewing or conferring with parents. This book should also be an appropriate reference for interested parents.

MARY PANNBACKER, Ph.D.
Louisiana State University
Medical Center
New Orleans, Louisiana

KROTH, ROGER, and SIMPSON, RICHARD, *Parent Conference as a Teaching Strategy.* Denver, Colorado; Love Publishing Company, 1977, 173 pages, $4.95.

Kroth and Simpson wrote this paperback because training in parent conferences is frequently neglected by college and university programs. The emphasis is on the interview or conference as an individualized, personalized opportunity for the significant adults in the child's life to interact in ways that can promote a better understanding of the child and lead to cooperative action for the purpose of facilitating growth and development. These significant adults include the parents, the teacher, and other professionals.

The content of the book is organized around the concepts that in working with children there are *inputs* needed to carry out a *process* which leads to certain *outcomes*. Chapters one and two consider techniques for clarifying or assessing values of the interviewer and the interviewee. Chapters three, four, five, six, and seven describe the interviewing process. Chapter eight is concerned with evaluation.

At the conclusion of each chapter, series of activities and references are presented. Appendix A presents a set of examples illustrating role play for three children. Appendix B provides a summary for role playing. A composite list of the 13 figures would have been valuable.

A strong resemblance to *Communicating with Parents of Exceptional Children* by Kroth can be seen. This book would be appropriate for students being introduced to interviewing and conferences and for professionals who are reviewing their approach to parent conferences.

MARY PANNBACKER, Ph.D.
Louisiana State University
Medical Center
New Orleans, Louisiana

MORRIS, HUGHLETT L. (Ed), The Bratislava Project: Some results of Cleft Palate Surgery. Iowa City: University of Iowa Press, 1978, 214 pages, $15.00.

The Bratislava Project represents a cooperative team research effort of the Department of Otolaryngology and Maxillofacial Surgery at the University of Iowa and Professor Stefen E. Demjen's patients at the Plastic Surgery Klinic, Komensky University in Bratislava, CSSR. The project evaluated maxillofacial growth and velopharyngeal competence in cleft palate patients who had received the Demjen surgical procedure which severs the neurovascular bundle to permit greater flap retropositioning.

The chapters are written by the five major contributors in the study. The initial chapters of this text identified the subjects. Patients who had been operated upon at about two years of age by Demjen were selected and ranged from four to 17 years of age with 70 per cent between seven and 14 years at the time of the study in 1969. The 105 cleft palate subjects selected included 46 unilateral and 12 bilateral cleft lip and palate, with 47 cleft palate only. Control subjects included data from 58 normals. The clinical records revealed data from 1) velopharyngeal competence records, 2) facial growth-cephalometric records, and 3) facial growth-clinical examination-dental modelrecords.

Chapters II and III review the background and history. Chapter III gives a step-by-step description of the WV-Y palatoplasty procedure. Chapters IV-IX outline the assessment criteria and procedures.

The results reported indicated that these patients who had had the WV-Y palatoplasty modified by Demjen, demonstrated a relatively low incidence of velopharyngeal incompetence and relatively little maxillofacial growth deficit. These findings did not determine the specific difference of severing the neurovascular bundle on palatal length and, therefore, of velopharyngeal competence. The differences in facial morphology between Bratislava cleft subjects and normals was not significant.

The significance of the Bratislava project cannot be documented statistically. Its uniqueness rests in the fact that the patient data collection of one technique by the same surgeon is being reported in an orderly way to foster continued sharing of interdisciplinary and international research on congenital orofacial anomalies. The availability of data at each step in the research and the detailed description of their procedures indicates the contributor's concern for high standards in research and service.

The report is of interest to all professionals involved in evaluating surgical procedures for cleft palate patients. For those who would not necessarily agree with the Demjen procedure, the study may be reviewed for its attempt in controlling the variables and for its detail in reporting the data.

