

The
**ROYAL CANADIAN
DENTAL CORPS**
Quarterly



TABLE OF CONTENTS

	<u>PAGE</u>
Dowel Abutment Crown - Taylor.....	1
Aims and Practices of Preventive Dentistry in the RCDC	
Part Two - Hillier.....	4
Failures in Amalgam Restorations - Boucher.....	8
Necrotizing Ulcerative Gingivitis.....	11
Consulting Staff to the RCDC - Its History and Functions - Covey.....	18
Welcome to the Corps.....	20
Promotions.....	20
Retirements and Releases.....	21
Postings.....	22
Training.....	24
Vital Statistics.....	26
Announcement of First Annual RCDC Golf Tournament.....	27
Directorate News.....	28
The RCDC School News.....	28
1 Dent Eqpt Dep News.....	30
11 Dent Coy News.....	31
12 Dent Coy News.....	32
13 Dent Coy News.....	32
14 Dent Coy News.....	34
15 Dent Coy News.....	34
4 Fd Dent Coy News.....	35
35 Fd Dent Unit News.....	35
CBUME News.....	36
RCDC Militia News.....	37

THE RCDC QUARTERLY

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

Editorial Board: Colonel GR Covey
Lt Col DH Hillier

SUBSCRIPTION RATES

The RCDC Quarterly may be subscribed for at \$4.00 per
year by writing to:

Director General of Dental Services
for the Canadian Forces,
Army Headquarters,
Ottawa, Ontario.

Cover Photo - Sergeants Geoff Dancer (foreground) and Paul Dumas take
pictures of the local Bedouin tribe and camels at the
CBUME water tower.

DOWEL ABUTMENT CROWN

Major AG Taylor, DDS

Experience has shown that it is better procedure to keep the reinforcing dowel or dowel abutment preparation separate from the veneer crown. In those instances where the crown and dowel are combined, any failure or replacement often results in the loss of the residual root. Not infrequently, an individual dowel abutment may be required later to serve as a bridge abutment. In these cases it is especially convenient to be able to remove the crown from the dowel abutment preparation and be able to continue the bridge construction with little or no further preparation of the abutment.¹

Soltanoff and Parris² describe a special technique using a segment of a silver point to seal the root canal apex in cases where it is anticipated that a dowel preparation subsequently will be made. A gutta-percha filling is inserted coronal to the apical seal. This technique permits the operator to obtain space for dowel construction without endangering the integrity of the apical seal.

Operative Procedure

The clinical crown is reduced, the extent of the reduction depending upon the amount of sound tooth structure remaining. Very often it will be found that the remaining clinical crown is so weakened by proximal restorations and the opening for endodontic procedures that its complete removal is advisable.³ The reduction is carried only to the crest of the gingival tissue at this stage. (fig. 1)

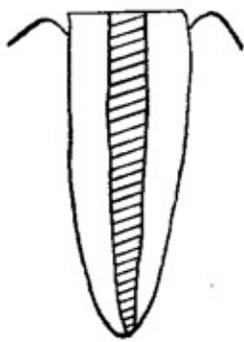
The dowel preparation is made by reopening the canal with a Peeso reamer #1, 2 or 3 depending on the size of the tooth. The root preparation is carried to a depth equal to or greater than the length of the restored clinical crown.⁴ If the canal has been filled with gutta-percha no difficulty will be encountered. Should a silver point be present, great care must be taken in reducing the point with a #2 SHP bur to avoid lateral perforation from the canal. When the silver point has been reduced to a sufficient depth, the canal is enlarged with a Peeso reamer. (fig. 2) To prevent rotation of the dowel abutment a keyway is prepared labiolingually with a flame diamond stone. (fig. 3)

The canal is cleaned with hydrogen peroxide followed by a water rinse and dried with a wisp of cotton on a #700 SHP bur. It is then lubricated lightly with microfilm. A piece of softened #14 gauge round wax wire is inserted and cut off flush with the root stump. This wax is condensed into the canal with a smooth-end plugger. The canal is filled with inlay wax by carrying the melted wax to position in the beaks of cotton pliers to just fill the canal and keyway.

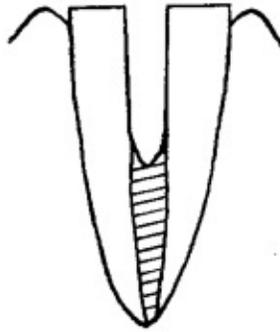
A specially prepared sprue-wire may be made from an ordinary paper clip. (fig. 4) The paper clip is straightened, a two inch length is cut off, and one end is bent to form a handle. The other end may be roughened with a disk to permit retention with the wax. The paper clip sprue-wire is heated and inserted into the wax to the bottom of the canal preparation. When cool, the wax pattern is removed from the canal for inspection (fig. 5) and then replaced into the canal.

A small ball of softened inlay wax is placed to the lingual of the wire pin and gradually forced to the labial sealing the wax to the previously prepared pattern as the additional wax is bent around the pin. While still soft the wax is shaped and after chilling, the abutment preparation may be carved. (fig. 6) The wax pattern is removed, the handle is clipped off, the wire sprue-pin is thickened with wax and attached to a crucible-former. (fig. 7)

DOWEL ABUTMENT CROWN



(1)



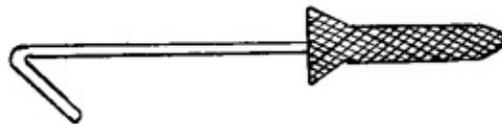
(2)



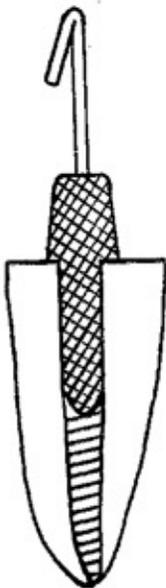
(3)



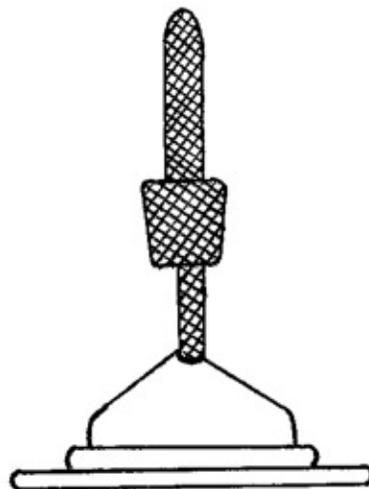
(4)



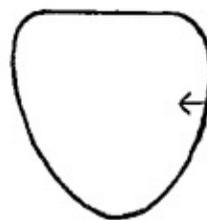
(5)



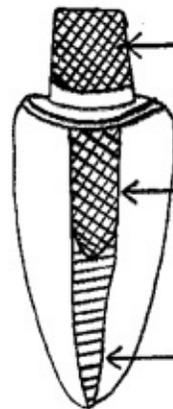
(6)



(7)



CROWN



ABUTMENT

DOWEL

RESIDUAL
PREPARED
ROOT

DOWEL
ABUTMENT
CROWN

(8)

After investing, casting and pickling, the casting may be cleaned with a wire brush and inspected for small bubbles that would prevent complete seating into the canal. Using the button as a handle, the fit is then tested. The button may now be removed and the dowel abutment cemented with zinc oxyphosphate cement. The preparation of the abutment is completed, carrying the preparation subgingivally beyond the junction of the dowel abutment with the tooth. (fig. 8) This procedure ensures protection of the cement margin from secondary decay. The dowel abutment is now ready for the impression to be taken and the full coverage crown is fabricated in the usual manner.

Conclusion

While it is unquestionably true that a tooth with a vital pulp is better than one without, some prominent writers have found through careful analysis of many case histories that pulpless teeth can serve satisfactorily as bridge abutments if the root canal is carefully prepared and filled, and is subsequently kept under periodic surveillance.⁵

Because the remaining coronal structure of a pulpless tooth is brittle, it is seldom capable of supporting the restoration without a post being placed in the root area.⁶ Even in cases where the crown is intact it is often advisable to insert a metal post to support the root and coronal portions from the stresses of mastication.⁷ In this way the jacket crown may be prevented from snapping off at the cervix, taking the tooth structure with it.

Best results will be obtained by keeping the dowel abutment separate from the veneer crown. Inasmuch as individual dowel restorations may be required later as bridge abutments, this principle applies to single restorations and bridge abutments alike.

Summary

Some reasons are presented for constructing a dowel abutment separate from the accompanying veneer crown. The use of a specific method for filling endodontically involved teeth has been recommended² and a direct technique for the construction of dowel abutments, as taught at the US Naval Dental School, has been detailed.

References

1. Postgraduate Manual, Crown and Fixed Partial Dentures. US Naval Dental School, Bethesda, Maryland.
2. Soltanoff, Walter, and Parris, Leonard. Controlled silver point filling technic for endodontically involved teeth. *Am. Dent. A.J.*, 65: 301-9, Sept. 1962.
3. Ewing, J.E. Fixed partial prosthesis. 2nd ed. Lea and Febiger, 1959, Chap. XIV, P. 123.
4. Johnston, J.F., Phillips, R.W., and Dykema, R.W. Modern Practice in Crown and Bridge Prosthodontics. Philadelphia, Saunders, 1960. (Chap. 11, p. 24)
5. Tylman, S.D., and Tylman, S.G. Theory and practice of crown and bridge prosthodontics. 4th ed. St. Louis, Mosby, 1960. (Chap IX, P. 81)

6. Markley, M.R. Pin reinforcement and retention of amalgam foundations and restorations. Am. Dent. A.J., 56: 675-9, May 1958.
7. Brecker, C.S. Crowns. Philadelphia, Saunders, 1961. (Chap. XXV, P. 418)

AIMS AND PRACTICES OF PREVENTIVE DENTISTRY
IN THE RCDC - *PART TWO

Lt Col DH Hillier, CD, DDS, MPH

Possibilities for future activity in Preventive Dentistry

Public Health Programmes

One of the aims of the public health programmes has been to stimulate the interest of clinic personnel in the value and methods of dental health education. Recent reports indicate that this purpose is being achieved and it has become apparent that dental education is now accepted as an integral part of the entire clinic commitment.

It may appear, therefore, to be a paradox to suggest that perhaps the Directorate should not sponsor a similar programme in 1963. This possibility is based quite apart from factors of time, effort and expense, on one of the fundamental values of this type of endeavour.

The "campaign" or "crash programme" is a highly successful device of health education which makes intensive use of all possible means of disseminating information for a specified period. The success of a "campaign" requires a great expenditure of enthusiasm, time and material and its particular value lies in the concentration of effort and the saturation achieved through the use of various media of communication and also through the novelty of the experience. Repeated and regular use of the device reduces its value and brings ever-diminishing results in comparison with the efforts required.

It is not suggested that the holding of local programmes should be discontinued or discouraged for these will always prove to be of value. However, they could be more restricted to fit in more readily, with normal clinic routine and scheduled for a time most suitable to local conditions.

Dental health education is more lasting and ultimately more valuable as a continuing programme, through person-to-person contact and the intermittent use of whatever media of mass communication are available. Dental health education should be a year-round endeavour and such is the case at the present time in many clinics, particularly those which employ a dental technician clinical.

