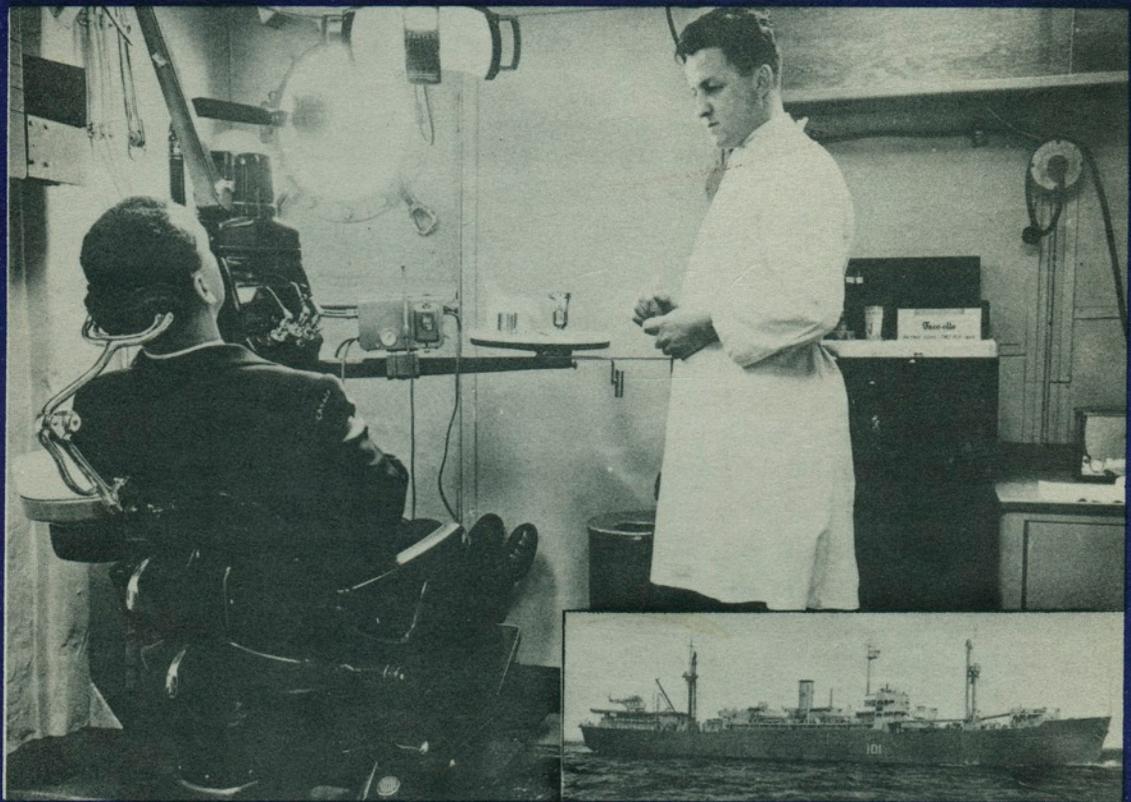


2913

The
**ROYAL CANADIAN
DENTAL CORPS**
Quarterly



NEW SUBSIDIZATION PLAN AUTHORIZED

Word has just been received that a new plan for subsidizing dental undergraduates for service in the RCDC has been authorized. This new plan replaces the Regular Officer Training Plan and the 21-Month Subsidization Plan and combines the best features of both. No further enrolments will be accepted in the old plans. Benefits provided include:

1. Up to 45 months (4 academic years) free tuition;
2. 24 months as an officer cadet with \$63 per month pay and \$65 per month allowance for food and quarters when these are not provided;
3. 21 months as a 2nd lieutenant with \$225 per month pay and \$75 per month allowance for food and quarters; or \$375 per month pay if married;
4. Actual cost of dental instruments and supplies;
5. Annual grant of \$75 for textbooks;
6. Enrolment is permitted at any level of dental undergraduate training;
7. Undergraduates enrolled in the ROTP or 21-Month Plan may transfer to the new plan.
8. No age limit is imposed except that an undergraduate must be young enough to complete the compulsory period of service following graduation before normal retirement age which is 47 for a Captain;
9. Undergraduates are permitted to be married after commissioning as a 2nd lieutenant.
10. A five-year period of service following graduation is mandatory. At the conclusion of this service the option is given to continue in the RCDC as a regular officer or be released to civilian life.

The points listed above are simply the highlights of the new plan. Many other benefits and privileges associated with military service and commissioned status are provided.

Interested dental undergraduates can obtain further information from their University Resident Staff Officers or write direct to:

Director General of Dental Services,
Army Headquarters,
Ottawa, Ontario.

Cover Photo

Sgt Doug Murley is shown with a patient in the dental clinic aboard HMCS Cape Scott (inset).

TABLE OF CONTENTS

	<u>PAGE</u>
12 Dental Company - Roger	1
A Simple Method of Cardiac Resuscitation - W.B. Kouwenhoven, Dr. Ing., James R. Jude, M.D., and G. Guy Knickerbocker, M.S.E.	4
Bell's Palsy - Report of a Case - Lovely	6
Steam Collector for Sterilizer - Morris	8
Factors Affecting the Quality of Extra-Oral Radiographs - Thorsson	9
The Case for Replantation - McDermott and Shaw	10
Reminiscences of Ireland - Egan	13
Bilateral Subluxation of the Temporomandibular Joint - Morrison	14
Let's Keep Them in School - Butcher	16
A Technique for Apicoectomy of Anterior Teeth - Susser	18
HMCS Bonaventure Cruise - Winter 1961 - McGaughey	20
Directorate of Dental Services News	22
No 1 Dental Equipment Depot News	23
The RCDC School News	24
11 Dental Company News	25
12 Dental Company News	26
13 Dental Company News	27
14 Dental Company News	29
15 Dental Company News	30
4 Field Dental Company News	33
35 Field Dental Unit News	33

THE RCDC QUARTERLY

Published by authority of Brigadier KM Baird, Director
General of Dental Services for the Canadian Forces

Editorial Board: Col GB Shillington
Lt Col JG Butler
Maj DH Protheroe

12 DENTAL COMPANY

Lt Col AT Roger, MBE, CD, DDS

For anyone interested in the military history of early Canada, a posting to No 12 Company RCDC(R) provides an excellent opportunity for on the spot investigation of historical events which occurred during the formative years of the region now known as the Atlantic Provinces.

The history of No 12 Dental Coy is relatively brief; however, as one of the original regular force companies it has seen a considerable number of changes take place in its establishment and area of responsibility. It might be of interest particularly to our younger members, to review in a few sentences some of the stages in the development of this unit to its present status. Shortly after the close of the Second World War three dental companies were formed to provide a dental service for Canada's peace-time forces. No 12 was designated as the "Navy Company" and soon a strong rumour was circulating to the effect that its personnel would shortly be changing from khaki to the navy blue of the RCN. Whether this was based on unfounded conjecture or high level deliberations is not known by the writer, however, it is certain that the unified corps which has evolved over the years is far preferable to three separate dental services, particularly for peace-time conditions with a continuing shortage of RCDC personnel.

The geographical area coming under 12 Coy jurisdiction originally extended all the way from the Quebec-Ontario border in central Canada to Newfoundland, Labrador and the three Maritime provinces in the east. During this period 12 Coy was responsible also for personnel aboard ships based on the Pacific coast.

As the need for dental service increased with the establishment of various new components of the three services, the situation was alleviated by the formation of No 15 Coy with headquarters in Montreal, 12 Coy retaining responsibility for the three Maritime provinces and Newfoundland.

The affairs of this unit have, since its inception, been guided by a series of illustrious commanding officers, the first of whom was the then Lt Col CBH Climo. On being posted to the Directorate, he was succeeded by the late Lt Col FJ MacLean. Lt Col WE Meldrum from the staff of the DGDS was next given command and he remained in Halifax three years until appointed Commandant of The RCDC School, then located in Ottawa. Brigadier KM Baird, then a lieutenant-colonel, was the next Commanding Officer, and he in turn was succeeded, upon his promotion to Colonel and posting to Trenton, Ont, by Lt Col HL Harris, previously CO of 13 Coy. After more than four years on the Atlantic coast Lt Col Harris was promoted and posted to the Directorate at AHQ. Lt Col WM Sinclair then was appointed Commanding Officer, remaining until his retirement in the spring of 1960.

Two of these gentlemen, Colonels Climo and Meldrum, on retirement returned to clinical dentistry and are at present augmenting the efforts of the Corps in the Ottawa area. Lt Col Sinclair has accepted a position with the Manitoba government and is now attending the University of Toronto to become qualified in Dental Public Health.

Over the years various new clinics have been established to meet the needs of changing service distribution and others closed when military establishments such as Camps Debart and Aldershot shut down. Existing clinical facilities are steadily being expanded and improved. As in other dental companies the main problem is the provision of personnel to man these facilities.

As would be expected, the majority of our clinics are situated at naval installations and the RCN provides a larger number of potential patients for our dental officers than the Army and Air Force combined. Postings within the unit provide opportunities for 12 Coy personnel to gain experience in the customs and methods of the three services.

Two new clinics which have been opened during the past 12 months are located in HMCS Cape Scott and at HMC Dockyard. The Cape Scott is a supply ship which accompanies the fleet on exercises and is equipped to make "on the spot" repairs when required. A compact but complete dental clinic has been provided, including laboratory and darkroom, and dental detachments are assigned from various shore establishments for the duration of fall and winter cruises. These usually include the coastal waters off Nova Scotia in the autumn and the Bermuda area during January and February.

The Dockyard clinic is strategically located "on the waterfront"; in fact it is on the second "deck" of a building which also houses repair facilities for ships, boats and other small craft. This is an extremely busy clinic, particularly when the majority of ships of the fleet returns from manoeuvres and the crews avail themselves of the opportunity to obtain dental care.

The clinic in HMCS Bonaventure includes two chairs and sections are posted on board for periods of approximately one year. A description of conditions on the aircraft carrier will be found elsewhere in this and previous issues of the Quarterly.

The Camp Gegetown detachment is another hard-working group and each summer arrangements must be worked out there for participation in, and dental service for the infantry brigade group concentration and exercise. During these few weeks of June and July there is an opportunity for dental personnel to familiarize themselves with the operation of a mobile dental van and the problems involved in its movement and camouflage.

The treatment carried out during this period is generally rather restricted as the troops are fully occupied with their training activities.

The clinic staff at the large naval training establishment at HMCS Cornwallis devotes the greater part of its efforts to rendering RCN recruits dentally fit for their initial tours of sea duty. This is no small task as the embryo seamen are undergoing intensive training and, once at sea, may be out of reach of dental relief for a considerable interval.

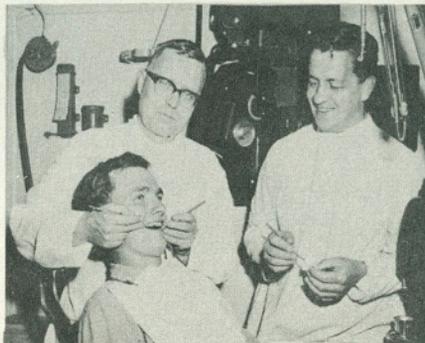
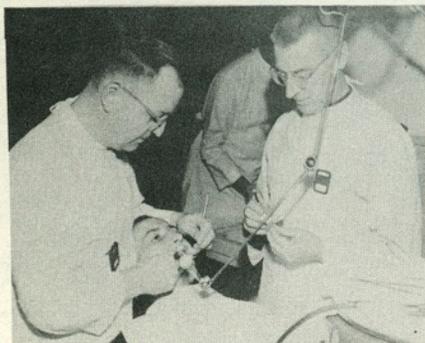
The sections with the RCAF at Greenwood, Chatham and Summerside also deserve mention for the large number of personnel on these stations provides ample work. However certain "fringe benefits" in these locations include opportunities for week-end "flips" to the Azores, Montreal or other glamorous spots.