SISTER LOURDES LEAL, Ph.D.
Associate Professor
Department of Communication and Language Disorders
Our Lady of the Lake University
411 S. W. 24th Street
San Antonio, Texas 78285

MYSAK, EDWARD, D. *Pathologies of Speech Systems,* Baltimore, Maryland: The Williams & Wilkins Company, 1976, 297 pages $13.25

This 1976 paperback is grouped into eight chapters and two appendices. The text is well-organized and replete with pertinent information concerning *speech systems.* Among several suggestions, the author advocates the utilization of the speech-system approach in speech pathology and audiology to remind the clinician that "specific" communicative disorders rarely occur in isolation and that the clinician would be better prepared in diagnosing and treating these disorders if he/she is alert to the potential interfacing of various sytems which may contribute to causation and maintenance of manifested disorders. In the introduction, the author refers to "simplexes" versus "complexes" with simplexes referring to speech disorders in a specific system which appear in relative isolation as in articulation or voice; while complexes suggest speech disorders involving more than one system and which may reflect combinations of symptoms as in respiratory and phonatory disorders; or respiratory, phonatory, and articulatory disorders. Also, the disorders may involve symptoms of perceptual, intellectual, and emotional deficits.

The author reviews the following speech and hearing systems: receptor, transmitter, higher-order integration, lower-order integration, effector, and sensor. In Chapter 2, he presents a challenging approach to evaluation and diagnosis of deviant speech systems. He recommends easy-to-follow search procedures for relevant data. In the evaluation and diagnosis of the lower-order speech integrator system, he defines the system as one being concerned with automatic tuning and fine tuning of verbal input and output. He suggests that this system is responsible also for paralinguistic features as reflected in body postures, facial expressions, hand gestures, and vocal patterns during vocal input and output. After explaining the system, he mentions the need for historical and normative data. His examination procedures cover input processing as related to arousal, localizing, fixing, and tracking capacities of the audiovisual system and the ability to sustain selective attention of audiovisual events under competing situations, status of reflexes, articulation, etc.

Although his review of diagnostic approaches is not new, he elaborates upon different types of diagnoses in terms of the capabilities of the examiner and the benefits and/or limitations of each type of diagnostic approach, including group or team input into the diagnostic process. Chapters 3 through 8 are devoted to analyses of the six systems. In his explication of each system, the author provides information concerning the need for and the utility of background information in regard to various disorders, clinical manifestations, diagnosis, prognosis, and therapy (treatment).

In Appendix A, the author includes a convenient summary table from which the reader may review speech and hearing systems in terms of physical components, innervation data, and peripheral and/or central areas. His outline in Appendix B reviews specific areas the diagnostician should examine for each of the speech and hearing systems. This review serves as a reminder for the clinician to assess the significance of examination results in terms of degree of severity.

Although the author utilizes references published predominantly in the 1960's, the reviewer found the book to be very informative and useful for current clinical confrontations. The author's skill in organizing this complex subject is apparent. His writing is concise and comprehensible. The book would be a fine adjunct to courses dealing with anatomy, physiology, diagnoses, and treatment of communicative disorders. Supervisors of speech and hearing clinicians would find this text to be an excellent source in regard to concepts of speech systems as related to diagnosis and treatment; practitioners and others would refer to it often as they research and service their patients.

LARRY TERANGO, Ph.D., Professor
Department of Special Education;
Coordinator, Speech Pathology & Audiology
Eastern Kentucky University
Richmond, Kentucky

New Concepts In Maxillofacial Bone Surgery. Edit. B. Spiessl. 15 contributors. 194 pp., 183 figs., 36 tables. Berlin, Heidelberg, New York: Springer-Verlag, 1976. (Price unknown.)

The aim of this text is to demonstrate how stable anatomical fixation, under preload, enhances the primary healing of fractures and osteotomies, the revascularization of bone transplants, and the long-term tolerance of implants and joint prostheses.

The text is divided into five sections with each section designed to bring the reader from basic principles to surgical application. This feature makes this volume particularly useful.

The first section reviews the principles related to the application of bone grafts and the basic histophysiology of a graft. The application of fresh autogenous bone to large defects is presented in the form of a case report. In keeping with new concepts in bone surgery, the application of microsurgical techniques in preserving a bone transplant is well presented.

The second section deals with the principles of rigid fixation as they relate to the treatment of traumatic injuries and reconstructive surgery. The armamentaria for placement of dynamic compression plates (DCP) and excentric dynamic compres-

sion plates (EDCP) is introduced, and their application is documented in the treatment of 25 patients with mandibular fractures.

Functionally stable internal fixation for combined fractures of the maxilla and mandible is achieved by interosseous wiring and suspension of the midface and internal fixation of the mandible. Again, case histories with good illustrations and photos document treatment.

Orthopedic maxillofacial surgery comprises the third section of the text. A very clever technique that utilizes an autogenous graft to limit excessive movement of the condyle is described as is the application of a condylar prosthesis for the treatment of ankylosis.