Dental Technician Clinical

It is becoming increasingly evident that the success of preventive dentistry in the Corps is linked directly with the number of dental technicians clinical available. Their training and motivation makes them particularly suitable for this work and the necessity of encouraging their participation in this phase of dental service cannot be over-emphasized. Indeed as the practices of prevention continue to develop it could well become expedient to reassign radiography to another trade in order to allow them to concentrate on preventive dentistry. It is estimated that

they currently devote over 30 percent of their time to radiography. If the current proposal to ultimately employ an additional 37 persons in this trade is approved, it should assist significantly in providing the trained personnel required for the furtherance of preventive dentistry and for the development of the concept of clinic programming.

Clinic Programming

The subject of clinic programming could have been dealt with earlier inasmuch as the recommended method is already detailed in the Manual of Dental Services and has been presented on officers' courses at the RCDC School for the past two years. Although some forms of clinic management have been carried out in the Corps at one time and another, with undocumented results, a comprehensive trial of the methods recommended in the Manual has not been undertaken up to this time. However, the basic principle involved, that of a comprehensive, precise and orderly approach to the treatment problems of each clinic, cannot be refuted and dental officers are strongly urged to base their clinic operations on this principle. Instruction in the method will continue to be included in officers' courses and the techniques of collecting the required data for the operation of such programmes is being presented to those personnel attending Group 4 dental technician clinical courses.

Fluoridization

As mentioned previously, the value of fluoridization with stannous fluoride in reducing the dental caries of experience of young adults is sufficiently well documented to warrant its use throughout the Corps. Lack of personnel at the present time requires that the routine use of this measure be restricted to recruits. However, dental officers are encouraged to make as full use as possible of this therapy and, as the availability of personnel permits, expansion of this programme should be possible.

Consideration is being given to the feasibility of making fluoridization available to school children in those areas for which the Corps is responsible for dependents. However, it is not anticipated that a firm decision on this matter can be available for some time.

Preventive Programming

This author has suggested that in prevention lies the ultimate solution to the problem of coping with dental disease and some of the current and planned preventive practices in the RCDC have been cited. However, a piece-meal and uncoordinated approach to prevention is not likely to reduce the prevalence of dental disease to a level with which the potential treatment capacity can cope adequately. Hence, a systematic and comprehensive plan is required.

A formalized approach to the treatment phase of RCDC practice has been developed in clinic programming. Preventive practice likewise requires a logical and complete formula. The public health approach which is incorporated in clinic programming is equally applicable to preventive programming. There are, however, significant and challenging differences which make the development and operation of such programmes much more difficult.

Whereas the long range objective of clinic programming to raise all personnel to Category 3 is practical, the prevention of all dental disease is not a practical aim at this time since the methods to achieve it are not available. Thus, the sights must be lowered and, once the ideal is discarded as impractical, it is readily realized that no all-embracing objective can be cited. Instead, a series of objectives must be developed in terms of the individual measures available. For

example, the fluoridization of all non-edentulous personnel could be one of these. Indeed, the long-range goal of clinic programming might become one of the intermediate goals of preventive programming. The various methods of prevention could be developed into separate programmes, giving due regard to phasing and to the relative efficacy of the measures available.

Unit Dental Public Health Officers

One of the difficulties in preventive programming lies in the relative unfamiliarity of dental officers with the measures available and in a lack of motivation for their employment. Inasmuch as the results of preventive dentistry are less apparent than restorative treatment, motivation is of extreme importance. Any apparent lack of this quality in dental officers is not surprising in view of the emphasis placed on restorative dentistry during undergraduate training.

It is felt that the change in motivation required might best be accomplished through a cadre of officers trained in dental public health. The implementation of this concept through the employment at unit headquarters of a Dental Public Health Officer (DPHO) has been suggested and the following terms of reference are offered for consideration:

- a. a Unit DPHO should be appointed to consolidate the preventive features of the unit operations and to act as advisor to the unit commander on all aspects of dental public health.
- b. the Unit DPHO should be responsible to the unit commander for the initiation, coordination and supervision of all preventive programmes carried on within the unit.
- c. he should engage in such studies and research as are of direct concern to the unit and should be available to participate in studies of a broader application as approved by DGDS.
- d. he should liaise with the public health agencies within his area.
- e. he should devote approximately one-half of his time to these activities.
- f. he should engage in clinical treatment with emphasis on the preventive aspects of such treatment. Restriction to the field of periodontics would appear to be worthy of consideration.
- g. the chain of communication between these officers should be as direct as possible and they should be fully aware of all activities throughout the Corps which relate to preventive dentistry.

Unquestionably, such a proposal is dependent on factors of the availability, and training of suitable dental officers and the inherent increase in the RCDC establishment so that full implementation would be unlikely for several years. The adoption of this policy in principle, however, could serve as the framework for a truly comprehensive programme of preventive dentistry throughout the Corps.

Summary

This article has reviewed some of the aims and practices of preventive dentistry in the RCDC and has dealt with certain features currently being considered for

References

1. Ellis, R.G. Manpower in dentistry - The dentist. J. Canad. D.A. 27:5-6, Jan 1961.
2. Council on Education, Cdn Dent Assn. Comments on the survey of dentistry in the United States : 3. Dental Education. J. Canad. D.A. 28:248-51, Apr 1962.
3. Dunn, W.J. Report on a workshop conference on auxiliary personnel in dentistry. J. Ontario D.A. 38:14-21, Jul 1961.
4. McCutcheon, James. Manpower in dentistry - The dental assistant. J. Canad. D.A. 27:7-12, Jan 1961.
5. Dunn, W.J. Organization and conduct of an evening course for dental assistants. J. Canad. D.A. 27:491-503, Aug 1961.
6. Anderson, J.A. Efficient use of space to conserve time and energy. D. Clin. N. America p. 185-95, Mar 1961.
7. Baird, K.M. Dental services for the Canadian Forces. Roy. Canad. D. Corps. Quart. 2:4-6, Oct 1961.
8. Bernier, J.L. and McFall, T.A. Role of prevention in military dentistry. J. A.D.A. 62:717-22, Jun 1961.
9. Brown, H.K. Health professions and the challenge of widening horizons and changing patterns. J. Canad. D.A. 28:1-5, Jan 1962.
10. A study of the prevalence of dental disease in serving members of the Canadian Armed Forces in Canada - 1960. Office of the Director General of Dental Services for the Canadian Forces, Sep 15, 1960. 17 p. typed.
11. Muhler, J.C. Recent advances in preventive dentistry. Internat. D.J. 10:89-106, Mar 1960.
12. Protheroe, D.H. A study to determine the effect of topical application of stannous fluoride on dental caries in young adults. Roy. Canad. D. Corps Quart. 3:20-30, Jul 1962.

Editor's Note

Subsequent to the presentation of this paper at the DGDS Conference, Ottawa, Dec. 62, it was decided that a Dental Health Programme would be conducted in 1963 in general accord with the format developed over the past four years. Certain modifications permit greater flexibility in the design, conduct and reporting of the local programmes.

In line with the policy of employing Dental Public Health Officers, at each Company Headquarters, Major WH Harrington has been chosen to attend the University of Toronto this autumn in order to obtain his Diploma in Dental Public Health.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

FAILURES IN AMALGAM RESTORATIONS

Capt GJ Boucher, DDS

Amalgam restorations make up the bulk of the restorative dentistry performed in day-to-day dental practice and consequently, amalgam failures are an important consideration for every dentist. It has been shown that this material has the lowest failure rate of any restorative material,¹ however, the very ease with which it can be used leads to a certain casualness in its employment and many failures result. Studies conducted by Moss² and Healey and Philips³ indicate that approximately 60% of amalgam failures are attributable to improper tooth preparation, with the balance due to faulty amalgam manipulation. Because these factors are within the dentist's control, the responsibility for failure must be assumed by the dentist.

Amalgam restoration failures fall into four categories:

- a. recurrent caries;
- b. fractures;
- c. dimensional changes; and
- d. excessive tarnish and corrosion.

Recurrent Caries

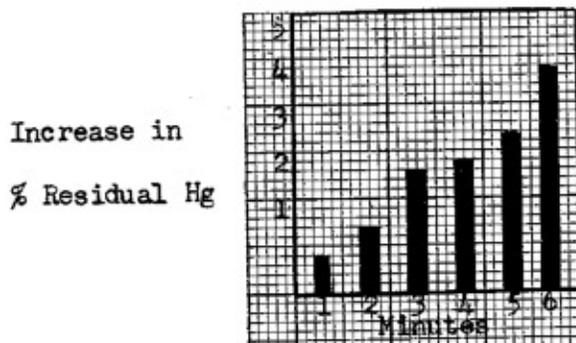
Assuming complete removal of the original decay, recurrent caries is caused by a lack of extension of the preparation into relatively caries-immune areas. Proximal boxes should be extended buccally and lingually and flared out at the gingival margin. Pits and fissures should be completely eradicated to prevent entry of organisms into the dentin. Rough margins, due to fracture of amalgam feather edges and unsupported enamel rods, create food traps which encourage caries.

Fractures

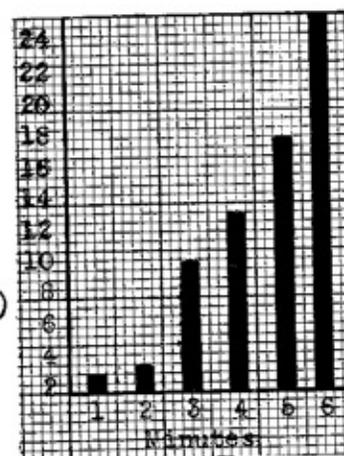
Before preparing a tooth for restoration, the type of material to be used must be considered. Amalgam restorations are retained mechanically and must be supported by tooth structure. Despite the many "amalgam crowns" in existence, this is not the material of choice if the tooth structure cannot support and retain the restoration or must itself be supported. In such instances, a casting is indicated. If amalgam is to be used, care must be taken to provide for sufficient bulk of material, particularly in the isthmus and marginal areas. At the margins, the amalgam should meet the surface almost at right angles. Adequate retention should be provided in the proximal boxes by means of definite axial grooves, although the necessity of a reverse bevel on the gingival seat is open to question. Another cause of fracture in the isthmus area that is frequently overlooked is the failure to round the pulpo-axial line angle. This precaution will reduce the concentration of stresses in the sharp, narrow angle of the restoration.

Dimensional Changes

The residual mercury content of the amalgam drastically affects the strength of the restoration and when it exceeds 55%, a dramatic reduction in strength is observed.



Loss of Strength
(1000 lbs / sq in)



Restriction of the residual mercury content to approximately 50% is both desirable⁴ and feasible if the following factors are carefully controlled:

- a. original mercury alloy ratio;
- b. amount of trituration;
- c. time elapsed from trituration to condensation; and
- d. condensation pressures.