The dispersal of various elements of the fleet, for refit and other purposes, to ports such as Sydney, Saint John and Shelburne poses a problem in providing dental care. We are fortunate in being able to utilize the services of our civilian confreres in these areas and comprehensive treatment is always available.

This unit also has a number of part-time clinics which must be attended at regular intervals, at such locations as Beaverbank, Moncton, Gander and St John's, Newfoundland. This additional commitment at times results in our available manpower being spread "pretty thin". However new surroundings and a change of scenery from time to time are a part of service life which most members enjoy, whether they will admit it or not. If nothing else, it provides opportunities to explore new fishing areas and this part of Canada is an ideal playground for addicts of this sport.

Our hunting enthusiasts, too, usually do not come home empty handed. Another popular pastime is sailing and facilities in this area are plentiful for all types of boating. Camping trips are becoming increasingly popular and opportunities for simply "admiring the scenery" are plentiful.

All things considered, life can be very pleasant in this Atlantic region and it is hoped that perusal of this article may prompt a few requests for posting to No 12 Company, RCDC.



12 Coy Personnel

- Top - L to R - Capt Harry Meisner, Cpl EL Schell, Major Gord Grant, Sgt Doug Murley, Capt RJ Lewis
 Centre - L to R - Cpl HD Wagstaff, Capt Denny Morrison and Cpl Wagstaff
 Bottom - L to R - Cpl AF Randall, Cpl Larry Barrett, Capt Lewis, Cpl Randall, Capt Meisner, Cpl Wagstaff, Lt Col Norm Butcher, S sgt Alec McIsaac, Capt Morrison, Cpl Schell

A Simple Method of CARDIAC RESUSCITATION

W. B. KOUWENHOVEN, DR. ING.,* JAMES R. JUDE, M.D.,**
and G. GUY KNICKERBOCKER, M.S.E.,*** Baltimore

DIGEST

Cardiac arrest results from a variety of causes, including anesthesia, anoxia, and myocardial infarction, and may occur when a patient is undergoing dental treatment. In circulatory arrest the heart may be either in asystole or ventricular fibrillation. When this emergency occurs prompt action is essential as the human brain can only survive three or four minutes without oxygenated blood. When the pulse disappears and the respiration ceases two measures must be effected: (1) artificial respiration, and (2) the circulation of the oxygenated blood. This article describes the procedure used to obtain cardiac resuscitation when an emergency arrest of heart activity occurs.

First Steps in Treatment

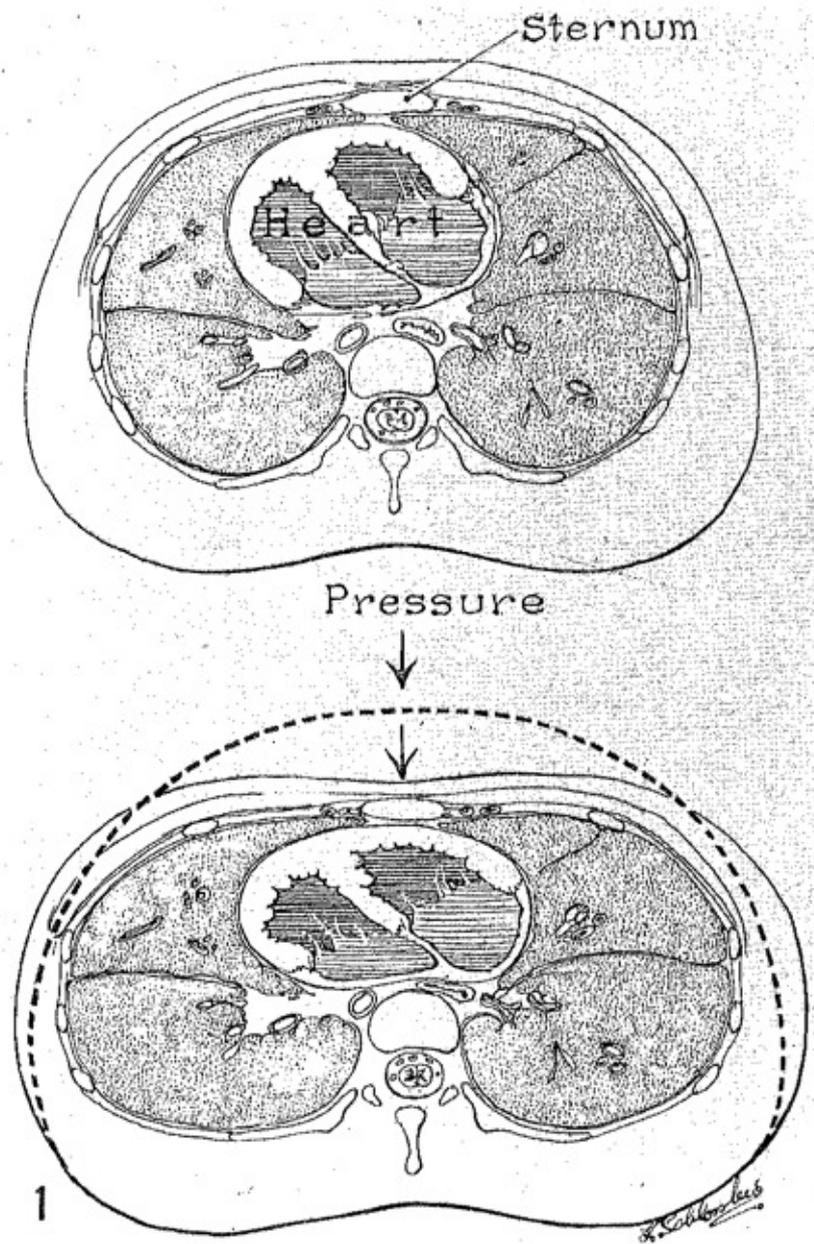
1. In treating cardiac arrest the patient must first be placed in a supine position, preferably on a firm support such as the floor or a table. If placed on a bed, a board should be placed under the patient's back.
2. The chin should be raised, the neck extended as is done in the practice of mouth-to-mouth respiration.
3. The blood is circulated by applying closed chest heart massage. Heart massage and artificial respiration should be applied simultaneously. When these measures are in process an ambulance should be called.

Heart Massage—Definition

Closed chest heart massage¹ is a method of squeezing the heart by pressing on the breast bone. This pro-

vides adequate circulation to nourish the central nervous system and maintain the tone of the heart without resorting to thoracotomy.

Method—The manner in which the heart is squeezed by pressing on the breast bone is shown in Figure 1 which



1. Cross section of chest.

is a cross section of the chest at the level of the lower third of the sternum. The heart lies between the sternum and the vertebral column and its lateral movement is restricted by the pericardium. The ribs are joined to the sternum by their costal-cartilages. The chest of a conscious person is rigid, but that of an unconscious person is remarkably flexible.

Blood Forced into Circulatory System—When the breast bone is depressed by the application of pressure, the heart is squeezed between it and the vertebral column and blood is forced out into the circulatory system. When the pressure is released the chest expands and the heart refills. The operation of the heart assures the circulation of blood when rhythmic pressures are applied to the sternum.

Steps in Procedure

1. Provide a patent airway.
2. Closed chest cardiac massage is applied by placing the two hands, one above the other, on the breast bone of the patient as illustrated in Figure 2. The cardinal points for the location of the hands are the xiphoid, at the lower end of the sternum, and the suprasternal notch at the upper end. The breast bone lies between these two landmarks.
3. The heel of the lower hand is placed on the lower third of the sternum, just above the xiphoid, and the other hand is placed on top of it. Firm vertical pressure should be exerted at the rate of 60 to 80 times per minute. No pressure is exerted with the fingers.
4. When pressure is released the hands may be lifted a fraction of an inch from the chest. Systolic blood pressures of 90 to 120 millimeters of mercury, and diastolic pressures of 30 to 50 millimeters are normally realized.
5. The operator may approach the

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***Assistant, in Surgery, Johns Hopkins University School of Medicine.

Author's Note: This study was supported by a grant from the National Heart Institute, National Institutes of Health.

¹Kouwenhoven, W. B.; Jude, J. R.; Knickerbocker, G. G.: Closed Chest Cardiac Massage, *JAMA* 173:1064 (July 9) 1960.

²Kouwenhoven, W. B.; Milnor, W. R.; Knickerbocker, G. G.; and Chesnut, W. R.: Closed Chest Defibrillation of Heart, *Surgery* 42:550 (Sept.) 1967.

³Kouwenhoven, W. B.; Knickerbocker, G. G.; Milnor, W. R.; Jude, J. R.: Field Treatment in Electric Shock Cases 11, *Elect. Eng.* 79:500 (June) 1960.



2

2.
Closed chest heart massage.

patient from either side, whichever is more convenient. It is less tiring and the best results are obtained if the operator is higher than the patient, so that he may hold his arms rigid and use some of his body weight in applying the pressure. If the patient is a child one hand is sufficient.

6. An airway has been inserted into the mouth of the patient shown in Figure 2 to assure the passage of air into and out of the lungs by mouth-to-mouth artificial respiration.

Airway Must be Present—If there is only one operator available in the emergency, he should first be sure that

there is a patent airway, and then inflate the patient's lungs with three or four quick deep breaths mouth to mouth. Then apply heart massage for about a minute before ventilating the lungs again. Continue until aid arrives to take over artificial respiration.

Signs of Resuscitation—The patient's condition may be observed during the application of massage and artificial respiration. The pupils should remain constricted. If they were di-

lated before the start of resuscitation, they should constrict afterward. In some cases a patient may make attempts to breathe on his own. These signs indicate that the resuscitative techniques are effective. With effective heart massage a palpable pulse may be detected, especially in a femoral artery.

Effective Aid in Hypotension—In some instances of cardiac standstill this massage plus artificial respiration may be sufficient to cause the heart to resume autogenous beats. In other instances, including cases of ventricular fibrillation, the heart will not resume sinus rhythm and if massage is stopped spontaneous breathing ceases and the pupils dilate rapidly. Closed chest cardiac massage may also be used as an effective aid in cases of marked hypo-

tension. It is not necessary to attempt to synchronize the massage with spontaneous cardiac activity.

Procedure Should be Continued Without Interruption—Both heart massage and artificial respiration should be continued in the ambulance on the way to the hospital. The hospital should be notified so that immediately upon arrival an electro-cardiogram may be taken and the nature of the arrest determined. If the heart is in fibrillation, it should be defibrillated with a closed chest defibrillator.^{2,3} Supportive drugs should be administered as needed.

Efficacy of Technique Demonstrated—At Johns Hopkins Hospital where this report was compiled, in more than 50 cases of cardiac arrest, three out of four patients who received closed chest

cardiac massage recovered to their former central nervous system status. The patients observed ranged in age from one month to 82 years.

Summary

When there is sudden loss of respiration and heartbeat, immediate action is necessary. If a few breaths in mouth-to-mouth artificial respiration are not sufficient to induce spontaneous respiratory and cardiac activity, there is no need to wait for further diagnostic attempts. Closed chest cardiac massage and artificial respiration should be applied at once. Because of the simplicity of this method anyone can now apply heart massage.