The importance of maintaining the relationship between condyle and fossa when using the sagittal split osteotomy is presented in terms of precise preoperative planning and the advantage of internal fixation. This topic is expanded in describing the utilization of radiographs and dental models as well as the simulograph to determine the center of rotation and the position for internal fixation. The results of sagittal split osteotomy with simulography and rigid internal fixation for 75 patients with a variety of problems is reviewed in detail.

The fourth section of the text is concerned with implantology. The principles governing the success of an implant are presented in terms of dynamic compression, i.e. the dynamic compression inplant (DCI). The greatest portion of this section is devoted to the stability of the DCI and the evaluation of 70 cases where it has been utilized. Additionally, consideration is given to the development of a total mandibular plate in conjunction with DCI after ablative surgery. Throughout this section basic principles in the application of implants are stressed, and every attempt is made to explain why the technique succeeds and fails in a variety of cases.

The final portion of the text deals with postoperative infection and prophylaxis. The risk of communication between the fracture site and the oral cavity, particularly with mandibular fractures, is discussed in relation to complications and the application of DCP or EDCP. Attention is also focused on the use of prophylactic antibiotics in maxillofacial surgery. While no firm rules are established, criteria are suggested based on documented clinical experience.

In toto, the editor and contributors to this volume are to be complimented. Each section gives pertinent references. The material is well presented with stress on basic principles, and the content follows a logical sequence.

HOWARD ADUSS, D.D.S.
Center for Craniofacial Anomalies
University of Illinois
Chicago, Illinois 60680

NICOLOSI, LUCILLE, HARRYMAN, ELIZABETH, and KRESHECK, JANET, Terminology of Communication Disorders—Speech, Language, Hearing. Baltimore: The Williams and Wilkins Company, 1978, 273 pages, $14.50.

The authors have compiled a much needed compendium of terminology from the field of speech/language pathology and audiology and related areas. The handbook presents a comprehensive list of terms and definitions important to speech/language pathology and audiology with particular emphasis on terminology from related disciplines. Specific terminology on communication disorders, including some terms infrequently used, is intermingled in the book's aphabetical sequence. In the appendices, there is useful information concerning a range of specific speech, language, and auditory tests as well as measures for intellectual, social, and motor assessment.

This dictionary of terms should be an easy reference and resource for students in speech/language pathology and audiology. There is a continuing critical need, however, for the development of precise, uniform definitions for key selected terms for basic major speech, language, and hearing disorders to strengthen research and clinical activity and to facilitate better understanding by related disciplines.

INEZ E. HEGARTY, Ph.D.
Amherst, Massachusetts

SKINNER, PAUL H., and SHELTON, RALPH L., *Speech, Language, and Hearing: Normal Processes and Disorders.* Reading, Mass.: Addison-Wesley Publishing Company, Inc., 1978, $12.95.

This new text is an introductory survey of normal processes and disorders in speech, language, and hearing for students majoring in speech and hearing and in related professions (medicine, psychology, education). It is edited by Paul Skinner and Ralph Shelton of the University of Arizona with eight contributing specialists.

Chapter 1 deals with the methods of communication and with speech, language, and hearing in particular. An explanation is given of the speech and hearing system, how it functions as a servosystem, and of interpersonal communication. The final portion deals with speech and hearing as a profession, a topic which seems out of context with other information in this chapter. Phonology, morphology, syntax, and semantics are the initial material of Chapter 2. The last half of this chapter has a clear but unfortunately brief description of language acquisition. Chapter 3 presents the anatomy and physiology of speech and is divided into respiration, phonation, articulation, and the nerv-

ous system. Anatomical diagrams and a phoneme chart are provided to clarify the text.

Speech acoustics and perception (Chapter 4) covers sound generation and propagation, simple and complex sounds, resonance, and formant frequencies. Figures visualize the characteristics of the acoustic signal. The peripheral and central structures of the hearing mechanism receive a concise presentation in Chapter 5. Diagrams progress from general to detailed representations of the middle and inner ear structures. The process of the transmission of sound energy through the system is described. Chapter 6 includes the measurement of the parameters of hearing and a discussion of the decibel and audiogram. The remainder of the text deals with disordered processes and clinical intervention.