Trituration of a mix containing a high proportion of mercury to alloy will result in high residual mercury content no matter what pressures are used in squeezing or condensation.⁵ In other words, once the excess mercury is mixed in, it cannot be removed sufficiently to provide the optimal ratio in the finished amalgam. Gravity-type slide dispensers are accurate if properly adjusted, however once the mercury-alloy ratio is established, it should never be altered by the addition of more mercury during or after trituration. Furthermore, the use of excess mercury is not economical since some of the alloy will be expressed in solution during squeezing and condensation, resulting in a much smaller amalgam mass from a given amount of alloy. Too low a ratio of mercury to alloy, on the other hand, will result in a lack of plasticity of the amalgam mass and a coarse, easily corroded surface of the finished filling. Final shrinkage, rather than the 3-13 micron/cm expansion required by ADA specifications, is theoretically possible through overtrituration, but should not occur if the manufacturers' instructions are followed carefully. Such shrinkage is difficult to demonstrate on a mass as small as a typical restoration and several investigators have been unable to verify actual shrinkage clinically.^{6,7} In any case, the anticipated expansion would probably take place in the direction of free surfaces rather than against the confining walls of the cavity. The real danger in dimensional change lies in undertrituration which will produce gross overexpansion, resulting in post-operative pain and even fracture of the tooth in extreme cases. Such undertrituration may be the result of overfilling the capsule used in mechanical triturators. Once mixed, the amalgam should be squeezed immediately in a clean linen cloth, since only one-half of the residual mercury can be expressed after a three minute delay and only one-quarter after six minutes.

The fine-cut alloys now in common use present a relatively large area for reaction with the mercury and consequently the trituration and the setting processes have been accelerated. Amalgam should be condensed within three minutes following trituration. The concept that the placing of an amalgam restoration should be commenced with a sloppy mix, followed by progressively drier material is a fallacy, since mercury will not diffuse upward through the mass and the restoration will be plagued by all the

faults which result from excess residual mercury. The initial material and each succeeding addition should be of the proper consistency to show a slight amount of mercury on the surface under heavy condensing pressures. This procedure will prevent lamination of the successive increments.⁸ Likewise, each addition should be carefully packed, since it cannot be expected that the condensation of subsequent amalgam will compress the original mass to any greater degree. Poor condensation leads to marginal failures, lower tarnish resistance, reduced crushing strength, increased flow and expansion.

Dimensional changes which follow the normal setting also must be considered. Amalgam which is high in residual mercury will remain somewhat plastic and have a tendency to distort under stress. This phenomenon is called "flow" and results in flattened contact points, overhanging margins and slight protrusion from the cavity. Expansion, resulting from moisture contamination at the time of insertion, will cause the restoration to protrude from the cavity preparation. Most alloys contain zinc which reacts with the contaminants to produce hydrogen which, in turn, causes expansion of the amalgam by the formation of internal gas bubbles.

Excessive Tarnish and Corrosion

Excessive tarnish and corrosion may occur for several reasons, but is generally due to a high mercury content. Some dentists attempt to put a "shiny" finish on a restoration immediately after carving, by burnishing the restoration. This procedure only draws mercury to the exterior and the shine will soon be replaced by the corrosion and tarnish inherent in a mercury-rich surface. Excessive heat generated during polishing will have the same effect, creating a frosty appearance. Undertriturated amalgam will result in a coarse surface covered by unalloyed particles. Moisture contamination causes gas bubbles to form throughout the restoration and results in a pitted surface which cannot be polished away.

Although no one would consider cementing an unpolished gold casting in the mouth, many dentists do not seem to recognize the obligation to polish an amalgam. The prime reason for polishing any restoration is to produce smooth, easily cleaned margins and a finish which is resistant to tarnish. Furthermore, well-polished amalgam restorations will engender not only the appreciation and cooperation of the patient but also the respect of the dentists' colleagues.

References

1. Brehus, P.J., and Armstrong, W.D. Civilization - disease. *Am. Dent. A.J.*, 23: 1459 - 70, 1936.
2. Moss, R.P. Amalgam failure. *US Armed Forces Med. J.*, 4: 735 - 6, 1953.
3. Healey, H.J., and Phillips, R.W. A clinical study of amalgam failures. *J. Dent. Res.*, 28: 348 - 55, 1949.
4. Swartz, M.L., and Phillips, R.W. Residual mercury content of amalgam restorations and its influence on compressive strength. *J. Dent. Res.*, 35: 458, 1956.
5. Phillips, R.W., and Boyd, D. Importance of the mercury alloy ratio to amalgam fillings. *Am. Dent. A.J.*, 34: 431 - 58, 1947.
6. Phillips, R.W. et al. Clinical observations on amalgam with known physical properties - final report. *Am. Dent. A.J.*, 320-4, 1945.
7. Miller, E.C. Clinical factors in the use of amalgam. *Am. Dent. A.J.*, 34: 820-8, 1947.

8. Miller, E.C. Improved technique for packing and condensing uniform amalgam restorations by hand. Am. Dent. A.J., 28: 1463-71, 1941.
9. Phillips, R.W. Research on dental amalgam and its application in practice. Am. Dent. A.J., 54: 309, 1957.

NECROTIZING ULCERATIVE GINGIVITIS

Major RA Fell, DDS

Introduction

"Necrotizing ulcerative gingivitis" is one of the terms used to indicate a necrotic ulcerative condition of the gingivae which is characterized by classical signs and symptoms and the abundant presence of certain organisms. Plaut and Vincent were probably the first persons to describe these organisms as early as the 1890's. There are many other terms by which this condition is known, some of which are: Vincent's infection, Vincent's stomatitis, Vincent's disease, Plaut-Vincent's disease, Plaut-Vincent's stomatitis, trench mouth, trench gums, necrotizing gingivitis, acute ulcerative gingivitis, acute fusospirochetal gingivitis (stomatitis), phagendemic stomatitis, ulceromembranous gingivitis (stomatitis), and spirochetal stomatitis.^{1, 3, 10} Since the trend in dental and medical terminology is to dispense with the use of eponyms, the term necrotizing ulcerative gingivitis has become the most widely accepted.^{1, 3, 21, 22}

According to Burket,³ the disease is less frequently reported of late and this decline in incidence is probably due to the widespread use of antibiotics in the treatment of many illnesses and infections, improved nutrition and increased dental education.

Daley⁵ states that the disease is common to all age groups, while Burket³ reports a preponderance in young adults, particularly males. Fatigue and emotional stress may contribute to the incidence and servicemen appear to be particularly susceptible following long furloughs and after living under field conditions for a protracted period such as occurred during World War I and II. Incidence may further be related to smoking or the consumption of alcoholic beverages, both of which factors tend to inhibit good oral hygiene. Socio-economic status, nutrition and the general physical condition of the individual may be involved but it appears unlikely that the prevalence of the disease is influenced by the season of the year.

There is a lack of uniformity in the evidence concerning ulcerative gingivitis. Schluger¹⁶ made a survey of 92 patients in two U.S. Army camps in 1943-44 and was unable to find any definite pattern to the spread of the infection. In one instance, only one man in a barracks of 70 men contracted the condition even though these men slept approximately 3 feet apart, and ate in the same mess hall. Carter and Bell⁴ were unable to establish any pattern of communicability among troops at the Great Lakes Naval Station. Some investigators have even injected fusospirochetal bacteria into their own oral tissues in an unsuccessful attempt to contract the disease.

Etiology

The etiological factors of necrotizing ulcerative gingivitis can be divided into predisposing factors and exciting factors.^{3, 4, 6, 7, 8}

The predisposing factors may be either local or systemic. The local factors involved are poor oral hygiene, calculus, gingival flaps, carious teeth, overhanging

margins and occlusal trauma, while the systemic factors include malnutrition, over-indulgence in alcoholic beverages and tobacco, fatigue, emotional stress and general debilitation.^{3,11,13}

A marked increase in the number of certain organisms normally found in the mouth is considered to be the exciting factor in the onset of the disease and there appears to be a direct relationship between a reduction in the number of such organisms and the healing process.¹ This correlation can be determined easily by taking smears as treatment progresses. Microscopically, a smear may reveal a variety of organisms. The Borella Vincenti appears as a gram negative rod 0.5 to 1 by 8 to 16 microns with 4 to 8 shallow or loose coils, thus distinguishing it from the Treponema Pallidum which has 10 to 12 tight coils. Bacillus fusiformis is a rod-shaped micro-organism about 0.5 to 1 micron wide and 5 to 12 microns in length. It may be straight or slightly curved with tapering or pointed ends, is gram-positive and stains easily with common aniline dyes. Vibrios of the oral flora are short, curved "comma-shaped" rods which are gram-negative. The oral streptococci are gram-positive, spherical or ovoid, non-motile organisms arranged in short or long chains or in pairs. Those commonly seen in necrotizing ulcerative gingivitis are alpha hemolytic streptococci.^{1,3} Rosebury states that there is a preponderance of spirochetes in the acute phase and very few, if any, in the subacute phase. The fusiform is present in large numbers in both phases.

A number of conflicting reports have been published on the histopathological aspects of necrotizing ulcerative gingivitis. Turncliff²² found that both fusiform bacilli and spirochetes were present in the necrotic tissue and were invading living tissue, with the spirochete being considerably in advance of bacilli. No cocci were observed in the living tissue. Schaffer¹⁴ reported on 36 patients with typical lesions of necrotizing ulcerative gingivitis. He found ulceration, necrosis, sloughing and erosion in all lesions, but these signs were not evident in the controls. The bacteria did not penetrate the vital tissues but infiltrated the tissues as they became necrotic. Schaffer¹⁴ feels that biopsy studies can be of diagnostic value in differential diagnosis.

Diagnosis

Acute Phase

The diagnosis of ulcerative necrotizing gingivitis can be made on the clinical findings alone, however, a bacterial smear is considered to be a valuable aid in differential diagnosis. The onset of the disease is usually quite sudden and the patient complains of severe pain around the teeth. He may not be able to specify any one particular area of pain but during clinical examination will indicate a greater pain response at the sites of ulceration. Bleeding of the gingiva is the second most important symptom and concomitant with this, the teeth may be sensitive during mastication. Alcoholic beverages, hot or cold liquids or spicy foods may be intolerable to the patient and he may also experience marked discomfort and bleeding upon brushing his teeth. Associated with these symptoms there is usually a metallic taste, a distinctive fetid odor and excessive salivation.^{1,2,3,6,7,22}

The most characteristic objective sign is the punched-out (crater-like) ulceration of the interdental papillae.³ In some instances the papillae may be reduced to a small triangular shaped mass of necrotic tissue which elicits acute pain and bleeding from the slightest pressure on the area. The marginal gingivae and interdental papillae may be bright red in colour, often described as "angry red". The mucosa of the lips, jaws, palate and tongue are often affected, and ulcerated areas at these locations may be covered by a pseudo-membrane. There is also present a distinctive odor which, once encountered is easily recognized by the dentist.

The grayish or yellowish pseudo-membrane which usually covers the ulcerated areas can be removed by light pressure with cotton or gauze leaving a bright red

bleeding area.³ Initially the interdental papillae may be the only areas affected but the tonsillar areas should be examined for incubation zones since they may also be affected in chronic and recurrent infections.