*Johns Hopkins University
School of Medicine*

Reprinted from the January 1961 issue of Dental Digest with the kind permission of the author, Dr. W. B. Kouwenhoven, Dr. Ing., and the editors of Dental Digest.

BELL'S PALSY - REPORT OF A CASE

Capt FW Lovely, DDS

Bell's Palsy usually develops suddenly. There are several precipitating factors which include cold, infection and injury, but the primary cause is thought to be a vasonervorum disturbance. The mechanism is believed to be an anoxic edema of the nerve sheath brought about by a local vasoconstriction which causes swelling within the nerve sheath. The swelling is limited by the bony canal of the facial nerve, especially the constriction at the stylomastoid exit from the cranium. This limitation of expansion, accompanied by the anoxic edema results in a compression of the facial nerve causing a unilateral flaccid facial paralysis.

REPORT OF CASE

This case is not being reported to present anything new in the prognosis or treatment of this condition, but to serve as an aid in diagnosis and treatment, should a similar case appear at another dental clinic.

The patient, nineteen years of age, a normal, white, healthy male reported with gross caries of the lower left first and third molars with periapical involvement of each tooth. They were extracted with 2% xylocaine HCL, using a mandibular block, on 25 October 1960 and recovery was uneventful. On 14 November 1960 the patient reported with a left upper motor neurone facial paralysis.

The patient was referred to the Canadian Forces Hospital, Halifax for further treatment. On admission he stated that the palsy had taken about three days to develop. It could be seen on examination that the supraorbital, temporal and buccal branches of the facial nerve were involved since the patient could not elevate his forehead, forcefully close his eye or retract the corner of his mouth. Further examination revealed the patient had altered taste sensation in the left side of the tongue as a result of the affected afferent fibers which innervate the taste

buds of the anterior two-thirds of the tongue. There was no decrease in the tears of the left eye. Also evident was a wet herpetic type of rash involving an area of two inches in diameter on the left side of his chest which appeared to follow the distribution of the second thoracic nerve anteriorly. There was no other herpetic rash suggesting Hunt's Syndrome, which frequently accompanies Bell's Palsy and is characterized by a rash within the ear canal. Faradic stimulation to the facial nerve gave a normal response.

TREATMENT

The patient was given 25 mgm. of cortisone q.i.d. for two days and infra-red heat therapy to the left side of the face twice daily for twenty minutes accompanied by physiotherapy to facial muscles. After two days there was some improvement and the cortisone therapy was reduced to 25 mgm. t.i.d. for one day and then 25 mgm. b.i.d. until a total of 350 mgm. of cortisone had been administered. There was gradual improvement until 22 November 1960 when all facial muscles showed normal movement, at which time the patient was discharged from hospital. Weekly examinations following discharge revealed no recurrence of symptoms.

DISCUSSION

The etiology of this attack of Bell's Palsy is very obscure, since the patient did not give any history of exposure to extreme cold or drafts and there was normal healing of extraction sockets with no remaining infection. The paralysis occurred seventeen days following nerve block and exodontia, which, it is interesting to note, is the average incubation period for a virus. It would appear that this attack of Bell's Palsy had no connection with the exodontia which preceded its appearance.

SUMMARY

A case of Bell's Palsy such as this, appearing subsequent to dental treatment could cause a dentist considerable concern. The general opinion was, however, that the attack occurred at a period when the patient had a lowered systemic resistance and was accompanied by an attack of herpes zoster affecting the anterior branch of the second thoracic nerve.

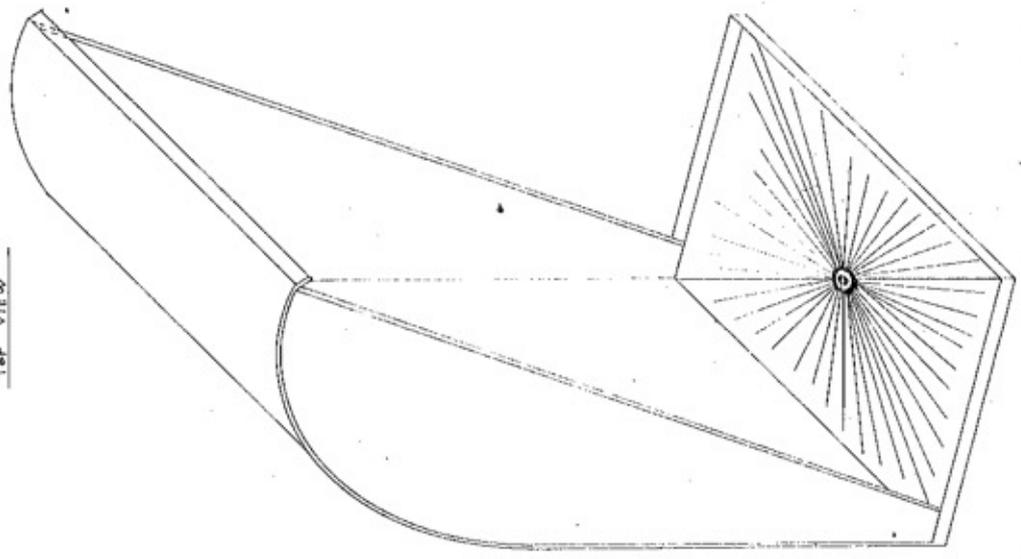
References

1. Mead, S.V. Oral surgery, 4th ed. p. 1029.
2. Grant, J.C.B. A method of anatomy, 5th ed.
3. Sicher, Harry Oral anatomy, 2nd ed.

AMALGAM had an unfortunate beginning. In 1833 the Crawcour brothers arrived in this country from France with their "royal mineral succedeneum" which they advertised for filling cavities with the least pain. While worthy dentists sat idle, the Crawcour brothers literally did a "land office business." It is said they did not excavate the cavities, merely pushed the filling material into place, and if no cavities were present, inserted the "royal mineral succedeneum" into the interstitial spaces. The wrath of the patients and that of reputable dentists prompted their departure from this country.

S.S. White Dental Manufacturing Co., "Early Amalgams," A Century of Service to Dentistry 1844-1944 (Philadelphia: S.S. White Dental Manufacturing Co., 1944).

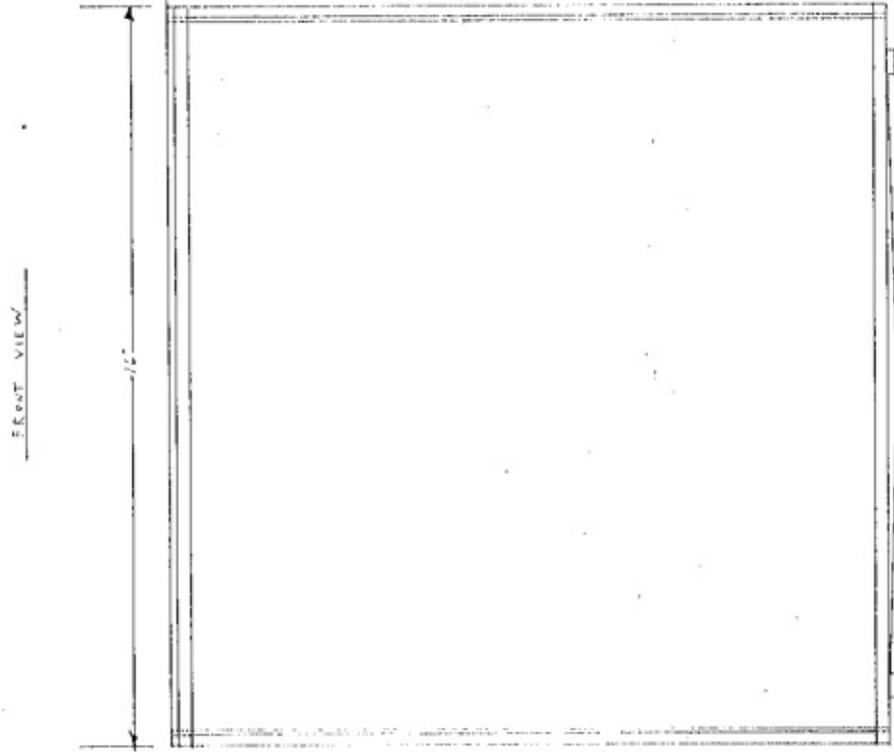
TOP VIEW



END VIEW



FRONT VIEW



STEAM COLLECTOR FOR STERILIZER

MATERIALS USED: STAINLESS STEEL

DRAWN BY: W.D. MORRIS

DESIGNED BY: W.O. RICE

FACTORS AFFECTING THE QUALITY OF EXTRA-ORAL RADIOGRAPHS

WO 2 H Thorsson

The diagnostic value of an extra-oral radiograph depends on the production of a clear and detailed image of the anatomical structures. In order to obtain such an image the dentist or clinical technician must be completely familiar with the variables that can affect the quality of the radiograph.

The controllable variables include: the tube-current (milliamperes); the accelerating potential (KVP); the focal-film distance; and the time. Of these, the use of tube current and time, or their product expressed in milliamperere-seconds, is most convenient for quality control. In addition, the use of intensifying screens and the problems of secondary radiation should be considered.

INTENSIFYING SCREENS

The use of intensifying screens reduces substantially the amount of radiation required, since the light given off by the fluorescing calcium tungstate crystals has a much greater darkening effect on the radiographic film than the X-ray beam used to make the exposure. The reduction in X-ray energy may be as much as 90% of that required for satisfactory film density in a screenless procedure.

The size of the crystals used in the screen determines both the screen speed and sharpness of the image. The larger the crystals, the greater is the amount of light produced, but since large crystals scatter the rays to a greater extent than do small ones, there is a corresponding decrease in detail. Screens which are coated with very minute crystals improve definition and only a fractional increase in exposure time is required.

The fact that temperature has an effect on the speed of the screens should be kept in mind. An intensifying screen used at 50 degrees F is approximately 20% faster than one used at 75 degrees.

FOCAL-FILM DISTANCE

Increased sharpness and detail may be obtained by increasing the focal-film distance, however, a considerable increase in exposure-time is required and movement of the patient becomes a problem. Decreasing the focal-film distance diffuses any intervening tissues and improves differentiation in the tissues closest to the film. If the X-ray head is tilted and the rays do not strike the film at right angles, a variation in focal-film distance of up to 10 to 15% may result, giving differences in density in the same radiograph.

OBJECT-FILM DISTANCE

The object-film distance should be as short as possible in order to produce a sharp and detailed image.

MOTION

Motion of the film, object, or tube impairs the quality and diagnostic value of the radiograph by blurring details that would otherwise be sharp and well defined. The use of a short exposure time and cassette holders will reduce this problem to a minimum.

DENSITY AND CONTRAST

The term density denotes the degree of blackness of a film, whereas, contrast refers to the difference in shading of two adjacent areas. Several factors affect

density and contrast, but these qualities can normally be controlled through the tube voltage or KVP. The shorter wave-lengths of the X-ray beam are the most effective and the least damaging to the tissue and since these wave-lengths are determined by the voltage applied to the tube, it becomes apparent that the relation of wave-length to applied voltage is most important. An increase in the tube voltage (a) decreases the wave-length of the X-rays; (b) increases the intensity of the rays; and (c) decreases the absorption of the rays in interposed tissue.