Chapter 7 discusses the scientific, artistic, and humanistic aspects of clinical intervention; the services related to and generated by therapy (evaluation, counselling); and clinical intervention procedures. It is doubtful that beginning students will understand or appreciate this information. Chapters 8 through 12 deal with disorders of articulation, phonation, fluency, and language in children and in adults. Each chapter presents the etiology, assessment procedures, and treatment approach for that particular disorder. Diagrams or pictures are provided but not always to advantage. For example, Chapter 9 has photographs of the vocal folds and of an elderly gentleman using an electrolarynx, neither of which contribute to an understanding of the text.

The final chapter is devoted to disorders of hearing. The etiology of hearing disorders, evaluation of hearing, basic interpretation of test results, amplification techniques, and special education are included.

The book is clearly written and well organized with each chapter supplemented by an introduction, conclusion, glossary of terms, study questions, and bibliography. It will certainly meet the needs of professors who wish to present an overview of the field in one or two courses. Each chapter provides the core of information upon which lectures can be built. This text should prove a worthwhile addition to the literature and provides a choice for those in need of a microcosm of information regarding normal and disordered communication.

Robert C. Thompson, Ph.D.
Children's Medical Center
Tulsa, Oklahoma

Trantham, Carla Ross, and Pedersen, Joan E., *Normal Language Development; the Key to Diagnosis and Therapy for Language Disordered Children.* Baltimore, MD: Williams and Wilkins, Co., 1976, $13.75.

This book summarizes the results of a longitudinal descriptive study of the expressive language of eight children, from ages 18 months to 36 months. Samples recorded at three-week intervals are analyzed in terms of sentence length, sentence types, percentage of sentences correct, Lee's Development Sentence Scoring, and the emergence and mastery of grammatical forms such as pronouns, negatives, interrogatives, conjunctions, and verb tenses. The presence or absence of jargon, echoing, verbal play, and gesturing is also recorded.

During the course of the study, it was discovered that one of the eight children showed atypical patterns of expressive language development, and he was later diagnosed as language disordered. The detailed information obtained about the language development of this child allows the authors to contrast normal and atypical patterns and draw strong inferences about qualitative and quantitative differences to be used as guidelines in the early identification and differential diagnosis of expressive disorders in preschool children. Two chapters are devoted to diagnostic and therapeutic techniques suggested by the findings.

The book is written in easily understood language and avoids the specialized terminology which so often limits the value of linguistic studies to those with specialized training in the area. The data are presented in graphs and charts with adequate explanations and examples.

This manual is a significant and valuable addition to the libraries of those working in the area of language problems. Although the method described is time-consuming and requires knowledge of Lee's DDS, it fills the need for a relatively simple model for the analysis of expressive language skills in very young children and for the evaluation of therapy. It will be of most value to clinicians working directly with pre-school or elementary school aged children but can also be helpful to all other specialists dealing with children with potential language problems.

Anna K. Pleasonton, Ph.D.
Tulane University School of Medicine
Section of Speech Pathology and Audiology
New Orleans, LA

ABSTRACTS

ABBS, J. H., and STIVERS, D., New cephalostat for speech physiology research, *J. Acoust. Soc. of Amer., 63,* 1174–1175, 1978.

A cephalostat which eliminates the need for ear-post attachments has been developed and is currently being employed in studies of speech production. Head stabilization is achieved through the use of a circular headband and support ring with threaded fastener screws. A major advantage is that a subject may remove his head voluntarily from the device without injury. However, the circular headband may prove uncomfortable to subjects over long periods of time because it must be firmly secured to obviate head movement. (Ruscello)

ABYHOLM, F. E., Cleft lip and palate in Norway, 1. Registration, incidence and early mortality of infants with CLP, *Scand. J. Plast. Reconstr. Surg., 12,* 29–34, 1978.

Despite the medical registration of births and required information on congenital malformations in the newborn having been introduced in Norway in 1967, examination of hospital records for patients born during the years 1967 to 1974 and operated upon for cleft lip and palate revealed an under reporting of 14.46 per cent. The corrected real incidence of cleft lip and/or palate in Norway is now estimated to be 2.08 per thousand live births. The incidence among still births was four per thousand. The main subgroups included cleft lip with an incidence of .66 per thousand live births; cleft lip and palate, −.77 per thousand; and cleft palate, −.65 per thousand. Of 1073 cases recorded, 59 per cent were males and 41 per cent females. Mortality in the first year of life among infants with cleft lip and/or palate was 6.54 per cent. Eighty percent of the infants dying had congenital malformations other than cleft lip and/or palate, and these multiple malformations were the cause of death in 52 per cent of these cases. (Cosman)

ABYHOLM, F. E., Cleft lip and palate in a Norwegian population, II. A numerical study of 1555 CLP-patients admitted for surgical treatment 1954–75, *Scand. J. Plast. Reconstr. Surg., 12,* 35–43, 1978.