The presence and amount of lymph node enlargement appear to depend upon the severity of the disease. However, Burket notes that adenopathy is more common in children and in patients with circumcoronal involvement about erupting teeth.³

Systemic findings may include fever, headache, general malaise and loss of appetite which seem to parallel the severity of the disease and are usually more marked in younger individuals.

The literature is conflicting concerning the present of changes in the blood picture caused by this disease and blood studies and differential counts are of little diagnostic value. However, such tests may be of value in the elimination of malignant neutropenia, the acute leukemias or aplastic anemia in differential diagnosis.³

Chronic Phase

In the so-called "sub-acute" or chronic form, the characteristic symptoms of the acute form, although present, are less marked and a smaller portion of the gingivae may be involved. There is usually general malaise and pain but no sloughing of the tissue, no pseudo-membrane and the temperature is normal. The gingivae are inflamed and bleed quite easily and may give the appearance of chronic marginal gingivitis with saucered papillae.

Differential Diagnosis

There are several diseases which produce oral lesions and microscopic evidences that are often mistaken for manifestations of necrotizing ulcerative gingivitis. These include acute herpetic stomatitis, desquamative gingivitis, streptococcal stomatitis, malignant neutropenia and leukemia, aphthous stomatitis, mucous patches of secondary syphilis, chronic marginal gingivitis and Vincent's Angina. A careful differential diagnosis may be required to identify any specific condition.

Acute Herpetic Stomatitis

The oral lesions of acute herpetic stomatitis are found primarily on the smooth mucosal surfaces and rarely on the gingival tissues. The typical metallic taste is lacking. The yellowish, cheesy-appearing lesions do not bleed as readily on pressure as the ulcers of necrotizing ulcerative gingivitis. The bacterial smears are negative for fusospirochetal forms. This disease usually runs a course of 7 to 10 days.

Desquamative Gingivitis

In desquamative gingivitis, the patient has a history of chronic involvement of the marginal gingivae. There may be patchy, diffuse desquamation of the gingival epithelium which is not always painful. Since the papillae do not undergo necrosis, there will be no saucering of these structures. A bacterial smear will show numerous epithelial cells and few bacterial forms. The characteristic foul odor of necrosis is not present.

Streptococcal Stomatitis

Streptococcal stomatitis is a relatively rare condition. There is a diffuse involvement of the marginal and alveolar gingivae and an absence of ulcerative lesions in these areas. Bacterial smears show a predominance of streptococcal forms which are of the viridans variety.

Leukemia and Malignant Neutropenia

With reference to these diseases Burket states: "The sudden onset of gingival ulcerative lesions in acute leukemia and malignant neutropenia may present problems in diagnosis. In the acute leukemias, gingival enlargement is usually marked and the patient complains of severe constitutional symptoms. In malignant neutropenia, the ulcerations do not elicit an acute inflammatory response, and they are usually less painful. They frequently have a greenish-black base which is not found in fusospirochetal ulcers. Bacterial smear findings are not diagnostically significant, but a hemogram will establish the diagnosis of malignant neutropenia or leukemia".³

Aphthous Stomatitis

According to Glickman⁶ the lesions of Aphthous Stomatitis are characterized by the appearance of discrete ovoid vesicles which rupture to form saucer-like depressions with elevated rim-like margins. These lesions run a definite course of from 7 to 10 days. They rarely, if ever, involve the marginal gingivae but occur more frequently on the floor of the mouth, mucobuccal fold and tongue. The location, discrete nature of the lesion and definite course serve as the basis for differentiation from acute necrotizing gingivitis.

Syphilis

The mucous patches of acute syphilis rarely occur on the marginal gingivae or the interdental papillae. They have a translucent appearance and they are less painful than Vincent's ulcerations. A serologic test for syphilis and, at times, darkfield examination, will permit a differential diagnosis.

Chronic Marginal Gingivitis

The main considerations in differential diagnosis of chronic marginal gingivitis are that the papillae are not cratered and the gingivae are not sensitive to the touch.

Vincent's Angina

This condition is often confused with the less serious acute necrotizing gingivitis. Glickman⁶ defines this condition as "a fusospirochetal infection of the oropharynx and throat ... The ulcerative lesions are formed in the tonsillar or pharyngeal tissues and they tend to involve the deeper structures ... There is usually a painful membranous ulceration of the throat with edema and hyperemic patches breaking down to form ulcers covered with pseudo-membranous material ... The process may extend to the larynx and middle ear". In Vincent's angina the constitutional symptoms are usually more prominent.

Treatment

The treatment of necrotizing ulcerative gingivitis should be directed toward the control of the acute bacterial phase, elimination of the predisposing factors, both local and systemic, and patient education. In treating this disease one should perform an oral prophylaxis and subgingival curettage of all pockets and sulci as early as possible.

Many drugs have been used in the treatment of the acute bacterial phase and before the advent of antibiotics, chromic acid and arsenicals were the treatments of choice. Antibiotics used topically have been found to relieve pain and promote healing more quickly than other types of drugs.^{3,6,7,8,9,10,12,15,17,18,19,22} Penicillin, aureomycin, terramycin or chloromycetin may be used for topical application. There are, however, many practitioners who disapprove of the topical use of antibiotics without systemic administration. They believe that such therapy may lead to sensitivity in the patient and produce resistant strains of organisms. Intramuscular in-

jections of penicillin or the oral administration of aureomycin or terramycin should accompany the topical application of these drugs. Many authorities believe that antibiotics should only be used when the patient has an elevated temperature and is in such pain as to preclude subgingival curettage.

Treatment Programme

First Visit

1. Determine all possible incubation zones such as overhanging fillings, periodontal pockets, gingival flaps and malposed teeth.
2. Irrigate the mouth with hot water and peroxide (3%) or hot saline solution (approximately 120°F); peroxide is used for its mechanical action only.
3. Gently remove soft deposits and tissue debris with cotton swabs or gauze.
4. Eliminate as much of the supra-gingival calculus as possible.
5. Administer antibiotics topically and systemically in very acute cases with severe symptoms. For topical application the following antibiotic treatment is recommended:
 Fifty mg of soluble aureomycin dissolved in a drop or two of water to make a paste. This paste is placed interproximally around the marginal gingivae and on all areas of necrosis and allowed to remain for a period of 5 to 10 minutes.
6. Instruct the patient in home care. It is advisable to provide the patient with the following written instructions:
 - a. Rinse the mouth vigorously every two hours with a hot salt and water solution;
 - b. Restrict the diet to soft foods including milk, eggnog, fresh orange juice and broth;
 - c. Drink plenty of water;
 - d. Avoid foods that are hard, fried, coarse, spicy or starchy;
 - e. Reduce smoking and the use of alcoholic beverages;
 - f. Rest as much as possible; and
 - g. Keep the mouth clean by rinsing after eating.

Second Visit

1. Repeat the treatment provided during the first visit.
2. Remove as much calculus as possible without causing undue pain.
3. Give the patient instruction on tooth brushing and, if the gingivae have healed sufficiently, commence a programme of oral physiotherapy.

Third and Subsequent Visits

1. Repeat flushing of the mouth.
2. Continue mechanical procedures until all irritants such as calculus and overhanging margins have been removed.
3. Restore proper contour of gingivae through gingivoplasty or other means.
4. Eliminate any periodontal pockets and tissue flaps.
5. Reduce plunger cusps that may be causing food impaction.
6. Equilibrate the occlusion, if indicated.
7. Have patient demonstrate his mastery of the correct tooth brush technique.

In the treatment of necrotizing ulcerative gingivitis, intensive periodontal therapy should be instituted once the acute phase has subsided. Failure to eliminate any predisposing factor, whether local or systemic, can cause recurrence of the disease. The chronic or "subacute" form may ensue if treatment is incomplete.

References

1. Appleton, J.T.L. Bacterial infection with special reference to dental practice. 4th ed. Philadelphia, Lea and Febiger, 1950. 644 p. (p. 540-55).
2. Beube, F.E. Periodontology, diagnosis and treatment. New York, MacMillan, 1953 XII and 752 p. (p. 399-423).
3. Burket, L.W. Oral medicine, diagnosis and treatment. 2nd ed. Philadelphia, Lippincott, 1952 (p. 49-67).
4. Carter, W.J., and Bell, D.M. Results of a three year study of Vincent's infection at the Great Lakes Naval Department. J. Periodont., 24:187-94, July 1953.
5. Daley, F.H. Studies of vincent's infection at the clinic of Tufts College Dental School from October, 1926 to February, 1928. J. Dent. Res., 8:108, 1928.
6. Glickman, Irving. Clinical periodontology. 2nd ed. Saunders, 1958. (p. 122,767).
7. Goldman, H.M. Periodontia. 3rd ed. St. Louis, Mosby, 1953. 750 p. (p. 646-73).
8. Goldman, H.M., and Bloom, Jack. Topical application of aureomycin for the treatment of the acute phase of ulcerative necrotizing gingivitis (vincent's infection). Oral Surg., Oral Med. & Oral Path. 3:1148-80, Sept. 1950.
9. Goldman, H.M., and Guralnick, W.C. Some uses of penicillin in dentistry. A collective review. Oral Surg., Oral Med. and Oral Path. 1:116-28, Jan. 1948.

10. Kozol, S.M. and Shuster, H.V. A description of the antibiotic bacitracin; its topical use in the treatment of vincent's infection. *Oral Surg., Oral Med. and Oral Path.* 5:717-27, July 1952.
 11. Mouton, Ruth, Ewen, Sol, and Thieman, William. Emotional factors in periodontal disease. *Oral Surg., Oral Med. and Oral Path.*, 5:833-60, Aug. 1952.
 12. Ostrander, F.D. The use of antibiotics in periodontics and endodontics. *Am. Dent. A.J.*, 46:139-44, Feb. 1953.
 13. Radusch, D.F. Nutritional and dental health. Vitamin C. *J. of Periodont.*, 17:27-33, Jan. 1946.
 14. Schaffer, E.M. Biopsy studies of necrotizing ulcerative gingivitis. *J. Periodont.*, 29:22-5, Jan. 1953.
 15. Schaffer, E.M. The effects of drugs in the treatment of necrotizing ulcerative gingivitis. *Am. Dent. A.J.*, 48:279-83, March 1954.
 16. Schluger, Saul. Necrotizing ulcerative gingivitis in the army: incidence, communicability and treatment. *Am. Dent. A.J.*, 38:174-83, Feb. 1949.
 17. Schuessler, C.F., Fairchild, J.M., and Stransky, I.M. Penicillin in the treatment of vincent's infection. *Am. Dent. A.J.*, 32:551-4, May 1945.
 18. Shpuntoff, Harry, and Shpuntoff, William. A prolonged activity of topically administered oxytetracycline (terramycin) in vincent's infection: a preliminary report. *Am. Dent. A.J.*, 40:563-80, May 1953.
 19. Stewart, G.G. Comparative methods of using penicillin in the treatment of vincent's infection and other oral lesions. *Am. Dent., A.J.*, 33:725-31, June 1946.
 20. Turncliff, Ruth, Fink, E.B., and Hammond, Carolyn. Significance of fusiform bacilli and spirilla in gingival tissues. *Am. Dent. A.J.*, 23:1959-65, Oct. 1936.
 21. Wilson, J.R. Necrotizing ulcerative gingivitis. *Post Graduate Medicine*, 8:56-7, July 1950.
 22. Orban, Balint, et al. *Periodontics: a concept-theory and practice.* St. Louis, Mosby, 1958.
- (The author provides 23 additional references which are not documented in the text).