MILLIAMPERE-SECONDS

Density of the film increases in approximate proportion to the increase in milliamperes (or tube current) and exposure time. When the milliamperage is increased the exposure time must be decreased to produce the same value: e.g., 10 milliamperes for 1 second and 15 milliamperes for $\frac{2}{3}$ second result in the same film density.

Exposure time affects the overall film density to a greater degree than it affects contrast. Over-exposure and under-exposure cause too great and too little density respectively, and in both cases the contrast is decreased. When the exposure time is increased and the KVP decreased to diminish the density, there is an increase in contrast by reason of the longer wave-length of the rays and their greater absorption in the tissues. There is less detail, however, and the longer wave-lengths are more damaging to the tissue and skin.

SECONDARY RADIATION

Since secondary radiation has an adverse effect on density, contrast and sharpness of detail, it is most important that its causes and means of control are understood. Just as the primary beam is produced by the impact of electrons on the target or anode, so secondary radiation arises when the primary rays strike interposed tissue. There are two main types of secondary radiation: - scattered and characteristic. The rays of scattered radiation travel in all directions from the points of impact, while the quality of characteristic radiation is determined by the type of tissue through which the primary rays travel.

Secondary radiation can best be controlled by limiting the area of exposure to the absolute minimum required for diagnostic purposes. This is accomplished by using suitable cones and diaphragms and the correct focal-film distance.

THE CASE FOR REPLANTATION

Major DE McDermott, CD, DDS
and Capt WF Shaw, BSc, DDS

The principle of replantation is certainly not new. Articles on replantation have been found in nearly all of the old and ancient writings of the dental profession. However, even though casual knowledge of the principles of replantation is prevalent amongst members of the profession, our experience has seen little of its actual practise.

As in any operative procedure the patients selected must be thoroughly screened so as to be certain that their oral condition warrants the contemplated operation. Patients especially susceptible to caries, with many missing teeth or with unhealthy gingiva, those in poor general health and those who, even after explanation, are not emotionally prepared to undergo this procedure, are unpromising cases. Also the tooth so evulsed must be suitable for replantation. There must be no acute pathological condition present in the host site. The therapeutic use of antibiotics systemically and locally in the host site no doubt has contributed to the reported success in many cases of replantation.

Grossman states that the tooth should be replanted as soon after its separation from the socket as possible since the prognosis is unfavourable if too long an interval elapses between the time of the accident and re-insertion of the tooth in the socket. He lists several points preparatory to the actual insertion of the tooth. These include thorough washing of the tooth, followed by a hydrogen peroxide bath; complete removal of pulp tissue; irrigation of the canal with an antiseptic and filling in the usual manner with a gutta percha cone. Excess gutta percha protruding through the apical foramen should be removed with a hot instrument and the root tip shortened and made smooth with sandpaper discs. Under anesthesia the tooth socket is curetted and the prepared tooth is replaced in its socket where it is supported by a splint or is ligated to adjacent teeth. Splints or ligations are removed after two or three months.

To date our experience has been limited to four cases of replantation. All but one have been successful. The reason for the failure of the one case is stated in the case reports. The replants are firm. It is noteworthy that, within one week of insertion, the gingival tissues were normal or almost normal. They were pink in colour, firm in texture, knife-like in contour interproximally, and had the stippling found in normal gingiva. Post-operative discomfort was minimal. In fact, the normal post-extraction tenderness was not present in all four instances; this was probably attributable to the following:

1. Lack of exposed bone.
2. Blood clot having a nidus (the replant) to adhere to and therefore not likely to be dislodged.
3. Adaptation of the gingival tissue to the smooth surfaces of the replant which has no local irritating factors.

Roentgenograms taken 6 to 8 weeks after insertion show that a substance resembling bone forms about the apex. The hope that blood clot, organization of clot, osteoid formation, calcification and mature bone would ensue appears to be supported by roentgenographic observation.

Cosmetically the replants are excellent. There is good stability of colour and functionally they have served well.

The following case reports illustrate some of the pitfalls encountered and some of the modifications to current techniques that were apparently advantageous, although basically the technique described by Dr. Louis I. Grossman was adhered to.

The first case which was attempted was unsuccessful. In describing it, some of the errors will be pointed out. The patient was an exchange pilot from the USN, flying jets in HMCS Bonaventure. He presented at the clinic one morning with his upper left central in his hand, the socket freshly bleeding. This was shortly after the CDA Convention in Halifax where Dr. Hare of the University of Toronto presented a paper in which he described the replantation of six teeth in the same patient successfully. So, encouraged by his success, it was decided to replant the tooth.

The first error, which was not immediately obvious, was that after refilling the root canal and curetting the tooth socket, the replant was too securely ligated in position. This placed the tooth in slight traction thus not allowing normal healing to take place. Another mistake was in the selection of the patient. He removed the acrylic splint after 24 hours without advice, then during recreational activities in the wardroom, was hit in the mouth and the tooth was displaced incisally.

This experience enabled a more realistic approach to the next case and it was decided to adhere to the following points:

1. Proper Selection of Patient

Although the age of the patient is very important, the most important factor is co-operation. The patient must really want to keep the tooth.

2. Tooth Treatment and Sterilization

The root canal must be opened, thoroughly cleaned, filed, irrigated and filled, preferably with gutta percha points as these can be sealed with a warm instrument at the apex.

The "sterilization" of the tooth should be by simply wiping with 3% Hydrogen Peroxide, or as second best, alcohol. The latter tends to dehydrate the cementum, which might interfere with union. Some periodontists have found that the presence of bare dentine stimulates the production of new cementum. With this in mind some gentle scaling of the surface of the root, exposing some dentine but not removing all the cementum, could be tried.

The tooth should be shortened about 1 - 2 mm at the apex. This reduces the hydraulic effect of seating the tooth and provides an area for new bone at the apex.

3. Preparation of the Socket

The socket should be curetted and irrigated with 3% Hydrogen Peroxide, to remove any clot debris. The walls of the alveolus should be freshened so that they are bleeding freely when the tooth is implanted.

4. Ligation

The tooth should be ligated in place firmly, but not too tightly. The ligature should extend mesially and distally the extent of two teeth and be placed under the height of contour, except for the replanted tooth, where it should be in the supra-bulge area exerting a retentive action on the implanted tooth. Kadon should then be painted into the embrasures to lock the ligatures in place. Further, Kadon should be painted on the lingual of other than the implanted tooth to remove the tooth from function. The Kadon should be left in place for about 1 month and then removed with a scaler. The ligature, if still functional, should remain an additional 2 weeks. To leave the ligature too long in place can reduce the favourable prognosis by keeping the implanted tooth too long out of function. The contention here is that the subsequent refunction of the tooth tends to stimulate the periodontal membrane thus decreasing the mobility.

The case of Pte T.P.Y. is cited next. He presented on 16 Sep 60 with an evulsed upper left central. Using the preceding technique the tooth was replanted. Ligatures were removed on the 20th of October and a radiograph taken. The tooth was firm and asymptomatic. Subsequent follow-up examinations as late as 11 Jan 61 showed the tooth completely functional with no signs of resorption. This case is considered a success, although it has not yet stood the test of time.

Replantation has been successful in each attempt since the first unfortunate but educational case. In addition to retaining a functioning tooth, it is thought to have other advantages:

1. It takes far less time than replacing the tooth with a bridge or partial denture when laboratory procedures are considered.
2. The prognosis compares favourably with a bridge or partial denture.
3. It develops a good dentist-patient relationship.

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REMINISCENCES OF IRELAND

S sgt PAA Egan, CD

We set out from London, England one August morning for the trip to Ireland boarding the "Irish Mail" at Euston station bound for Hollyhead, North Wales. This famous train was the first in the world to be referred to by an official name. From Hollyhead we crossed the Irish Sea via the British Railways' steamer "Hibernia", landing at Dun Laoghaire the same evening.

We spent seven days in Dublin, a fascinating city, seeing as many of the highlights as possible. Notable among these was Trinity College, founded in 1591, the library of which is of great interest. One of its most famous possessions is the Book of Kells, an illustrated manuscript of the Gospels dating from about the eighth century and generally considered to be the world's most beautifully illustrated book. Other interesting places architecturally were Christ Church Cathedral and St Patrick's Cathedral, founded in the eleventh and twelfth centuries respectively.

On a more mundane level were the Irish Sweeptstake buildings and the Guinness brewery. At the latter we followed the brewing of Stout through all its stages and after the two-hour tour we welcomed the refreshments which were supplied gratis.

Another interesting institution was the Abbey Theatre. It first opened its doors in December 1804. By 1807 "The Abbey" had achieved international fame. Among the well-known dramatists of the Abbey group are W.B. Yeates and Sean O'Casey. Unfortunately, this theatre was destroyed by fire in July 1951 and only the shell remains. Up to 1954 the Abbey productions were staged in the Queen's Theatre, Dublin.

From Dublin we toured county Wicklow, visiting Glendalaugh and Avoca, and as I had always wanted to see Galway and more particularly Galway Bay, we crossed Ireland via Tora and the Curragh, visited Galway and toured Connemara and Mayo. Incidentally we didn't find Galway Bay all we expected it would be.

For the second half of our leave we made our headquarters in Cork City. From Cork it is only a short trip to Blarney, where we had the opportunity to kiss the famous stone, although this was a risky business. After climbing the two hundred winding stone steps to the battlements of the castle, we had to hang suspended head first (grasping an iron railing) from the parapet of the battlements in order to kiss the stone and thus acquire the gift of eloquence.

We also toured the counties of Cork and Kerry, visiting Tralee, Killarney and Glengariff. Unfortunately time was running out and the many other points of interest will have to wait until our next trip, which we hope will be in the not too distant future.

The return to England was made on board the "Inisfallen" from Cork to Fishguard, South Wales and thence by train to London.

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BILATERAL SUBLUXATION OF THE TEMPOROMANDIBULAR JOINT

Capt ES Morrison, BA, BSc, DDS

In order to get a clearer picture of the condition known as Bilateral Subluxation of the Temporomandibular Joint, it is necessary to be familiar with the pertinent anatomy. This joint is a ginglymo-arthrodial, or gliding-hing joint. The two osseous parts are the glenoid, or mandibular fossa and the condyle of the mandible. The glenoid fossa is bounded anteriorly by the articular eminence and posteriorly by the tympanic plate of the petrous portion of the temporal bone. The temporomandibular joint may have various shapes and still be normal. Its movements are: (1) depression; (2) elevation; (3) protraction; (4) retraction; and (5) lateral excursions. The essential muscles involved in these movements are: (1) temporal; (2) masseter; (3) internal pterygoid; (4) external pterygoid; (5) mylohyoid; (6) geniohyoid and (7) digastric.

The T.M. joint is innervated by the auriculo-temporal and masseteric branches of the mandibular nerve. It receives its blood supply from the superficial temporal branch of the external carotid artery.

The two bony components of the T.M. joint are held in place by the capsular, temporomandibular, sphenomandibular and stylomandibular. It is injury to these ligaments, particularly the capsular ligament, that results in pathological changes.

The joint is divided into superior and inferior parts by an articular disk, known as the meniscus which is attached to the capsular ligament. Both parts of the joint are lined with a synovial membrane.

Normally the condylar head glides forward onto the articular eminence when the mouth is opened. In the fully-open position the condyle rests opposite and below the crest of the articular eminence. Any further movement of the condyle anterior to this point is considered abnormal, and usually results in dislocation of the temporomandibular joint. There are two types of dislocation, subluxation and luxation. Subluxation of the T.M. joint is usually defined as a self-reducing incomplete dislocation. The term luxation is commonly reserved for those cases of complete dislocation which require manipulation to reduce the condition. Only subluxation of the temporomandibular joint will be considered in this article.