From 1954 to the present, about 60 per cent of all patients with cleft lip and/or palate in Norway have been treated in the Department of Plastic Surgery at the Rikshospitalet, Oslo. Of these patients, cleft lip alone constitutes 27.5 per cent, cleft lip and palate 33.8 per cent, and cleft palate alone 38.7 per cent. In males the most common defect was cleft lip and palate. In relationship to females, the ratio was two to one. Isolated cleft palate was most common among females. In unilateral clefts, the left side was affected in 68.6 per cent of the cases and the right side in 31.4 per cent. In bilateral clefts, 60.5 per cent of the left side was the most severe. More than one fourth (27.5 per cent) of the entire group showed a positive family history. Patients with complete clefts had a positive family history more often than those with incomplete clefts. Associated congenital malformations were found in 11.5 per cent of this population with the highest incidence being in the isolated cleft palate group. (Cosman)

BARINKA, L., A new method of lip suture in unilateral clefts, *Acta Chirugiae Plasticae, 18,* 3, 1976.

Thirty-eight hundred patients with cleft lip were operated upon from 1949 to 1971 at the Department of Plastic Surgery in Brno by a modified method based on the principle of Veau's operation with V excision. From 1971 to 1975, 320 patients with unilateral cleft lip were operated upon with very good results by a new simplified method which is demonstrated in diagrams and figures. (Peskova)

CAREY, J. C. and HALL, B. D., The Coffin-Siris Syndrome, *Amer. J. Dis. of Child, 132,* 667–671, 1978.

Five new cases and one previously reported case of the Coffin-Siris syndrome are described. These cases, plus the

remaining four already published, bring to ten the number of cases available for scrutiny. Constant features (100 per cent frequency) include variable degrees of mental retardation, nail hypoplasia or absence with predominantly fifth digit involvement, hypotonia, infancy feeding problems, and retarded bone age. Frequent features (75 to 90 per cent) include postnatal growth deficiency, microcephaly, wide nasal tip and mouth, prominent lips, eyebrow/eyelash hypertrichosis, and scalp hair hypotrichosis. Significant but less frequent findings include short philtrum (50 per cent) scoliosis (40 per cent) decreased fetal activity (40 per cent) smallness for gestational age (30 per cent), and congenital heart defects (30 per cent). It was found that the craniofacial phenotype was mild in the young infant but progressively more characteristic with age. Autosomal recessive inheritance is suspected on the basis of the brother- and-sister pair. (Glaser)

FARA, M, Medial cleft lips, *Acta Chirurgiae Plasticae, 19,* 1, 1977.

Twenty-five cases of medial cleft lip treated at the Department of Plastic Surgery in Prague are used as a basis for a discussion of systematics, embroyogenesis, incidence, and treatment. The significance of an early diagnosis of medial "pseudocleft" caused by the pull of a shortened hypertrophic upper lip frenulum is emphasized. Surgery is needed soon after birth in these cases. In medial cleft lips, attention is called to the importance of severing stumps of the orbicularis oris muscle from their atypical attachments to the maxilla, turning them downwards, and suturing them "end to end" in the reconstruction of the lip. (Peskova)

HATA, Y., and OHMORI, S., A method of reconstruction of the sublabial sulcus and the vermilion tubercle in the secondary repair of the bilateral cleft lip deformity, *Brit. J. Plast. Surg., 31,* 165–169, 1978.

The problem of forming a sublabial sulcus in patients with a bilateral cleft lip has been a difficult one, and the approaches of Z-plasty, V-Y-plasty, free skin or mucosal grafts, distant flaps and orthodontic appliances have all created difficulties. An M-flap technique is described, using two lateral mucosal flaps and a central flap, which incorporates the mucosa and the muscle. The procedure has been used in twenty cases of varying grades of deformity with good results. (Reid)

HEALY, G. B., MCGILL, T. and STRONG, M. S., Surgical advances in the treatment of lesions of the pediatric airway: the role of the carbon dioxide laser, *Pediatrics, 61,* 380–383, 1978.