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

CONSULTING STAFF TO THE RCDC
ITS HISTORY AND FUNCTIONS

Colonel G.R. Covey, MBE, CD, DDS

In the month of August, 1959, the Director General Dental Services initiated action at Army Headquarters, Ottawa, Ont to establish a staff of civilian consultants to the RCDC. The primary function of this proposed staff was to advise him in the various specialty fields which affected dental services in the Canadian Forces. In addition, they would assist in solving specific dental problems and advise on the broader aspects of treatment policy and the training of dental officers and auxiliary tradesmen.

To ensure the broadest coverage of the dental specialties, it was proposed that individuals be appointed from eight different fields of dental interest, namely, Oral Surgery, Periodontics, Orthodontics, Oral Diagnosis and Roentgenology, Prosthodontics, Restorative Dentistry, Dental Research and Dental Legislation and Ethics. Those selected to fill the various appointments would be asked to serve for three years without remuneration except for out-of-pocket expenses in connection with necessary travel. As far as possible and in addition to their pre-eminent position in the profession, the previous service records and geographical locations of those appointed would be considered.

The proposal to establish a Board of Dental Consultants received the approval of the Minister of National Defence, The Honorable George R. Pearkes, on 5 January 1960 and on 19 January 1960 the Treasury Board approved the payment of their expenses in accordance with Travel Regulations when engaged on official duties of their appointments.

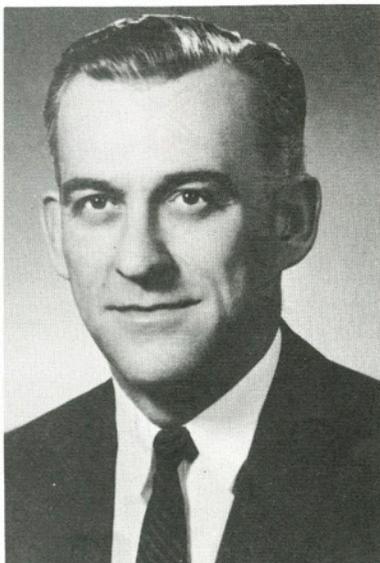
Following this approval and on recommendation of the DGDS, the Minister invited the underlisted specialists to accept appointments on the Staff of Dental Consultants to the RCDC until February 1963.

Orthodontics	-	Dr. J.E. Abra, Medical Arts Building, Winnipeg, Man.
Periodontics	-	Dr. J.W. Neilson, Dean, Faculty of Dentistry, University of Manitoba, Winnipeg, Man.
Oral Surgery	-	Dr. D.M. Tanner, M.B.E., Sunnybrook Hospital, Dept. of Veterans Affairs, Toronto, Ont.
Prosthodontics	-	Dr. R.J. Godfrey, 230 College St., Toronto, Ont.
Restorative Dentistry	-	Dr. J.D. McLean, Dean, Faculty of Dentistry, Dalhousie University, Halifax, N.S.

- | | | |
|-------------------------------------|---|---|
| Dental Research | - | Dr. J.P. Lussier,
Dean & Director of Studies,
Faculty of Dental Surgery,
University of Montreal,
Montreal, Que. |
| Oral Diagnosis
and Roentgenology | - | Dr. H.R. MacLean,
Dean,
Faculty of Dentistry,
University of Alberta,
Edmonton, Alta. |
| Dental Ethics | - | Dr. D.W. Gullett,
Secretary Treasurer,
Canadian Dental Association,
234 St. George Street,
Toronto, Ont. |

These appointments were accepted with great pleasure by all concerned and each expressed his desire to assist the Director General in any capacity requested. As a gesture of appreciation for participating on the Board, each Consultant was presented with a suitably engraved framed certificate.

Although only one formal meeting of the Board has been held since its inception, the services of these Consultants have been used many times by the DGDS and their prompt response to his requests have been most appreciated. To those who have completed their term of service and are retiring from active participation on the Board, all members of the Corps extend their sincere thanks and best wishes for continued success in their specialty fields. To those who have accepted the invitation to serve an additional term and to the new members the DGDS bids his welcome. Photographs of all members of the Board are not immediately available but pictured below are the recently appointed consultants, Dean J. McCutcheon and Dr. James P. Coupland.



Dean James McCutcheon
Faculty of Dentistry
McGill University
Montreal, PQ
Consultant in Prosthodontics



Dr James P Coupland
225 Metcalfe St
Ottawa, Ont
Consultant in Oral Surgery

WELCOME TO THE CORPS

Congratulations are extended to the eighteen graduates of dental schools across Canada who have recently been promoted to the rank of Captain and are now active members of the Corps in the following locations:

Capt	LW	Armstrong	Alberta	Fort Churchill
Capt	GE	Brissette	Montreal	HMCs Cornwallis
Capt	JHG	Charron	Montreal	3 Det RCAMC Quebec
Capt	JCL	Giguere	Montreal	RCAF Stn Namao
Capt	JL	Girard	Montreal	RCAF Stn Winnipeg
Capt	GW	Hill	Alberta	RCAF Stn Cold Lake
Capt	RWR	Horn	Toronto	RCAF Stn Clinton
Capt	JMM	Houde	Montreal	HQ 15 Dent Coy Montreal
Capt	MB	Krickan	Alberta	HMCs Naden
Capt	WR	Kyle	Toronto	RCAF Stn Camp Borden
Capt	RM	MacDonald	Dalhousie	RCAF Stn Trenton
Capt	CM	Mason	Alberta	Griesbach Bks Edmonton
Capt	PR	McQueen	Alberta	Camp Valcartier
Capt	RT	Mori	Alberta	RCAF Stn Trenton
Capt	DR	O'Hara	Toronto	RCAF Stn Rockcliffe
Capt	AN	Swanzy	Dalhousie	HMCs Stadacona
Capt	MD	Taylor	Alberta	RCAF Stn Saskatoon
Capt	PS	Wade	Toronto	RCAF Stn St Jean

An equally warm welcome is offered to the following Corps transfers, Airwomen and Part V Dental Nurses:

Cpl	MJ	Hall	-	Griesbach Bks Edmonton
Pte	RL	Geddes	-	HQ 12 Dent Coy Halifax
Pte	NL	Highfield	-	RCAF Stn Trenton
LAW	EJ	Deveaux	-	RCAF Stn Downsview
LAW	M	Kant	-	RCAF Stn Rockcliffe
AWL	EM	McCoy	-	RCAF Stn St Hubert
Mrs	R	Zagalsky	-	RCAF Stn Winnipeg

PROMOTIONS

The following Corps personnel are congratulated on their promotions:

Lt Col	GR	Covey	-	to Colonel
Lt Col	RHG	Cunningham	-	to Colonel
Major	JC	Brick	-	to Lt Col
Major	LR	Pierce	-	to Lt Col
Major	LA	Richardson	-	to Lt Col
Capt	GT	Crossman	-	to Major
Capt	LE	Kelly	-	to Major
Capt	DJ	MacPhee	-	to Major
Capt	WA	Sugars	-	to Major
Cpl	LR	Barrett	-	to Sgt
Cpl	EB	Borden	-	to Sgt
Cpl	JIJ	Boulanger	-	to Sgt
Cpl	H	Chamberlain	-	to Sgt
Cpl	JRM	Chayer	-	to Sgt
Cpl	WR	Dawson	-	to Sgt
Cpl	N	Demedash	-	to Sgt
Cpl	TY	Dundas(RCAF)	-	to Sgt

PROMOTIONS (cont'd)

Cpl	DL	Fenton	-	to Sgt
Cpl	WG	Harmer	-	to Sgt
Cpl	WA	Jackson	-	to Sgt
Cpl	EA	Jermain	-	to L/Sgt
Cpl	EJ	Lansey	-	to Sgt
Cpl	G	Sapergia	-	to Sgt
Cpl	AE	Werkmann	-	to Sgt

RETIREMENTS

The following officers have recently retired from the Corps, and to them are extended best wishes for the future:

Colonel	GB	Shillington	-	DDGDS, Ottawa
Lt Col	OW	Crummey	-	Senior Clinician, Griesbach Bks, Edmonton
Major	JG	Andrews	-	RCAF Stn Trenton
Major	WR	Cunningham	-	Ceased Call-Out at HMCS Stadacona

RELEASES

Good wishes for the future are offered to these officers who have taken their release on completion of their short-service commissions.

Capt	MA	✓ Abramson	-	HMC Dockyard Halifax
Capt	LJE	✓ Bosse	-	CMR St Jean
Capt	DG	Gardner	-	HMCS Cape Breton
Capt	LC	✓ Gray	-	RCAF Stn Vancouver
Capt	WB	✓ Hudgins	-	RCAF Stn Camp Borden
Capt	MAJ	✓ Lachapelle	-	HMCS Stadacona
Capt	HC	✓ Stewart	-	Ft Osborne Bks Winnipeg
Capt	OA	✓ Tucker	-	RCAF Stn Portage la Prairie

A sincere expression of hope for future happiness is also extended to the following personnel who have left the Corps:

Cpl	SR	Monahan	-	RCAF Stn Cold Lake
Pte	LA	Russell	-	Ft Osborne Bks Winnipeg
LAW	DF	Adams	-	RCAF Stn Cold Lake
AWL	AM	Burdell	-	RCAF Stn Namao
LAW	DJ	Kokoski	-	RCAF Stn Downsview
AWL	MA	Lawrence	-	RCAF Stn Camp Borden
Cpl	EE	Steeves	-	RCAF Stn Goose Bay
LAW	ML	Wilson	-	RCAF Stn Summerside
Mrs	NJ	Jakubowicz	-	(Part V) - Ft Osborne Bks Winnipeg

POSTINGS

The following changes in location and appointments have occurred or will take place in the near future:

Colonel IAL Millar has been appointed to the position of Deputy Director General of Dental Services at Army Headquarters, Ottawa. Colonel Millar has served as Director of Dental Services (Navy) for the past two years.

Colonel AC Leman has been posted to the Directorate as DDS (Air) from Trenton where he was Commanding Officer of No 13 Dental Company and Command Dental Officer for Central Command, Cakville.

Colonel AT Roger has relinquished command of No 12 Dental Company, Halifax and his appointment as CDO Eastern Command and has been appointed CO of No 13 Dental Company, Trenton, and CDO Central Command.

Colonel GR Covey, DDS (Navy) at the Directorate will be appointed Commandant of the RCDC School, Camp Borden, replacing Colonel CE Purdy who is retiring from the Canadian Army.

Lt Col JC Brick has been posted from RCAF Stn Uplands to the No 1 Dental Clinic, RCAF HQ, Ottawa as Senior Clinician, Ottawa area.

Lt Col CM Cornish who has served for the past two years as Senior Clinician at the RCAF HQ clinic in Ottawa has been posted to RCAF Stn Trenton as Senior Clinician.