This condition is a common source of facial pain, although pain may be absent. Clinically, subluxation of the T.M. joint may be diagnosed by digital palpation of the condyles while the patient opens and closes his mouth. The movements of the condyles may be accompanied by "clicking" noises and the patient's mouth may appear to literally fall open. Radiographically the head of the condyle will appear anterior -- but not usually superior -- to the articular eminence.

The treatment of any condition is governed, to some extent at least, by the cause. Similarly, in treatment of subluxation of the T.M. joint, local causes such as malocclusion should be eliminated. To demonstrate specific treatment for this condition the following case report is presented:

CASE REPORT

History and Clinical Findings

The patient concerned was an 18 year old male. He enlisted in the RCN, and was sent to HMCS Cornwallis to undergo New Entry training. It was noted during dental examination for Condition on Enrolment that his mandible became dislocated when the mouth was fully opened. However, the patient had no pain or discomfort of any kind and the mandible returned to its normal position upon closing the mouth. This condition had existed for about a year. About 4 or 5 weeks later this man reported to the dental clinic complaining of pain in the T.M. joints. He also reported that his jaw fell out of place when he was tired. The case was diagnosed as bilateral subluxation of the temporomandibular joint. At this time the patient was fitted with a headcap and chin support and warned about opening his mouth too widely. This form of treatment did not prove successful. About one week later at night he reported to the medical sick bay with a complete dislocation of the mandible. The patient had fallen in his living quarters and received a blow on the head. He was not wearing the headcap at the time. The dislocation was reduced by manipulation.

The patient's past history showed two serious head injuries at the ages of 6 and 8 years respectively. Deciduous teeth were extracted under general anaesthesia around 6 years of age. He suffered a fractured nose at about 12 years of age and again at 16 years of age he was knocked unconscious. The patient stated, however, that he was not aware of his jaw becoming dislocated after any of these injuries. He attributed the condition to holding his mouth open too wide and too long during dental procedures. It was after this experience, about a year ago, that he noticed his jaw "coming out of place". It was painful at first, but soon became asymptomatic, except for "clicking" noises.

Treatment by Injection

It was decided to treat this case by injecting both T.M. joints with a sclerosing solution, 5% Sodium Morrhuate. In this particular case the operation was performed in the "plaster room" of the hospital. The patient was premedicated with 75 mgms of Demerol to reduce pain and relieve apprehension. He was allowed to remain on a hospital carriage in the supine position. The area overlying both T.M. joints was prepared by shaving and then swabbing with an antiseptic solution. The skin of the area was infiltrated with 2% Xylocaine Hydrochloride containing Epinephrine 1:100,000, using a regular dental syringe. A 10 minim luer-lok syringe was loaded with 2% Xylocaine Hydrochloride without Epinephrine and a 21 gauge needle was attached. It was then carefully inserted until the T.M. joint was entered and using the aspiration technique, 4 minims of the 2% Xylocaine were injected into the right T.M. joint. Leaving the needle in place the syringe was removed, replaced with a syringe containing 5% Sodium Morrhuate and 4 minims of this solution were injected. Next the left T.M. joint was injected using the same technique. It was felt that the left joint was entered more readily than the right.

Post-operatively Demerol 75 mgms q.4.h. was prescribed to control pain. The reaction to the sclerosing solution was very painful. The patient was put on a high protein, minced diet and the headcap was replaced to restrict mandibular movements. Hot compresses were also applied regularly to the area of the T.M. joints.

For the first 24 hours the patient had severe pain which was effectively controlled with Demerol. The pain was more severe on the left side and for a couple of days the patient had difficulty articulating his posterior teeth.

Results

The tenderness in the T.M. joints subsided about one week after the operation, at which time, both left and right T.M. joints were normal. The patient could not force the condylar heads past the articular eminence and there was no restriction of movements of the mandible. This was demonstrated both clinically and roentgenographically. On examination, about 6 weeks post-operatively, both joints were functioning normally. After another few weeks the capsule of the right T.M. joint was loosened so that there was a "clicking" noise without dislocation. It was considered that the right joint should be re-injected. The patient was happy with the result of the first operation, and so is willing to undergo the second one which has not been done as yet.

Conclusions

Subluxation of the temporomandibular joint can be treated successfully by injection of a sclerosing solution, such as Sodium Morrhuate, into the joint. This operation can be performed relatively painlessly and post-operative pain can be well controlled by the use of anodynes. The joint can be returned to normal function without danger of residual damage.

The degree of reaction to the sclerosing solution seems to be indicative of the success of the operation. In this case there was more pain on the left side and a better result was obtained on this side than on the right. The injection may be repeated safely until symptoms of subluxation disappear and the operation may be performed in the standard dental chair.

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LET'S KEEP THEM IN SCHOOL

Lt Col NA Butcher, CD, DDS

Parents must assume the full share of responsibility for the education of their children, for the education they receive in this fast-moving world of today will greatly influence their happiness and success in the world of tomorrow.

A few years ago a person was considered adequately educated if he completed Junior Matriculation. Parents who harbour this opinion today are not keeping abreast of the times because Junior Matriculation is no longer adequate in many fields of employment and will be much less so a few years hence.

Each year thousands of young Canadians leave school to enter the world of work unprepared to meet even the minimum requirements of industry. A recent Department of Labour survey reveals that 70 per cent of children are now leaving school without Junior Matriculation or its equivalent, a level of education many industries demand today for training positions. If this rate continues, it means, according to 1957-58 figures, that 270,000 of the 398,000 students who enrolled that year will drop out of school before reaching this level. These young people will be forced, in most instances, to seek unskilled or semi-skilled jobs which usually present little in the way of career possibilities.

Only 30 per cent of all the jobs in Canada fell into the semi and unskilled categories and the educational demands of industry are lowering this percentage further. Where are the other 40 per cent of this huge body of former students going to be employed? Surely these hard, cold figures show that parents must do their best to keep their children in school as long as possible.

What Can Be Done?

There are several ideas that might be advanced. First, the child must be guided into the educational system from the time he starts to talk and think for himself. A child is a mimic; the care parents give to speech and mannerisms, or the lack of care, will be reflected in the child. Parents must show continued interest in the child's progress in school, and encourage him in his efforts.

Second, parents must be familiar with the educational systems. These vary greatly from province to province, city to city and town to town. It does not take long to determine why a child must study phonetics or why a high school student must take the prescribed language courses. Teachers are dedicated to the education of children and are only too willing to help the parent understand the educational system. A look into the mechanics of the local educational machinery should prove enlightening, interesting and beneficial.

Third, parents should respect the teacher's responsibilities. The parent who eagerly awaits the day he can dump his child into kindergarten and then feels his job is done is not only fooling himself but doing untold harm to the child.

Parents are very quick to criticize, but are slow to help and seldom thank the teacher for doing the job for which parents are partly responsible. Paying taxes does not give parents the right to shift the complete responsibility for educating their children onto the teachers. Home interest and help is essential and the teacher must be assisted by understanding and interested parents.

Fourth, interested parents will become familiar with adult educational facilities and avail themselves of opportunities to increase their own education. It is estimated that 7,000,000 adult Canadians have never finished high school. There is an ever-increasing demand for adult education classes; some are being provided by the schools, others sponsored by industry. The benefits derived from participating in adult education schemes will improve the parent's education, encourage other adults to participate, and set an example for the children.

Finally, parents must do all they can to help raise the educational standards. This may seem like a rather large order for an individual but a group of interested parents together can accomplish much. The Home and School Association with over 300,000 members is making a steady effort to raise standards. Parents should take their places on school boards, and do all they can locally to help improve education.

To summarize, parents must assume some responsibility for the education of their children, who in their adult years are certain to appreciate the interest taken in their education welfare. This responsibility includes: encouragement at an early age; knowledge of educational standards and procedures; participation in adult education; respect for the teacher's position; and efforts to help raise Canadian standards of education. The future citizens of Canada deserve all the education they can absorb. Let's keep them in school!!

A TECHNIQUE FOR APICOECTOMY OF ANTERIOR TEETH

Major IW Susser, BSc, DDS, LDS

Apicoectomy and periapical curettage are considered to be a necessary part of the endodontic treatment required to retain a tooth when radiographic examination reveals a relatively large apical area of rarefaction.

Pre-operative treatment in such cases consists of a prophylactic dose of penicillin (500,000 units of Penicillin V orally t.i.d.) and antihistamine (Chlorpheniramine - 4 mgms t.i.d.) 24 hours before commencing treatment.

The treatment is carried out in two phases: (1) root canal filling; and (2) root resection and periapical curettage.

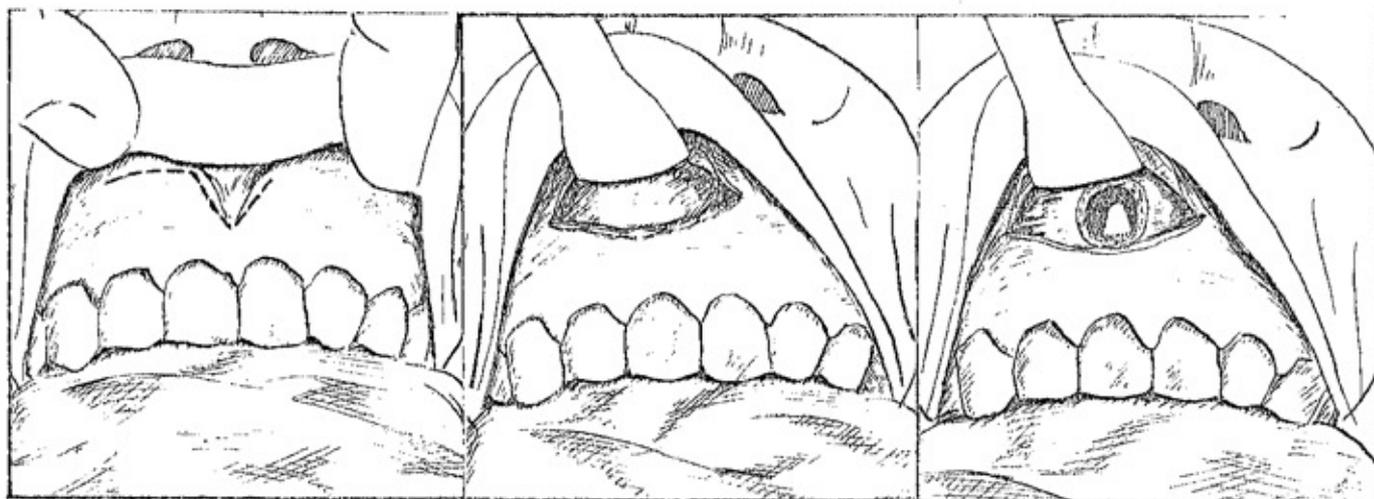
Phase 1 - Root Canal Filling

The tooth is isolated with a rubber dam and the canal is opened, filed, flushed with Hydrogen Peroxide 3% and Sodium Hypochlorite solutions and then dried. A Gomco aspirator with a sterile luer-lok needle (gauges 20-22) inserted into the canal will hasten drying. The canal is obliterated with a silver point of proper size and Kerr Sealer or with several gutta percha points liberally buttered with Kerr Sealer and condensed laterally with a Kerr #3 spreader. The pulp chamber is filled with gutta percha or cement.