Transoral microsurgery of the larynx has now made it possible to treat multiple lesions heretofore only treatable by external approach. The introduction of the surgical carbon dioxide laser has been a great advance in transoral surgery of the airway in the past 15 years. This modality of therapy offers many features not found in any other known form of surgery. It is especially useful in the pediatric airway where the avoidance of edema and the need for minimal scarring is most critical. Its unique aspects make this form of treatment most desirable in the pediatric laryngotracheal region. The use of the carbon dioxide laser is discussed. (Glaser)

HELLQUIST, R., PONTÉN, B., and SKOOG, T., The influence of cleft length and palatoplasty on the dental arch and the deciduous occlusion in cases of clefts of the secondary palate, *Scand. J. Plast. Reconstr. Surg., 12,* 45–54, 1978.

A group of 99 children was studied and an attempt made to relate the linear dimensions of the maxilla both before and after palatoplasty to the extent of the cleft of the secondary palate prior to closure. In general, with a large cleft, a contraction of the maxilla was noted postoperatively except in the tuberosity region where the increase in width noted was smaller than in a small cleft case. Large palatal clefts showed a frequency of anterior crossbite double that found in small clefts. This finding held in cases of complete, unilateral cleft lip and palate. Unexplicably, the frequency of anterior crossbite was 12.6 per cent higher for boys in this study in spite of the fact that the frequency of large clefts was somewhat lower for them than for girls. (Cosman)

JACKSON, I. T., HIDE, T. A. H., and BARKER, D. T., Transposition cranioplasty to restore forehead contour in craniofacial deformities, *Brit. J. Plast. Surg., 31,* 127–130, 1978.

A modified Stricker approach is described preserving the temporalis muscle so that it is available for soft tissue contouring in the lateral orbital area where concavity occurs after many cranio-orbital procedures. Increased bone resorption has not been noticed despite absence of the muscle pedicle. The operation involves the transposition of an upper forehead transverse bone flap and a lower transverse bone flap. The procedure deals with the anterior part of the skull deformity only but, as the remainder of the scalp is covered by hair, correction of the posterior deformity is deemed unnecessary. (Reid)

JAWORSKI, S., Macrostomia, a modified technique of surgical repair, *Acta Chirugiae Plasticae, 18,* 2, 1976.

An account of surgical treatment of macrostomia is presented. In the Research Institute for Mother and Child in Warsaw, Poland, the children were operated upon by the author's modification of Longacre's technique which respects the reconstruction of the oral angle. The method is demonstrated on the diagram and figures. (Peskova)

KIPIKASA, A. and POTOCKA, E., Pierre Robin syndrome. *Acta Chirurgiae Plasticae, 19,* 3–4, 1977.

The possibilities of the management of acute asphyxia are discussed in 13 cases of the Pierre Robin Syndrome. Six cases were treated with success by using a double anterior suspension of the mandible by means of Kirschner wires. The method is relatively simple with a minimum of risk. (Peskova)

MCGILL, T. J. I. and HEALY, G. B., Congenital and acquired lesions of the infant larynx, *Clinical Pediatrics, 17,* 584–589, 1978.

A review of the more common causes of congenital and acquired lesions of the infant larynx causing respiratory distress is presented. These causes include laryn-

gomalacia, retention cysts, laryngocoeles, cystic hygromas, webs, papillomas, laryngeal paralysis, bifid epiglottis, and subglottic stenosis. (Glaser)

RINTALA, A. and UUSPÄÄ, V., Anophthalmia and agenesis of columnella, prolabium, and premaxilla without hypotelorism—a new syndrome? Case reports, *Scand. J. Plast. Reconstr. Surg., 12,* 69–74, 1978.

Three patients with anophthalmia, midline upper lip pseudocleft with absent columnella, prolabium, and premaxilla, but without hypo- or hypertelorism are presented together with three borderline cases with either anophthalmia or microphthalmia and a lack of the distal half of the nose or cleft lip and palate. The authors attempt to organize these somewhat disparate features and to identify them as a new syndrome. Relationships with other facial anomalies are discussed. (Cosman)

SASAKI, C. T., GAUDET, P. T., and PEERLESS, A., Tracheostomy decannulation, *Amer. J. Dis. Child., 132,* 266–269, 1978.