Lt Col RHG Cunningham has been posted to Halifax and assumes command of No 12 Dental Company and the appointment as CDO Eastern Command. Lt Col Cunningham has been Senior Clinician at RCAF Stn Trenton for the past two years.

Lt Col GC Evans, former CO of No 4 Field Dental Company, Germany, has been posted to Army Headquarters, Ottawa as a Deputy Director of Dental Services.

Lt Col G McDougall has been appointed CO of No 4 Field Dental Company and proceeded to Germany from HMCS Naden where he served as Senior Clinician.

Lt Col JW Turner, on completion of a two-year exchange posting at the US Naval Dental School, Bethesda, Md, returns to the RCDC School at Camp Borden where he has been appointed to the post of Chief Instructor.

Major WH	Carter	- to AFHQ Clinic, Ottawa from RCAF Stn Cold Lake
Major TD	Cobb	- to Camp Gagetown from Griesbach Bks, Edmonton
Major JL	Craig	- to 35 Fd Dent Unit from AFHQ Clinic, Ottawa
Major JI	Gordon	- to RCAF Stn North Bay from RCAF Stn St Hubert
Major WH	Harrington	- to No 6 PD (HL) Toronto from 35 Fd Dent Unit
Major AT	Hinch	- to RCAF Stn Cold Lake from 35 Fd Dent Unit
Major AL	Kelland	- to RCDC School from CBUME
Major LE	Kelly	- to RCAF Stn Comox from 4 Fd Dent Coy
Major JA	Lauziere	- to RCAF Stn Uplands from Ft Osborne Bks Winnipeg
Major DE	McDermott	- to 35 Fd Dent Unit from Camp Gagetown
Major RJK	Pyne	- to CBUME from RCAF Stn Comox
Major LR	Pierce	- to HMCS Naden from RCAF Stn Clinton

POSTINGS (cont'd)

Major	MP	Quinn	- to HMCS Bonaventure from HQ BC Area, Vancouver
Major	CJ	Sivell	- to Griesbach Bks, Edmonton from 35 Fd Dent Unit
Major	JJN	Wright	- to RCAF Stn Clinton from RCDC School
Capt	NH	Andrews	- to Portage la Prairie from RCAF Stn Winnipeg
Capt	JOL	Bourget	- to 35 Fd Dent Unit from CBUME
Capt	MDG	Conrad	- to HMCS Stadacona from CBUME
Capt	JLY	Cyrenne	- to CBUME from RMC Kingston
Capt	PA	Dailyde	- to HMCS Cape Breton from Griesbach Bks, Edmonton
Capt	JF	Eadon	- to 4 Fd Dent Coy from RCAF Stn Penhold
Capt	DH	Evans	- to Pers RCDC from 35 Fd Dent Unit
Capt	WJ	Froese	- to Camp Petawawa from Fort Churchill
Capt	BA	Gaudet	- to HQ BC Area, Vancouver from 3 Det RCAMC, Quebec City
Capt	JH	Marion	- to 35 Fd Dent Unit from Camp Valcartier
Capt	NA	McFarlane	- to RCAF Stn Cold Lake from HMCS Cornwallis
Capt	RJ	Paturel	- to CBUME from RCSME Vedder Crossing
Capt	LA	Reynolds	- to 4 Fd Dent Coy from RCAF Stn North Bay
Capt	A	Van Ryssel	- to 35 Fd Dent Unit from RCDC School
Lieut	M	Kostyniuk	- to 35 Fd Dent Unit from 1 Dent Eqpt Dep
WO1	CH	Loken	- to RCDC School from 35 Fd Dent Unit
WO2	EK	Aberernethy	- to 4 Fd Dent Coy from Griesbach Bks
WO2	AG	Cross	- to AFHQ Clinic, Ottawa from 35 Fd Dent Unit
WO2	RH	Daw	- to RCAF Stn Trenton from HMCS Naden
WO2	FL	Gourlay	- to HMCS Naden from 4 Fd Dent Coy
WO2	DW	Riddell	- to 4 Fd Dent Coy from RCAF Stn Trenton
WO2	DD	Robertson	- to Camp Gagetown from 4 Fd Dent Coy
Sgt	WA	Bennett	- to DGDS from 4 Fd Dent Coy
Sgt	EMB	Everett	- to HQ 12 Dent Coy Halifax from RCAF Stn Trenton
Sgt	MM	Fediuk	- to HMCS Naden from RCAF Stn Cold Lake
Sgt	JF	Heard	- to RCAF Stn Trenton from AFHQ Clinic, Ottawa
Sgt	RG	Stewart	- to 1 Dent Eqpt Dep from HQ 12 Dent Coy Halifax
Sgt	TW	Sullivan	- to 4 Fd Dent Coy from 1 Dent Eqpt Dep
Sgt	CA	Young	- to DGDS from HQ 14 Dent Coy, Winnipeg
Sgt	JR	Cahill	- to Kingston from 4 Fd Dent Coy
Sgt	JP	Carrier	- to Pers RCDC from DGDS
Sgt	G	Dancer	- to 25 COD Montreal from CBUME
Sgt	J	Dion	- to HQ BC Area Vancouver from CBUME
Sgt	DI	Fenton	- to HQ 14 Dent Coy Winnipeg to RCAF Stn Winnipeg
Sgt	A	Fox	- to RCAF Stn Cold Lake from 35 Fd Dent Unit
Sgt	P	Fox	- to RCAF Stn Penhold from CBUME
Sgt	GR	Jennings	- to 35 Fd Dent Unit from RCDC School
Sgt	CC	Jewson	- to 4 Fd Dent Coy from Camp Gagetown
Sgt	RK	Jones	- to 4 Fd Dent Coy from HMC Dockyard, Halifax
Sgt	JH	Kay	- to HMCS Stadacona from 4 Fd Dent Coy
Sgt	FM	Kennedy	- to HQ Calgary Grn from RCAF Stn Cold Lake
Sgt	AD	Lillico	- to HQ 14 Dent Coy, Winnipeg to DGDS
Sgt	RJ	Lowery	- to 11 Dent Coy from RCDC School
Sgt	G	MacQuish	- to 1 Dent Eqpt Dep from HQ 12 Dent Coy Halifax
Sgt	EE	McFadden	- to 35 Fd Dent Unit from RCAF Stn Lincoln Park
Sgt	CC	Millard	- to RCAF Stn Downsview from 4 Fd Dent Coy
Sgt	W	Olynyk	- to 4 Fd Dent Coy from RCAF Stn Centralia
Sgt	JM	Roberts	- to DGDS from 35 Fd Dent Unit
Sgt	VH	Shaw	- to 35 Fd Dent Unit from 4 Fd Dent Coy
Sgt	KJ	Smallshaw	- to DGDS from Pers RCDC

POSTINGS (cont'd)

Cpl	PJ	Dumas	- to 1 Dent Eqpt Dep from CBUME
Cpl	EA	Duve	- to RCAF Stn Trenton from 1 Dent Eqpt Dep
Cpl	CYS	Forsythe	- to RCAF Stn Trenton from 3 Det RCAMC, Quebec
Cpl	ADT	Gardner	- to RCDC School from DGDS
Cpl	WG	Harmer	- to 4 Fd Dent Coy from HQ BC Area, Vancouver
Cpl	FB	Johnson	- to CBUME from RCAF Stn Penhold
Cpl	DB	Loosely	- to 4 Fd Dent Coy from Camp Petawawa
Cpl	JM	MacLean	- to RCAF Stn Centralia from Fort Churchill
Cpl	RW	McDonald	- to CBUME from 1 Dent Eqpt Dep
Cpl	G	Sapergia	- to CBUME from RMC Kingston
Cpl	GM	Wadden	- to Camp Gagetown from HMCS Stadacona
Pte	RS	Black	- to Fort Churchill from HMCS Cornwallis
Pte	N	Cable	- to RCAF Stn Winnipeg from Ft Osborne Bks, Winnipeg
Pte	DJ	Davies	- to HMCS Shearwater from HMCS Stadacona
Pte	BF	Hannah	- to RCAF Stn Saskatoon from Ft Osborne Bks
Pte	DH	Hardy	- to RCAF Stn Cold Lake from Camp Gagetown
Pte	WD	Horne	- to Camp Gagetown from HMCS Shearwater
Pte	JP	Lambert	- to RCAF Stn Uplands from RCAF Stn Trenton
Pte	DK	Mand	- to 4 Pers Depot, Montreal from Ft Churchill
Pte	OR	Sorensen	- to RCAF Stn Downsview from Camp Picton
WO2	P	Savage(RCAF)	- to RCAF Stn Winnipeg from RCAF Stn Trenton
F/Sgt	CMB	Torrens	- to 35 Fd Dent Unit from RCAF Stn Winnipeg
LAW	MH	Boles	- to RCAF Stn Winnipeg from RCAF Stn Parent
LAW	JA	Bowes	- to RCAF Stn St Hubert from 35 Fd Dent Unit
LAW	E	Byrne	- to RCAF Stn Parent from RCAF Stn Winnipeg
AW2	SDJ	Clutterbuck	- to RCAF Stn Goose Bay from RCAF Stn St Hubert
AW1	MM	Delory	- to RCAF Stn Summerside from RCAF Stn St Hubert
LAW	SD	Fitzpatrick	- to RCAF Stn Namao from RCAF Stn Chatham
AW1	I	Gruener	- to RCAF Stn Goose Bay from RCAF Stn St Jean
AW2	MYC	Lachance	- to RCAF Stn St Jean from RCAF Stn Parent
AW1	SJ	McMillan	- to 35 Fd Dent Unit from RCAF Stn Goose Bay
AW1	JE	Patterson	- to RCAF Stn Bagotville from RCAF Stn Trenton
AW1	JM	Roberts	- to 35 Fd Dent Unit from RCAF Stn Bagotville
LAW	FB	Schmaltz	- to RCAF Stn Comox from RCAF Stn St Hubert
LAW	LP	Yakemchuk	- to RCAF Stn Namao from RCAF Stn St Hubert

TRAINING

During the past three months, Corps personnel have completed the following training:

Ash Temple Ltd, Toronto

Airrotor Handpieces - 27 - 28 May 63 - Lt EA Church

RCDC School

Senior Dental Technician Laboratory Course - 22 Apr - 17 May 63

WO1	AM	Gareau
WO2	CS	Madge
WO2	CD	Mann
WO2	W	Powers
Sgt	C	Johnston

TRAINING (cont'd)Dental Assistant Group 1 - 22 Apr - 24 May 63

Pte	CS	Brown
Pte	DE	Fraser
Pte	JJ	Gallivan
Pte	GMR	Gravel
Pte	JF	Hill
Pte	MD	Longford
Pte	LI	McLean
Pte	H	McRae
Pte	RJ	Rutledge
Pte	JE	Silverson
Pte	JA	Strasdin
Pte	RD	Veinot
Pte	PD	Whynott

LAW	MN	Boles
AW2	SJD	Clutterback
AW1	MOB	Cyr
AW2	MM	Delory
AW2	JE	Richardson
AW2	EM	Romanick
AW1	ND	Scarborough

1 Dent Eqpt Dep, Camp PetawawaSummer Training - 24 - 30 Jun 63

Major CG Hunt - 54 Dent Unit (M)

DER Assessment Training - 1 - 26 Apr 63

Sgt DL Fenton

QM Stores, No 14 Dent Coy WinnipegSummer Training - 2 - 5 Jul 63

Sgt WH Beckett - 57 Dent Unit (M)

No 1 Clinic, Ft Osborne Bks, WinnipegSummer Training - 2 - 5 Jul 63

Pte R Grech - 57 Dent Unit (M)

Pte KL Topp - 57 Dent Unit (M)

Command Jr NCO Courses

Cpl	RB	Johnson
Cpl	JM	MacLean
Pte	JPL	Nadeau

VITAL STATISTICSRCDC SCHOOLBirths

To Cpl and Mrs HC King, a daughter, Jill Christine, on 21 May 63.