Phase 2 - Root Resection and Periapical Curettage

A large pad of sterile gauze is placed between the teeth and the patient is instructed to bite on it throughout the operation. The field is carefully swabbed with 3% iodine and a straight line incision is made at the muco-labial fold extending over the roots of the adjacent teeth. It may be necessary, when treating central incisors to outline the base of the frenum with the scalpel and detach it to provide more access. The frenum can easily be sutured back to place at the end of the operation (Fig. 1). The soft tissue is elevated superiorly and inferiorly, opening the straight line incision to an elliptical shape. The superior tissue is held back with a retractor or large periosteal elevator (Fig. 2).

Moderate pressure and a slowly revolving bone bur are used to punch a hole through the labial plate into the pathological area. A granuloma or cyst will often erode the labial plate to almost paper thinness and in such cases the bur will practically fall into the cavity. The window is enlarged with rongeurs or a well irrigated bone bur until the apex of the tooth is completely exposed and access is provided to all pathological tissue around it. (Fig. 3).



(Fig. 1)

(Fig. 2)

(Fig. 3)

Root resection may not be necessary if there is sufficient access to allow the removal of all pathological tissue. It is indicated, however, where access is blocked by the apex of the root or where a cyst adheres so firmly to the apex that it cannot be removed in toto.

When the bony cavity is completely devoid of pathological tissue the cavity is dusted with penicillin G powder and the incision is closed with 3 to 4 interrupted silk sutures.

If the operation has been performed under strictly aseptic conditions and all diseased tissue has been removed, the blood clot under the flap remains sterile, undergoes organization and finally bone is regenerated around the root end. The incision, under these circumstances, usually heals by first intention and sutures can be removed in about 5 days.

The patient is given Penicillin V and Chlorpheniramine for two days post-operatively.

Discussion

It has been noted that the straight line incision at the muco-labial fold will heal very rapidly, leaving a scarcely visible scar even when the lip is retracted; whereas the U-shaped incision advocated in many texts, leaves a rather unsightly crescent which is plainly visible in patients with a high lip line. It has also been noted that, in most cases, the apices of the anterior teeth lie in line with or above the muco-labial fold.

It is advisable to leave as much as possible of the apical portion of the root in order to give better support to the tooth. In later years, when the paradontium recedes, one will be grateful for the extra root length. Nature takes care of any rough or sharp edges which may be inadvertently left in curetting the exposed root surface. There is no need to resect to the very base of the bony cavity.

Use of pre-operative and post-operative chlorpheniramine over a period of three years in all types of oral surgery has convinced the writer of its efficacy in helping to control post-operative swelling. Another drug currently being used as a specific against post-operative inflammation is C.V.P. with Cortisone (Arlington-Funk). However, this drug is more costly and no statistics have yet been accumulated.

The need for pre-operative and post-operative antibiotics is self-evident. Penicillin V (500,000 i.u. t.i.d.) gives adequately high blood levels to warrant its use as a prophylactic in many cases of mouth surgery. Others of the wider spectrum variety may be used, e.g., Erythromycin 250 mgms q.i.d. and Achromycin 250 mgms q.i.d.

Within about 3 months post-operatively, X-ray evidence of bone regeneration should be clearly seen and, in 6 months to one year, the bony cavity should be filled with new bone.

The same technique may be used for both upper and lower anteriors but it must be remembered that the labial plate of the mandible is considerably thicker than that of the maxilla.

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HMCS BONAVENTURE CRUISE - WINTER 1961

Major J McGaughey, CD, DDS

HMCS Bonaventure left Halifax on 24th January with the members of the Permanent Joint Board on Defence aboard as guests. The following day we encountered extremely rough seas which must have been a real experience for many of the guests. On Friday, 27th January the PJBD members disembarked at Bermuda and proceeded to their various destinations. For the next week we carried out exercises at sea in the Bermuda area under pleasant weather conditions and the following week-end spent four enjoyable days ashore in Bermuda, and then proceeded to Norfolk, Virginia. During the eleven days spent at Norfolk, a two-day symposium was carried out at sea, the Bonaventure again being host to a large number of important people. From Norfolk we returned to Bermuda carrying out exercises in the meantime and on 3rd March left the Bermuda area for San Juan, Puerto Rico and a very pleasant six days. On 12th March we sailed from San Juan and arrived in Halifax on 17th March to discover that we had left beautiful summer weather and returned to the rigors of winter climate.

A great deal could be written about any one of the places visited but discussion will be limited to the points of interest which I personally visited in Bermuda, Norfolk and Puerto Rico, and in that order.

Bermuda, a chain of semi-tropical islands with a population of approximately 38,000 people, is about 24 miles long. The roads are narrow and winding and for the most part paved. The chief means of transportation is by small motor car, bicycle, or motor assisted bicycle. The weather is very pleasant and, based on a 65-year study, the average low temperature is 56.5° F. which occurs in February and the average high temperature is 85.8° F. which occurs in August. There is no rainy season and no month in which the rainfall is excessive or sufficient to interfere with the enjoyment of outdoor recreation for any length of time.

The buildings and private homes of Bermuda have an unusual feature which immediately impresses the visitor. The roofs are designed to funnel all rain water into eave gutters which in turn drain off into tanks which are a fundamental part of the structure. This is most necessary since there is no other source of fresh water.

Hamilton, the capital of Bermuda, is a clean, well-planned city. Some of the interesting places to visit are the Bermuda Cathedral, the Parliament Building and Session House, which is the second oldest parliament in the British Empire, the Bermuda Library and the Historical Museum. There is a wonderful shopping district where perfume which is produced locally, may be purchased at a relatively low price which makes a nice gift for your wife or sweetheart.

For those who like to participate in sports there are many facilities available. There are three fine 18-hole golf courses and two with nine holes. Fishing is very popular and excellent facilities are available for swimming, sailing, underwater sports, water skiing and tennis. Generally speaking, Bermuda is a home for retired wealthy people and for tourists who can afford to spend the winter months there.

Having spent eleven days in Norfolk, this article would not be complete without briefly discussing two places of great interest, Jamestown and Colonial Williamsburg. At Jamestown, in 1607, one hundred and five men and boys arrived from the Old World and laid the foundations of the United States of America. At the Jamestown Festival Park are hung paintings and portraits which dramatize the life and struggles of the first permanent English settlers in America. The three ships which brought the colonists to America are also on display, still well preserved and apparently sea-worthy.

Williamsburg, which is about 20 miles from Jamestown, has a very important historical past. In 1698 the legislators of the new colony in America moved their capital from Jamestown to Williamsburg, which was named in honour of the reigning English monarch, William III. Until 1780, when the capital was moved to Richmond, this town was the political, social and cultural centre of the whole colony. Also during this period Williamsburg was the seat of government for Britain's largest colony in America, and was the headquarters for legislation which overthrew the rule of the Crown. From 1780 until 1926 Williamsburg fell into the background but beginning in 1926 through the generosity of Mr John D. Rockefeller Jr., the city has been restored to its early appearance and is now called Colonial Williamsburg.

Colonial Williamsburg, which is one mile long and one-half mile wide has a population of 8,000 inhabitants. The neat weather-boarded houses of colonial days have been restored in great detail, including their beautiful gardens. In addition, they have re-created a living community in which the inhabitants wear the costumes of their ancestors and work with the tools of colonial days. We were escorted on a guided tour through many places of interest such as the Governor's Palace, the Capitol, the Gaol, Bruton Parish Church, and Raleigh Tavern. The British influence of the period is evident and in many cases the furniture, tapestries, oil lamps and cooking utensils are original.

Having visited Norfolk and Bermuda, let us now proceed 750 miles farther south and visit one of the beautiful islands in the Caribbean, the land of sunshine, fruit and flowers, Puerto Rico.

Puerto Rico (Rich Port) has played a major role in the turbulent history of the West Indies for more than four centuries. Its history reads like fiction rather than fact. The Spanish slave traders, smugglers and buccaneers have all left their imprint upon its present day culture. Discovered by Christopher Columbus in 1493, Puerto Rico is the only island that Columbus actually visited which flies the American flag. In 1509 Ponce de Leon became its first governor and formed the first white settlement. For nearly 400 years the island was a strong outpost of the mighty Spanish Empire, successfully resisting occupation by the British and Dutch. After the Spanish-American War, under the Treaty of Paris, the island was ceded outright to the United States and in 1952 was proclaimed a Commonwealth, making it a self-governing member of the Union.

San Juan, the capital of Puerto Rico, has a population, including the metropolitan area, of about 590,000 people. It is comprised of two sections: old San Juan which is situated on two rocky islets guarding a fine harbour and linked by bridges with the mainland; and new San Juan which is a very modern city in all respects. Old San Juan with its narrow streets and plazas maintains its Spanish character and has many well preserved historic buildings. Some of the most significant buildings and structures

are: the high battlements of El Morro commanding the entrance to San Juan Bay; La Fortaleza, now the Governor's Palace; the old Spanish Cathedral with the tomb of Juan Ponce de Leon; the Federal Building; and part of the University of Puerto Rico.

To appreciate the varied beauties and fascination of this "Island of Enchantment", one has to go beyond the environs of the large luxury hotels in San Juan. In this respect I was fortunate enough to be among a group of five who were provided with a car and chauffeur to drive about the island on a sight-seeing tour. As a point of interest, we selected El Yunque which is a 3500 foot mountain about 40 miles from San Juan. Driving through the country we were much impressed with the large dairy herds and the rich agricultural area which produces mostly sugar-cane. Having reached the top of El Yunque, we marvelled at the giant tree forms and lush vegetation which grew there. This is part of the Caribbean National Forest, where 200 inches of rain falls annually, and is one of the few tropical rain forests in the world.

Tuquillo Beach which can be seen from El Yunque is one of the most beautiful in the Caribbean. The lovely white sand beaches, shaded by tall, stately palm trees inspired most of the ship's company to acquire a Puerto Rican tan. The water temperature was about 80° F. on Friday, 10th March.

For history lovers the old fortresses provide a veritable paradise. Probably the most outstanding are the ancient El Morro and San Cristobal, both of which remain essentially the same as when occupied by the Spanish and are considered to be the best examples of old military architecture in United States territory. On the site of El Morro fortress is Fort Brooke which has one of the world's most unique golf courses. At one hole the golfer must tee off over a thirty foot wall built more than 400 years ago.

A visit to San Juan would not be complete without patronizing some of the elegant night clubs. The bands and floor shows are excellent and the environment magnificent. The El Calypso, with its wonderful steel band and nightly limbo contests, should not be missed. The hospitality and friendliness of the Puerto Ricans is inspiring and we should drink with them their toast "Salud y pesetas -----" - "health, wealth and the time to enjoy them".

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DIRECTORATE OF DENTAL SERVICES NEWS

New Appointment

The Minister of National Defence has granted authority for the appointment "Director General of Dental Services" to be re-designated "Director General of Dental Services for the Canadian Forces". It is generally known in the Services that this appointment carries a tri-service responsibility and the new title should clarify this for other government departments and civilian organizations.

Duty Visits and Trips

Dental facilities in No 12 Coy were inspected by Brig KM Baird in March. On the 10th of April he attended the Workshop Conference on the Role of Auxiliary Personnel in Dentistry held in Toronto.