Tracheostomy may be necessary in the surgery for congenital maxillo-facial anomalies. This pediatric group may suffer from decannulation difficulty. A review of 123 consecutive pediatric tracheostomies is presented showing that 44 patients experienced such difficulties. Among those patients suffering decannulation delay, subglottic stenosis had developed in 36 per cent, tracheal granuloma in 25 per cent, and fused cords in 11 per cent, temporary laryngeal abductor failure was high. More than 60 per cent of those patients affected respond to treatment when diagnosis was prompt and accurate. In this regard, the laryngologist plays a central role in the management of the pediatric decannulation process. (Glaser)

SCHRUDE, J., Latest results in labio-maxillo-palatine clefts treated by primary bone graft, *Cir. Plast. Ibero-Latinamer, 4,* 139, 1978.

The author habitually treats labiopalatine fissures by means of bone grafts placed like a bridge between the arcs of the fissure. The author concludes that a successful primary bone graft offers the possibility of creating physiological conditions so that the maxilla can adequately react to the normal tension stimuli to which it is subjected. (Jose Guerrero-Santos)

SEKHAR, H. K. C., TOKITA, N., ALEXIC, S., SACHS, M., and DALY, J. F., Temporal bone findings in hemifacial microsomia, *Ann. Otol., Rhinol. and Laryng., 87,* 399–403, 1978.

A two-and-a-half-year-old child who showed a normal chromosome pattern and had no family history of congenital anomalies was born with bilateral cleft lip, cleft palate, and cleft nose together with right hemifacial microsomia. Except for small tags, the right auricle was absent as was the external auditory canal. There was no right eye, and the orbit was atropic. The right maxilla and mandible were hypoplastic. There were multiple cervical hemivertebrae, a ventricular septal defect, mitral stenosis, Arnold-Chiari malformation, and absent deglutation reflex necessitating gastrostomy for feeding purposes. The child died during the post-operative interval following cleft palate repair. Histological findings in the temporal bones included hypoplasia of the affected petrous bone, total dehisence superiorly of the internal auditory meatus, deformity of the otic capsule with an underdeveloped cochlear modiolus, deficiency in the spiral ganglion nerve cell population, partial deficiency of the interscalar septum between the apical and middle coils of the spiralling cochlear shell, short cochlear duct, normal organ of Corti, without structural abnormality of the vestibular system except for degeneration and reduction in the number of the Scarpa's ganglion cells and nerve fibers, and total absence of the facial nerve on the affected side except for its nervue intermedius component. (Gregg)

SELLERS, S. L., and BEIGHTON, P. H., Deafness in osteoplasty of Melnick and Needles, *Arch. Otolaryng., 104,* 225–227, 1978.

This uncommon skeletal dysplasia includes prominent forehead, dental malocclusion, micrognathis, hyphoscoliosis, genu valgum, bowing of the forearms, and foreshortening of the distal phalanges. On x-ray, irregular ribbon-like constrictions of the ribs and long bones, coxa valga, deformity of the pelvis, sclerosis of the mastoids and the base of the skull, rudimentary paranasal sinuses, and patchy sclerosis in the cortices of the long bones are seen. The oto-audiological findings in a 12-year-old boy are presented along with a brief resume of the literature. In this instance, mixed conductive and perceptive hearing loss was found. Serous fluid was present in both middle ears, and on the right side there was no round window. (Gregg)

SMITH, D. W. and TONDURY, G., Origin of the calvaria and its sutures, *Amer. J. Dis. Child., 132,* 662–666, 1978.

Studies indicate that the dura is the guiding tissue in the morphogenesis of the calvaria and its major sutures, which develop from ten to sixteen weeks of fetal life. Overlying the central zones between the dural reflections, ossification takes place, whereas none occurs over the reflections of dura, these being the suture sites. Strong evidence for the role of the dural reflections in determining the suture sites was obtained from the evaluation of instances of major brain malformations that must have antedated calvarial morphogenesis. These included holoprosencephaly, craniopagus, and dicephaly. The altered dural reflections, which related to the aberrant form of the brain, coincided with the position of the unusual sutures. Furthermore, a lack of a dural reflection was accompanied by a lack of development of a suture at that site. (Glaser)

ANNOUNCEMENTS

COURSE ON CLEFT LIP AND PALATE TREATMENT

The Children's Memorial Hospital, Chicago, Illinois, announces a two day course and work-shop for Plastic Surgeons and Orthodontists on the combined surgical and orthodontic treatment of the new born cleft lip and palate child.

The two day course (March 26–27, 1979) will stress the integrated and sequential treatment procedures involved, including maxillary orthopedics, surgical repair, primary osteoplasty and long term results.