11 DENT COYBirths

To Capt and Mrs WTH Harley, a son, William Scott Hamilton, born 4 Jun 63.

To Capt and Mrs GA Johnson, a son, Glen Allan, born 23 May 63.

Hospital

WO2 EK Abernethy - 19 - 24 May 63

Sgt MF Conkey - 12 - 14 Jun, 24 Jun - 3 Jul 63

12 DENT COYBirths

To Capt and Mrs LTFB Archambault, a daughter, Marie-Claude Gisele, born 21 May 63.

14 DENT COYMarriages

Capt WJ Froese was married to Miss Hazel Louise Harper at Killarney, Man on 6 Jul 63.

On 25 May 63, AW1 RD Armstrong married LAC JW Lewis.

Births

To Capt and Mrs RJ Gillis, a son, Christopher John, at Winnipeg on 1 May 63.

To Capt and Mrs NH Andrews, a daughter, Catherine Ann, at Winnipeg on 12 Apr 63.

To Pte and Mrs BF Hannah, a son, Cameron Frederick, at Winnipeg on 31 May 63.

Hospital

Sgt FR Taylor - 30 Mar - 24 Jun 63.

15 DENT COYBirths

To Lt Col and Mrs WW Anglin, a son, Walter Mark, on 29 Apr 63.

To Capt and Mrs LJE Bosse, a daughter, Marie Paule Julie, on 16 Apr 63.

To Capt and Mrs JCRR Roy, a daughter, Marie-Elaine, born 13 May 63.

VITAL STATISTICS (cont'd)

To Capt and Mrs JFA Marcil, a son, Joseph Rodolphe Normand Alain, on 16 Jun 63.

To Sgt and Mrs JRM Chayer, a daughter, Marie Angela Michel, on 24 Apr 63.

Marriages

Capt BA Gaudet was married to Miss Helene Laliberte on 27 Apr 63.

Hospital

Capt	PS	Wade	-	12-20 Jun 63
Ssgt	HEG	Franzgrote	-	21 Jun - 10 Jul 63
Sgt	JIJ	Boulanger	-	18-21 Jun 63

CBUMEBirths

To Lsgt and Mrs PJ Dumas, a daughter, Darlene Anne, born 9 Apr 63.

FIRST ANNUAL RCDC GOLF TOURNAMENT

TO BE HELD AT CAMP BORDEN

SATURDAY 21 SEP 63

All members of the RCDC (Regular) and (Militia) are eligible.

Gross and net prizes will be presented.

The Entry Fee of \$5.00 includes greens fees, prizes and dinner.

Quarters are available for all single and unaccompanied personnel.
Hotel/Motel reservations will be arranged for accompanied personnel if required.

Entries are to be submitted to the Adjutant, The RCDC School by 15 Sep 63 and should include the following:

- a. Rank and name.
- b. Handicap.
- c. Accommodation required.
- d. Entry Fee.

If participants wish to make up unit teams, please specify.

Further details will be forwarded later to all units.

DIRECTORATE NEWSDirector General Appointed to Board of Governors of CDA

Brigadier KM Baird has been selected as the first representative of the Federal Dental Services on the Board of Governors of the Canadian Dental Association. During his three-year term, Brigadier will speak for all dentists employed by the Departments of National Defence, National Health and Welfare and Veterans Affairs.

Wife of Former Director General Passes Suddenly

A sincere expression of sympathy is extended to Brigadier EM Wansbrough and family on the death of Mrs Ruth Wansbrough, the 29th of June.

Colonel Shillington Tendered Retirement Dinner

A large number of officers and their ladies gathered at the Army Headquarters Officers' Mess on the sixth of June to express best wishes to Colonel and Mrs GB Shillington on the occasion of Colonel Shillington's retirement from the Canadian Army.

After supper, Brigadier KM Baird reviewed Colonel Shillington's 24 years of service and wished both he and Mrs Shillington every success and happiness on their return to civilian life. Among the presentations made was a suitably engraved silver chafing dish from the officers of the Corps.

Colonel Millar Receives New Appointment

Colonel IAL Millar, who has served as Director of Dental Services (Navy) for the past two years has been appointed Deputy Director General of Dental Services, which position became vacant on the retirement of Colonel GB Shillington.

Directorate Officers at Gagetown

Major HR Kettlys has been despatched to Camp Gagetown for the summer concentration as senior officer in charge of the dental component of the Experimental Brigade Service Battalion. Colonel IAL Millar spent a short period during July observing the field operations of the new unit.

Corporal Gardner Wins Small Arms Award

Corporal ADT Gardner was a most successful competitor in the AHQ Small Arms Competition, placing among the top ten marksmen and is congratulated particularly for winning the "Falling Plates" event.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

THE RCDC SCHOOL NEWSCamp and Community Activities

Many of the members of the School staff have been prominent in the local news during the past few months through their election or appointment to positions in Camp and Community Organizations.

On 27 Jun Major DH (Hap) Frotheroe was appointed Editor-in-Chief of the local weekly newspaper "The Camp Borden Citizen".

Colonel CE Purdy continues to chair the local School Board Committee, a position he has held for the past two years.

Capt Charlie Casterton was promoted from Vice-President to President of the Camp Borden Golf Club.

Lt Col Bill Thompson has the honour of being the first RCDC officer to be elected President of the CFMSTC Officers' Mess.

WO 2 Herb Bilbey was elected President of the CFMSTC Sergeants' Mess in Jun.

WO 2 Tommy Batten was chosen as manager-coach of the Camp Borden Juvenile baseball team entered in the South Simcoe League.

WO 2 Recce Jackson, Sgt Ken Libby and Pte Gerry Fathers have volunteered their services as umpires for the Camp Borden Little League Baseball.

Sports

WO 2 Tommy Batten's name has been engraved on "The Fletcher Trophy" for 1963, emblematic of golf supremacy in the annual School tournament. The championship was never in doubt as Tommy played steady golf through eighteen holes to finish with a score of 81. Capt Charlie Casterton and Major Jim Wright both made gallant bids to catch him and ended up second and third respectively.

For the benefit of the many Corps personnel who are members of the Ash Temple Fishing Club and didn't make the annual trip to Northern Ontario this year, Capt Charlie Casterton landed the big one and received the Ash Temple Trophy plus the usual cash award.

The first annual RCDC golf tournament will be held this year in Camp Borden sponsored by the School. A trophy, yet unnamed, will be awarded to the low team score for the day as well as individual gross and net prizes. See the notice in this issue of the Quarterly and send your entry in now.

Dedicate RCDC Chapel Window



Thirty RCDC personnel are shown parading to the chapel for the dedication of the RCDC window.

The crest of the Royal Canadian Dental Corps in stained glass was unveiled and dedicated in Trinity Chapel on Sunday 12 May 63. The impressive ceremony was witnessed by a capacity congregation of servicemen, dependents and guests. Following the unveiling by WO 2 EM Lobb, the window was dedicated by the Commandant of The RCDC School.

The installation provides everlasting evidence of the unity of purpose and effort on the part of members of the RCDC and their wives.

Grade I Pupils Visit RCDC School

Approximately 265 Grade I pupils visited the RCDC School on May 27, 29 and 30th as part of the 1963 Dental Health Education Programme for Camp Borden. On arrival, the children were shown an appropriate movie on dental health and then split up into small groups for a tour of the building which included tooth brushing instructions, dental examinations and familiarization with dental equipment. The fact that not a single tear was shed is proof of the value of introducing children to a dental environment under pleasant conditions. The accompanying photographs show the children receiving instruction from WO 2 EB Morse and Miss IM White.



Candidates on the dental technician clinical group 3 course visited each public school and presented films and dental health instruction to the remainder of the public school children. The Dental Health Education Programme for dependent children will continue in the fall.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★

NO 1 DENTAL EQUIPMENT DEPOT NEWS

Sports

Sgt AF Davison skipped his mixed rink to the Camp Petawawa Curling Club championship and was also a member of the mens' championship rink.

The volleyball team from this unit won the finals in the static unit regimental volleyball league. Under the guidance of Lt M Kostyniuk the following personnel made up the winning team: Sgt JW Hutchinson, Sgt AF Semple, Sgt AL Strub, Cpls Beattie, Duve, McRoberts, Rochon and Pte Nadeau.

Major JW Fletcher had the honour of being captain of the bowling team which won the Camp Petawawa Garrison Mens' League Championship.

Unit Fishing Derby - 5 Jun 63

Trophy Winner - Pte PD Whynott of No 3 Clinic RCDC.

Annual Spring Party

Personnel from this unit and No 3 Dental Clinic combined for the Annual Dental Spring Party held in Dundonald Hall, Camp Petawawa on Friday, 14 Jun 63.

11 DENT COY NEWS

Mary Otter Trials

The HQ BC Area team, of which Sgt Nicholson is a member, placed third in the tri-service competition for the Mary Otter Trophy in Canada.

Unit Members Compete in Small Arms Competitions

Cpl Schuh and Pte Herrett participated in the Alberta Area Meet of the Canadian Army (Regular) Small Arms Competition 1963 at Camp Sarcee. Cpl Schuh placed first in individual high scorers not on the winning pistol team and third in the overall competition. His position enabled him to participate in the Western Command Meet at Wainwright where he placed tenth.

Corps Flags Presented to Chapels

RCDC Flags have been presented to and will hang in the chapels at Griesbach along with the corps flags of the other units serving in the Griesbach Area. The flags were dedicated in St John's and Our Lady of Fatima Chapel on 21 Apr and 28 Apr 63 respectively.



Sgt H Hodgkinson, Sgt RH Palmer, Major TD Cobb, Padre SH Clarke and Padre J Cardy



Father CH Belanger, Col BP Kearney, Cpl A Schuh, Capt AP Dailyde and Capt PP Morin

12 DENT COY NEWSUnit Officers Present Table Clinics

Major RE Dyer and Major AG Taylor presented table clinics at the Atlantic Provinces Convention held in Fredericton early in July.

Social

This unit has bid farewell to many of its members in the past few months.

Colonel Roger was guest of honour at a Stag on the occasion of his posting as CO of No 13 Dental Coy and both he and Mrs Roger were tendered a mixed party aboard HMCS Bonaventure, at which best wishes for future happiness in Trenton and mementoes of their stay in the Maritimes were presented.