In early February Col GB Shillington visited the US Navy Dental Corps Headquarters in Washington and proceeded on to Chicago where he attended the meetings of

the American Denture Society. A later trip took him to The RCDC School to interview officers on course and to Toronto as the DGDS representative at a meeting of the Council on Education of the Canadian Dental Association.

The annual inspection for the Militia General Efficiency Competition has just been completed by Col HL Harris.

Lt Col JG Butler, Major Protheroe and Major DH Hillier have represented the DGDS at meetings of the Editorial Board of Oral Health.

Arrangements for the last phase of the RMC Fluoride Study were made on 21 April in Kingston by Major DH Protheroe, the study director.

Postings

We all wish Cpl JG Moore well in his new duties with 11 Coy.

Training

Lt Col JG Butler and Major DH Hillier attended the Physicians' and Dentists' Indoctrination Course at the Civil Defence College in March.

A short course designed to demonstrate the application of public health principles to the RCDC was presented to senior RCDC and US dental officers at Camp Borden by Major DH Protheroe and Major DH Hillier.

Special Events

A mixed mess dinner was held at the AHQ Officers' Mess on 7 April. The guests of honour were the Adjutant-General, Major-General JDB Smith and Mrs Smith.

Lt Col JG Butler was again a member of Lt Col Bill Timmerman's rink which won the local Inter-Service Bonspiel for the third straight year.

NO 1 DENTAL EQUIPMENT DEPOT

Duty Visits and Trips

In late February WO 1 Church spent a week in Chicago at the Midwest Dental Mfg Co where he received instruction in the repair and maintenance of their equipment. He later visited Ottawa to carry out repairs to equipment.

Promotions

Our congratulations to Sgt Dick Claydon on his promotion to S sgt. A native of Ottawa, Staff Claydon has served continuously since 1941, seeing service in Canada and UK during the Second World War, and in the post-war period he has had tours in Korea and Germany as well as Canada.

Postings

We extend a warm welcome to Cpl McRoberts, a recent transfer from the RCAC and to Mrs Thelma Gendron. At the same time we bid farewell to Mr Allan Anderson who has resigned his position with us.

Special Events

Major Fletcher and WO 1 Church have completed interesting but arduous tours as PMC of their respective messes.

We are in the midst of a physical fitness programme using the 5 BX plan and the results are most encouraging.

Major Fletcher has been elected President of the Petawawa Curling Club for 1961-62.

WO 2 Maxie Fisk had a very good year on the curling ice, skipping rinks to victory in three events and to the semi-finals in the Command Bonspiel in Camp Borden.

THE RCDC SCHOOL

Promotions, Retirements and Releases

Congratulations to Sgt Bradley on his promotion to S sgt. A native of Pickering, Ont, Staff Bradley enrolled in 1940 and following two years with the infantry transferred to the CDC. He remained with the Corps following the Second World War and following a tour with the "I" Staff in BC Area came to The RCDC School in 1958. Staff Bradley is employed as a DT Cl and resides in Barrie with his wife and two children.

Congratulations also to Cpl Arnold Semple on his recent promotion to Sgt. A native of Toronto, he enrolled in 1951 and has seen service in Korea and CBUME as a storeman. Much to the relief of the CFMS Softball Team, the School Volleyball Team, and the QM, Sgt Semple will continue to serve at the School.



US Dental Officers Attend RCDC School

The first US Dental Officers to attend a Clinical Course at The RCDC School are shown discussing a problem with members of the School staff.

L to R - Lt Col LG Craigie, Lt Col J Lancaster (US Army, Fort Dix, New Jersey), Col BP Kearney, Cdr L Armstrong (US Naval Dental School, Bethesda, Maryland), Lt Col SG Bagnall

Training

Major George MacDougall departed 19th February to attend a 12 weeks' Prosthetic Course at the US Naval Dental School, Bethesda, Maryland.

Vital Statistics

Major Bill Thompson is in Toronto Military Hospital.

Special Events

On 16th March, the second annual curling classic was held between members of the Officers' Clinical Course and the School Staff for the coveted trophy, presented

and won last year by the 1960 Clinical Course skipped by Major Bill Dickie. This year the School rink skipped by Col Kearney with Lt Col Craigie as third and Captains Wright and Van Ryssel on the sweeping end defeated the Clinical Course team composed of Skip Major Frank Charman, Majors Don Schwartz (US Army Dental Corps), Pete Falkner and Capt Frank Lovely (on loan from the School).

The Garth C Evans Trophy, for annual competition between the officers of the CFMS and the RCDC in Camp Borden, was won by the RCDC School with a 14-point advantage for the two games. This is the first time that competition has been held for the trophy donated by our former Chief Instructor.

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11 DENTAL COMPANY

Duty Visits and Trips

Col HL Harris and Capt WJ Bignell were recent visitors to the Coy.

BC Area clinics were inspected by Col Millar in January. During this trip he joined medical and dental officers for a most informative clinic on facial injuries presented by staff members of Shaughnessy Hospital.

Capt Lloyd Wansbrough also completed a tour of the company recently.

Service personnel and dependents at Aklavik and Inuvik were made dentally fit by Capt Lee Reynolds and Sgt Gerry Keogh, and the team of Major Ty Cobb, Sgt Mickey Kidd and Sgt Ralph Thornton completed treatment at Dawson Creek and Fort Nelson. In January Capt Dick Welsh and Cpl Bob Lowery visited RCAF Stn Holberg and another trip to that location was made in April by Capt Jack Bowman and Sgt Bingo Shaw.

Promotions and Retirements

Our congratulations to Alex Ponton and Merv Fediuk on their recent promotions to WO 2 and S sgt respectively.

WO 2 Ponton, a native of Brantford, Ont served from September 1939 in Canada, UK, Italy, and NWE until he took his release in November 1945. Alex re-enrolled in 1949 as a Storeman and in addition to service in Canada had a tour with the Air Division in France. He is married with one child.

Staff Fediuk was born in Watson, Sask in 1935. He enrolled in the RCDC in 1952 and has interspersed his time in 11 Coy with trips to Korea and CBUME. Originally trained as a DA he was remustered to a DT Cl in July 1960. Merv, who is single, is stationed in Cold Lake.

Capt Dick Welsh, Cpl Pete Coupe and Cpl Pete Eastwood have taken their release and Mrs Delia Wickes has also retired. We wish all of them well.

Postings

Since the last issue we have welcomed Sgts RA Malpas and NC Petersen from CBUME, Cpl Gil Moore from DGDS and Pte Walter Webster from PPCLI. Our losses to other units were Sgt John Christiansen to CBUME, Sgt W Olynyk to 13 Coy and Sgt Marc Tremblay to 15 Coy.

Training

The following personnel have completed the courses listed:

Lt Col Crumney and Major Charman - Officers' Casualty Care and Clinical Course at The RCDC School

Major Kettlys - Crown and Bridge at the University of Michigan

Major Walker - Oral Surgery at Ent Air Force Base, Colorado Springs

Sgts Dean, D'Eon, Kidd and Robertson - Dental Assistant Instructors' Course

Sgt Kennedy - Dental Technician Laboratory Instructors' Course

Cpls Wilkinson and Moore - Sr NCO Course

Sgt Franzgrote, Cpl Taylor, Cpl Lowery, Pte Schwarze and Pte Monahan are currently attending courses

Expression of Sympathy

Our sincere sympathy is extended to Major and Mrs Leon Richardson on the recent death of their son, Peter Bruce.

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12 DENTAL COMPANYDuty

The most important event in the past three months was the inspection of the unit by the DGDS. It is very gratifying to be able to talk out problems and learn a little about future career probabilities. The only group missed were aboard HMCS Bonaventure off the coast and the sea was too wild to board.

Capt Frank Lovely has returned after four weeks' replacement duty at The RCDC School clinic.

Training

The following personnel attended courses:

Lt Col WR Cunningham	RCDC(S) Offrs Clinical & Casualty Care
Lt Col NA Butcher	RCDC(S) Offrs Clinical & Casualty Care
Major Al Taylor	RCDC(S) Offrs Clinical & Casualty Care
Capt Ike Gordon	USNDS Partial Dentures
Sgt Ken Wallace	RCDC(S) DT Lab Instr
Cpl Earl Schell	RCASC(S) Sr NCO
Cpl Roy Matheson	RCASC(S) Sr NCO
Cpl Frank MacKay	RCASC(S) Sr NCO
Cpl Henry Nogler	RCASC(S) Sr NCO

Accommodation

Our QM Stores has been enlarged by the addition of two clinic bays from the Stadacona clinic.

Vital Statistics

Congratulations to the following:

Major and Mrs Tom Gaudet	-	a daughter
Capt and Mrs ES Morrison	-	a daughter
S sgt and Mrs Bob Stewart	-	a daughter
Sgt and Mrs George Ryder	-	a daughter

Our 1960 graduates Captains Syd Campbell and By Johnston are both recuperating from spells in the hospital. Reports indicate that this is a predominant trend throughout the Corps.



Camp Gagetown Clinic Personnel

Front Row - L to R - Capt WF Shaw; Major DE McDermott; S sgt PAA Egan

Back Row - L to R - Pte A Pink, Sgt KL Wallace; Cpl RF Matheson; Cpl FW MacKay

(Four members of the clinic are missing from this photograph)

Special Events

Sgt Doug Murley returned from Bermuda in time to proceed to the Command Hockey Championships at Camp Gagetown; Capt Bill Shaw took part in the Command Basketball Championship in Halifax; Capt Jack Quackenbush and his Stadacona rink bowed out of the Nova Scotia Consols playdown with a 2-2 record. Capt Hal Bunston and his cohorts from Shearwater won the Atlantic Command Volleyball Championship and Capt Mullins has all his fishing gear in good shape for 15th April.

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13 DENTAL COMPANY

Promotions and Retirements

Major George L. Finkbeiner commenced retirement leave on 1 Apr 61 following 18 years' service with the Corps. A native of Milverton, Ont, he attended High School in Listowell, Ontario and received his dental undergraduate training at Marquette University, graduating in 1935. Following a year's graduate studies at the University of Toronto he entered private practice in Listowell. In Oct 40 he joined the Corps and served in Canada, the United Kingdom and Northwest Europe until Oct 45 when he returned to private practice in Listowell. He rejoined the Corps in Apr 48 and has served in 12, 13 and 14 Coys since that time.

Major Finkbeiner, who is married with two children, plans to continue his association with the Corps in a civilian capacity.

Also recently retired from the Corps is Sgt Amerigo Pasquini after 17 years of continuous service. He enlisted in Montreal in May 44 and has served in 11 and 13 Coys as well as a tour in Germany from 1954 to 1956. Sgt Pasquini plans to continue residence in Kingston with his wife and two children.

Our congratulations are offered to three members of this Coy promoted since the last issue of the Quarterly:

S sgt JE Shiner to WO 2 effective 9 Dec 60
 Sgt JCA Therrien to S sgt effective 30 Dec 60
 Pte NAJ Eady to A/Cpl effective 15 Dec 60

A native of Vancouver, WO 2 John Shiner enlisted as a chair assistant in the CDC in Oct 40. During the war he took part in the Kiska Expedition to the Aleutian Islands and served in Londonderry, Ireland with the Navy until his discharge in 1945. He re-enrolled in the Corps in Nov 47 as a dental assistant, later remustered to DT Lab, and has since qualified and remustered to a DT Cl Gp 4. John, at present stationed in Ottawa, is married with two children.