The course will be under the direction of Sheldon W. Rosenstein, D.D.S. and Desmond A. Kernahan, M.D.

For further information write to: Mrs. Martha E. Argueta, Division of Plastic Surgery, The Children's Memorial Hospital, 2300 Children's Plaza, Chicago, Illinois 60614.

ORTHODONTIC CHAIRPERSON WANTED

The School of Dentistry at the University of Mississippi Medical Center is seeking a qualified person to serve as full-time chairperson of the Department of Orthodontics. This position will be available July 1, 1979. Candidates should be board eligible and have experience in administration, teaching, private patient care, and research. The opportunity to conduct research and to participate in an intramural private practice is available. Salary and academic rank are commensurate with education and experience. Interested individuals should submit their curriculum vitae to Dr. Glen E. Robinson, School of Dentistry, University of Mississippi Medical Center, 2500 North State Street, Jackson, Miss. 39216. Equal Opportunity Employer, Male/Female.

19th ANNUAL SYMPOSIUM AND SHORT COURSE ON CLEFT PALATE AND CRANIOFACIAL DISORDERS—APRIL 5 AND 6, 1979

The Center for Craniofacial Disorders of Montefiore Hospital and Medical Center and Albert Einstein College of Medicine Announces its 19th Annual Symposium and Short Course on Cleft Palate and Craniofacial Disorders, April 5 and 6, 1979.

Guest speakers R. Bruce Ross, Dentist in Chief, Hospital for Sick Children, Toronto, Canada, and Ronald Pigott, F.R.C.S., F.R.C.S.I., Consultant Plastic Surgeon, Frenchay Hospital, Bristol, England will join the faculty of the Center in the multidisciplinary program.

This course is accredited for 14 hours of Category I AMA credit.

More detailed program information is available from: Center for Craniofacial Disorders, Montefiore Hospital and Medical Center, 111 East 210 Street, Bronx, New York 10467. Phone: 212-920-4781.

The 4th Dental Congress of Rio Grande do Sul and the 14th Brazilian Dental Congress will be held in Porto Alegre, Rio Grande do Sul, Brasil (Dental School, UFRGS, P.O. Box 1118), July 14th–20th 1979.

The official program of such meeting will include: (1) Pedodontics; (2) Dental Prothesis; and (3) Endodontics.

Dr. Luis Alberto A. Kramer, Presidente, 14° Cong.Bras.Odontologia, 4° Cong. Odont.Riograndense, Dental School UFRGS, P.O. Box 1118, Porto Alegre, Rio Grande do Sul, Brazil.

THE CANADIAN CRANIOFACIAL SOCIETY WAS FORMED ON MAY 7, 1978

On May 7, 1978, the Canadian Craniofacial Society was formed in Saskatoon, Saskatchewan. The Society is for all interested in the management and research of disorders of the face and skull, and will be of interest to audiologists, dentists, geneticists, neurosurgeons, orthodontists, oral surgeons, ophthalmologists, otolaryngologists, psychologists, radiologists, plastic surgeons, social workers, speech pathologists, and many other specialties concerned with the habilitation of these patients.

Mary Anne Witzel, M.S., Speech Pathologist, at the Hospital for Sick Children, Toronto, was elected the first President.

Charter memberships ($10.00) are available by contacting Dr. Ronald Hill, Treasurer, Canadian Craniofacial Society, Suite 101, 230—20th Street East, Saskatoon, Saskatchewan, S7K 0A6.

The next Scientific Meeting for the presentation of papers will be held at the Chateau Laurier Hotel in Ottawa—April 28–29, 1979. Deadline for submission of abstracts is February 15, 1979. For information contact Dr. Frank Wilson, Corbett Hall, University of Alberta, Edmonton, Alberta T6G 2G4.

WANTED: DIRECTOR OF CENTER FOR CRANIOFACIAL ANOMALIES

California—Director, Center for Craniofacial Anomalies, Department of Growth and Development. Primary duties include coordination of an ongoing research program in craniofacial growth, coordination of clinical treatment of craniofacial anomalies with associated teaching responsibilities. Rank and salary determined by experience and credentials. Available July 1, 1979. University of California, San Francisco is an Equal Opportunity/Affirmative Action Employer. Women and minorities are encouraged to apply. Send curriculum vitae to Dr. Robert J. Isaacson, Department of Growth and Development, School of Dentistry, University of California, San Francisco, San Francisco, CA 94143.