A Dining-out Night was held for Captains Lachapelle and Abramson to mark their release from the Canadian Army. Marc will set up practice in Simcoe, Ont, while Arnold is going to Calgary. Our best wishes for success go with him.

A stag party for Ssgt Stewart preceded his departure from the unit and we trust he will enjoy his new posting to Camp Petawawa.

Warrant Officer's Son Made Queen's Scout

Our congratulations are extended to Donald Shiner, son of WO2 John Shiner who was recently presented with his Queen's Scout Badge by the Lieutenant-Governor at Halifax.

Sports

Catching up with winter sports awards, Sgt Frank Martell was a member of the Greenwood bowling team which won the Maritime Five Pin title at St John's, Nfld, and Cpl Barrett and his partner were declared mixed double badminton champions at Cornwallis.

In curling, the rink of Major McDermott, Capt Johnston, Corporal Peterson and Corporal Mason finished the season as Grand Champions of the Gagetown League.

13 DENT COY NEWSOutgoing CO

Colonel AC Leman's many service and civilian friends in this area have joined with all personnel of 13 Dental Coy wishing him the very best in his new posting and appointment in DGDS. It is hoped that his four year tour as Commanding Officer of this unit will provide him with as many pleasant memories as he has left with us.

Incoming CO

A warm and sincere welcome is extended to Colonel AT Roger our new Commanding Officer who has come to us from 12 Dental Coy.

Retirement

Major JG (Jim) Andrews has left the Corps on retirement and at last report was planning on setting up practice in Toronto with our very best wishes for happiness, success and health ringing in his ears.

Unit Officer Addresses Provincial Specialists

Major AG Andrews of RCAF Stn Rockcliffe and Wing Commander HC Robinson of National Defence Medical Center presented a two-part paper on Cystic Lesions of the Mandible before the Ontario Otolaryngological Society in Toronto on 6 Jun 63.

Lt Col Brick Competes at Bisley

A member of the Canadian Army Rifle Team, Lt Col JC Brick has recently returned from temporary duty in England where he competed in the Bisley Rifle Match.

Four Swimming Awards to Pte Lindsay

Pte RS Lindsay of 21 Dental Clinic London was selected as a member of the Western Ontario Area swimming team and attended the Central Command Olympics swimming meet held at Kingston, Ontario 21 - 24 May 63. Pte Lindsay amassed the following array of awards for which he should be justly proud:

- a. 100 metre free style - 3rd-bronze medal.
- b. 100 metre individual Relay - 2nd-silver medal.
- c. 4 x 100 metre free-style relay (4 man team) - 2nd-silver medal.
- d. 4 x 100 metre medley relay (4 man team) - 2nd-silver medal.

Lt Col Windsor Wins Golf Trophy



Lt Col GE Windsor is shown seated with the S.A. Moore Trophy presented to him as winner in the 35th Annual London and District Dentists' Golf Tournament. Standing left to right are the other major prize winners, Alan Humphreys, Murray Dewis and Ron Galbraith. (London Free Press Photo).

14 DENT COY NEWSUnit Officers Attend Dental Convention

The Western Canada Dental Society Dental Convention was held in Winnipeg during 9 to 12 Jun 63 and was attended by Lt Cols RB Jackson and LA Richardson, Major JA Lauziere and Capt RJ Gillis.

A feature of the convention was the RCDC Association cocktail party and reception on Tuesday, 11 Jun 63. 57 Militia Dental Unit displayed photographs of all wartime Dental Companies. This exhibit was particularly interesting to the many ex-CDC dentists present.

Unit Holds Bonspiel

The annual mixed curling bonspiel was held on Thursday, 18 Apr 63, at the Fort Osborne Curling Club with all ranks, their ladies and associated personnel participating.

Eight teams competed through three draws for the Jackson trophy, emblematic of curling supremacy in 14 Coy. On completion of regular play rinks skipped by Lieut Herb Doyle and Capt Jaques Boulay were even on points.

The play-off was won by Lieut Doyle's rink, composed of Lieut and Mrs Doyle, Ssgt and Mrs Kelly MacFarlane. Runners up were Capts Boulay, Houde and Andrews, and Sgt Nick Demedash. After a late afternoon break-off the group reconvened for an evening of dancing followed by a delicious mixed sea food dinner.

Appointments to Golf Club Executive

Lt Col RB Jackson has been appointed Chairman of the Fort Osborne Golf Club and Capt GJ Moore as Secretary.

Posting Party

Personnel of this unit and their ladies together with RCAF and civilian associates employed in Winnipeg gathered in the lounge at the Fort Osborne Curling Club on the evening of 14 Jun 63 for an annual posting party and to bid farewell to members who will be departing from Winnipeg during the summer months. Guests of honour included Major JA Lauziere, Capt HC Stewart and Capt JR Boulay, Ssgt CA Young, and Fsgt CMB Torrens.

After an evening of dancing, a delicious supper was served and farewell gifts were presented to the departees.

15 DENT COY NEWSDental Increment on Exercise

Capt JPP Prud'homme, Sgt MD Crockett and Pte JAY Ferland, the Dental Increment to the UN Standby Bn, proceeded to Wainwright, Alta with 1 Bn R22e for Exercise Qui Vive 3.

Training

Our congratulations go to Ssgt Hans Franzgrote who recently completed the Air Defence Command Supervising and Management Course with a mark of 94% and an overall average of 90%. A/V/M Hendricks presented the certificate.

Unit Officer Presents Table Clinic

Capt JRA Vincent presented a table clinic "Quelques Trucs du Metier - Dentisterie Operatoire" at the Association Dentaire de la Province de Quebec Convention, 24 May 63.

Duty Trips

Majors JD Bourque and JI Gordon were despatched on temporary duty to RCAF Stations Chibougamau and La Macaza respectively during June. Both stations reportedly have excellent fishing but the Majors state that the treatment load was too heavy to leave time for recreation. However, we would still wager that their fishing lines were dampened a few times. Ptes Ferland and Hill were the DAs on these trips.

Fond Farewell

A gift was presented to Capt LJE Bosse by the members of St Jean's detachment, to which we add our best wishes on his transfer to civilian life.

4 FD DENT COY NEWS

Dental Conferences

Lt Col Evans, Capt Collier and Capt MacPhee attended the annual USAFE - USAEUR dental conference at Garmish from 9 to 11 May.

Major Chatwin was present at the Federation Dentaire Internationale meeting, 1 - 3 Jul at Stockholm, Sweden.

Unit on Summer Exercises

With one sub-section remaining in static location, the unit moved with 4 CIBG into concentration at Sennelager for the period 25 May to 15 Jun.

Capt Collier, Sgt Lansey, Sgt Hossdorf and two RCASC drivers made up the dental sub-section which proceeded with 3 RCHA to the Hohne Artillery Ranges for summer exercises.

35 FD DENT UNIT NEWS

Officers Attend Conference

For the period 9 - 11 May, Lt Col Craigie, Major Harrington, Major Susser and Capt Boucher attended the USAFE - USAEUR dental conference at Garmish, Bavaria.

Practice Alert Sounded

A work stoppage occurred at unit headquarters during the afternoon of 24 April when all personnel proceeded to the Casualty Clearing Centre at Fort Jury as part of a practice alert for HQ 1 Air Division.

Golf Tournament Held

Lt Col Craigie, in his capacity as Chairman of the committee, made the

arrangements for the No 1 Air Division Golf Tournament which was held at Luxembourg on 12 - 13 June and won by No 1 Air Division Headquarters.

CBUME NEWS

Leave and Tours

All members of the Dental Detachment have had the opportunity to take advantage of a one-day tour through the UNRWA Establishments in the Gaza Strip. UNRWA looks after the relief and welfare of the Palestinian refugees located in this area. During this tour refugee camps, food supply centres, hospitals, schools and other welfare establishments were visited. Everyone was most impressed and a better understanding was gained of the many problems involved in caring for these displaced people.

On July the first, Capt Paturel, along with other Canadian Contingent officers, was the guest of the Canadian Ambassador to Egypt at a Dominion Day reception in Cairo.

The United Nations Leave Centre was recently re-opened for the summer season in Beirut, Lebanon, and everyone is now busy planning his leave and looking forward to a change in climate and atmosphere.

Change of Command

On the third of May, Major RJK Pyne officially took over Command of the Canadian Dental Detachment and the duties of Senior Dental Staff Officer for UNEF in the Middle East. He replaced Major AL Kelland, who has since departed for employment at the RCDC School. A hand-over parade was held in the morning, and at this time Major AL Kelland presented the UNEF Medal to Sgt Shechosky.

A Calypso Star is Born

The musical talents of Sgt Pete Sprathoff were recognized and rewarded at a recent HQ Coy talent show in "B" Men's Mess. Following an accordion solo, Pete appeared in black face and appropriate costume to accompany himself on the ukelele while he rendered his interpretation of the "Banana Boat Song". The act won him first prize which was later presented to him by the Commander of Camp Rafah, Colonel DH Rochester.

Another feature of the successful evening was the "A" Sgts Mess Band which included Sgt George Shechosky playing his home-made Devils Harp.

Dental Crew Win Surf Event

Rumour has it that Sgts Pete Sprathoff and Paul Dumas may go Navy following their display of seamanship during the beach party held to celebrate Canada's birthday.

The main athletic event of a full program was a surf boat race with four crews competing. With only one paddle per two-man crew, the high surf threatened to throw the boats back on the beach and, to the spectators at least, most of the event took on the appearance of a suicide party. At one moment the boats would appear on top of the high waves and in the next instant be lost to view in the valley of the oncoming rollers.

At the turning point, Pete and Paul executed a clever manoeuvre which led

them to victory and they lay on the beach exhausted for quite some time. However, they later managed to shake hands and smilingly accept the first prize from Colonel Rochester.

RCDC MILITIA NEWS

Colonel Commandant Takes Salute



(Harvey Studios-Saint John, NB)

More than 600 members from all units of No 6 Militia Group in Saint John, New Brunswick took part in the group's annual church parade recently. Colonel JF Edgecombe, Colonel Commandant of the RCDC is shown taking the salute during the march past which followed the church services. One of the units taking part was the 3rd Field Artillery Regiment, which Colonel Edgecombe joined in 1916 when it was known as the 3rd Canadian Garrison Artillery. The history of this unit dates back to 1793.

Moore Trophy Awarded to Edmonton Unit

Making it two in a row, No 60 Dental Unit of Edmonton, commanded by Lt Col SG Geldart, was considered to have demonstrated the highest general efficiency during the past training year and was awarded the Moore Trophy.

The Trelford Trophy was won by No 57 Dental Unit, Winnipeg, commanded by Lt Col MJ Snidal, for placing second in the competition and No 54 Dental Unit, Ottawa, commanded by Lt Col HJ Chartrand showed the greatest improvement and thus took the Saskatchewan Dental Association Memorial Trophy.

With the Moore Trophy, in this Edmonton Journal photo are shown, left to right - Sgt E McDonald, Lt Col SG Geldart and Capt PG Finnigan.