S sgt Therrien is a New Brunswicker. He enlisted in Jan 51 as a dental assistant and has seen service in Germany and on "I" Staff. In Jun 60 he qualified as a DT Cl and is currently employed at RCAF Station Clinton, where he resides with his wife.

A native of London, Ontario, Cpl Eady is a former Navy Administrative Writer, having served a five-year hitch with the senior service in HMCS Naden and Bonaventure. He enrolled in the RCDC in Jun 58 and has qualified as a DA Gp 2, but is currently employed at Coy HQ in Trenton for training as a Clk Adm. Cpl Eady resides in Trenton with his wife and two daughters.

New arrivals include Sgt AJC Gagnon and Sgt W Olynyk, now stationed at Uplands, as well as, Cpl DB Loosley, a transfer from RCA who reported to Camp Petawawa on 3 Jan and Pte OW Mandrusiak from the PPCLI Depot who is employed at 15 Clinic in Trenton.

Training

The following attended courses during the period Jan - Mar 61:

Col AC Leman	- Civil Defence, Armprior
Lt Col RHG Cunningham	- Officers' Clinical and Officers' Casualty Care
Major FL Falkner	- Officers' Clinical and Officers' Casualty Care
Major PS Sills	- Dentistry Advanced - Walter Reed Army Medical Center, Washington, DC
Sgt JRAOLP deBlois	- DT Cl Gp 3
Cpl G Sapergia	- DT Lab Gp 1
Cpl BH Sims	- Sr NCO
Cpl RJJ Tremblay	- Sr NCO
Pte C St C Sabine Pasley	- DT Lab Gp 1
Pte RH Stenabaugh	- DT Lab Gp 1
Pte RL Geddes	- Jr NCO

Vital Statistics

A son, Charles Keith, was born 5 Jan 61 to Capt and Mrs CG Travis.
 A son was born to Lt Col and Mrs WA Anglin on 21 Apr 61.

We regret the sudden passing of S sgt Weir's wife, Dorcas, following a car accident near Cobourg on Sunday 22 Jan in which Bill and his two children were seriously injured. The children are expected to be up and around shortly. Bill, however, will be in hospital for some time yet.

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14 DENTAL COMPANY

Promotions, Retirements and Releases

Capt Dave Cook, one of the Corps' originals, has received advice that his retirement will be effected in June. Dave was born in England, coming to Canada as a youngster of three and receiving his education in Victoria, BC. He began his military service with the Militia in 1924, enlisted with the Canadian Scottish in 1939, transferred to the CDC in 1940 and attained the rank of WO 2. He was commissioned in 1956 and at present is Captain QM with 14 Dental Company in Winnipeg. Dave will be SOS to 8 PD for release proceedings on 30 Jun 61. The Cooks have two children and intend to make their retirement home in Victoria, BC.

Retirement also has claimed Sgt Howard Habart who served with the CDC from 1941 to 1946 and re-enrolled in 1951. Howard was born in the province of Quebec, is married with three children and expects to continue to reside in Winnipeg. He will be SOS to 8 PD for release proceedings on 27 Jun 61.

Postings

Cpts Doug Bunt and Claude Arpin have been alerted for a tour with the Dental Detachment in the Middle East.

Training

Cpts Bob Bryant, Leo Bourget and Herman Cashin are anxiously awaiting the results of the Captain to Major Pre-Course exams which they wrote in March.

Courses attended by 14 Coy personnel recently are:

Major Joe Lauziere	- Medical and Dental Practitioners Indoctrination Course, Civil Defence College, Arnprior
Capt George Moore	- Unit Fire Prevention Officers' Course - RCSME, Chilliwack
Sgt Dawson Casson	- DT Lab Instructor Course at The RCDC School

Lt Col Purdy has been lending assistance to the teaching staff at the Faculty of Dentistry, University of Manitoba in the Department of Prosthodontia, which is headed by Dr Harold Hart, a former respected member of the Corps who retired in 1958.

Visits and Trips

Recent visitors to the unit from Ottawa have been Col HL Harris and Capt John Bignell. The latter visited in January to discuss personnel matters and Col Harris was in Winnipeg to inspect No 57 Dental Unit (M) in early April.

Major Jim Jolly and Cpl Richard Walker of Fort Churchill are now listed among small groups of personnel who have provided treatment at Alert, NWT by virtue of a trip there in March.

Lt Col and Mrs Purdy have returned from a most pleasant mid-winter vacation in Mexico City and Acapulco, where they spent the time sunning, swimming and sight-seeing.

Special Events

The Unit Annual Curling Bonspiel was held in March at the RCAF Winnipeg rink. Teams from Camp Shilo, RCAF Station Winnipeg, Fort Osborne Barracks and HQ Staff competed. The defending rink from Camp Shilo skipped by S sgt Ross Taylor won the event. Sgt Keith Laurence is to be congratulated for so successfully organizing the curling, the supper and dance which followed.

Sgt Gord McGunigal's rink dominated the Camp Shilo bonspiel and won most of the honours at this event.

Capt George Moore has been recently appointed Fort Osborne Barracks Officers' Mess Secretary.

A committee, headed by WO 1 Ben Gareau, is making arrangements for a dinner dance at the Fort Garry Hotel, Winnipeg, when presentation of prizes will conclude the unit Bowling League activities for the season.

15 DENTAL COMPANY

Promotions

Cpl P Dignard's promotion to Sgt was very welcome news. Sgt Dignard enlisted in 1950 and following service in Korea the old Van Doo transferred to the RCDC as a DT Lab. He is now stationed in Quebec City where he resides with his wife and three children.

Pte JAJ Fret's promotion to Cpl was also announced recently. Cpl Fret, who was born in Antwerp, Belgium and came to Canada in 1952, first served as a gunner from 1956 to 1959. He re-enrolled in 1959 in the RCDC as a DA and is now employed at St Jean where he resides with his wife and one child.

Postings

Major Bob Dyer has recently left us for the saltier clinics of the Maritimes.

Major PH Guevremont has once again rejoined the "15 Dent" after a tour aboard the "Bonnie".

Sgt M Tremblay made the long trek from BC and is now firmly entrenched in the new clinic at St Hubert.

Capt Ted Lesage will be leaving us soon and we all wish him good luck on civvy street.

Duty Visits and Inspections

This unit was recently honoured by a visit from Brig KM Baird who officially opened the new dental clinic at RCAF Stn St Hubert. (See photo next page)

The Air Officer Commanding Training Command, AVM HM Carscallen, DFC, CD, visited our QM Stores at St Jean 21 Feb 61. He was very impressed by the wide range of clinics supplied from this outlet and by the stores layout in general.

Col TL Marsh recently made his final inspection of all detachments in this Command prior to his forthcoming retirement.



New Clinic Opened at St Hubert

The new Dental Clinic at RCAF Station St Hubert was officially opened on 6 Mar 61. Brigadier KM Baird, Director General of Dental Services is shown in the centre photograph cutting the ribbon. Looking on (R - L) are Group Captain WB Hodgson, Commanding Officer of RCAF Stn St Hubert, Air Commodore JB Harvey, Chief Staff Officer, Air Defence Command and Major ED Fraser, Senior Dental Officer of the new clinic.

The clinic is situated in the station hospital and, as can be seen in the other photos, is beautifully appointed and equipped.

Training

The following personnel successfully completed courses:

Lt Col AR Smith	-	Officers' Clinical Officers' Casualty Care
Major J Durand	-	Officers' Clinical Officers' Casualty Care
Major JD Bourque	-	Minor Oral Surgery
Major HE McKenna	-	Periodontics
Capt WA Sugars	-	Radiology
Sgt A Bourgeois	-	DT Lab Instrs
Sgt JP Dignard	-	Sr NCO
Cpl AW Hussey	-	Clk Adm Gp 3
Cpl JAJ Fret	-	Jr NCO

Cpls AE Werkmann and G Dancer are still battling with the DT Lab Gp 1 course at the School. Good luck fellows.

L Sgt "Ernie" Jermain, the Kapuskasing Kid, recently passed his Sr NCO pre-course assessment and is huptwo-threeing it at QM Stores anxiously awaiting the next step.

Vital Statistics

LAW Donna McNeill was married to RCAF Cpl DJ Hollins on 9th March at St Jean. Best wishes, Donna, and good luck in Europe.

The engagement of AW1 Babish to LAC Bob Kennedy of RCAF Goose Bay was recently announced. Congratulations!

New arrivals were confined to College Militaire Royal this time. The proud parents are:

Capt and Mrs Luke Bosse	-	a son - Joseph Jacques Marc Andre
Cpl and Mrs Marcel Chayer	-	a daughter - Lise Guylaine Marie

Special Events

Col and Mrs Marsh were patrons of the Annual Formal Ball of the Dental Students of McGill University on 3rd March. They also represented Major-General and Mrs JM Rockingham at the Montreal St Patrick's Society Ball 17 Mar 61.

Curling seemed to be the most popular sport in the Coy this winter, even Capt Lionel Jacob got into the act. Skiing, although not indulged in by everyone, enjoyed a fairly good season, particularly at Command HQ. Capt Harrison again helped out in the capacity of treasurer and assistant secretary of the Montreal Branch of the Canadian Army Ski Club. Members at Goose Bay seem a bit downcast since all ice fishing shacks had to be off the ice by 1st April. They have a summer fisherman's paradise, however, at Muskrat Lake, about 45 minutes from the base. With food, sleeping accommodation, boats and motors for \$3.00 per day, plus the fringe benefit of "no women allowed", this is indeed a haven to which work-weary members may retire.

4 FIELD DENTAL COMPANYPostings

Capt Bisailon, Sgts Palmer, Shields and Toole make up the group returning to Canada from 4 Field this summer. Word has been received that they will be employed in 14, 11, 15 and 11 Coys respectively.

We look forward to welcoming as replacements, Capt DJ MacPhee and Sgt McDonald.

Training

WO 2 PL Gourlay, Sgt JR Cahill, Sgt JAR Shields and Cpl CC Millard attended a course on the Organization of Medical Services, 24 Basic Procedures and First Aid held by 1 Field Ambulance in January.

Visits and Trips

Lt Col Evans and Sgt Toole visited Antwerp for 2 weeks in February to examine DND school children and provide treatment for personnel of 1 Cdn Base Ordnance Unit.

Maj Skinner and Cpl Posyluzny have both visited 35 Fd Dent Unit recently.

Vital Statistics

Congratulations to Sgt and Mrs JE Clarke on the birth of a son at BMH Iserlohn on 10th March.

35 FIELD DENTAL UNITPromotions, Retirements and Releases

Congratulations are being offered to Capts Lew Kelland and Art Hinch on their promotions to Major, effective 1 Apr 61 and 16 May 61 respectively.

Major Kelland, a Nova Scotian, attended St Francis Xavier University in New Brunswick and Dalhousie University, receiving a BA, BEd and DDS. Following graduation in 1954 he was posted to 12 Coy and in 1958 was transferred to France. Major Kelland is married with two children. Capt Hinch, a Haligonian, attended Dalhousie University, graduating in 1947. After enrolling in 1956 Capt Hinch served in 12 Coy until he was posted to France. He is married with one child.

Cpl Shirley Morken has returned to Canada to take her release from the RCAF.

Postings

Personnel of the unit returning to Canada this summer on completion of their tours include Lt Col Ross Covey, Majors George Windsor, Ian MacDonald, Lew Kelland and Sgt Gar Grundy.

Training

Sgt Helmut Marckwort returned to Crostenquin in February following attendance on the Senior NCO Course at Camp Borden.