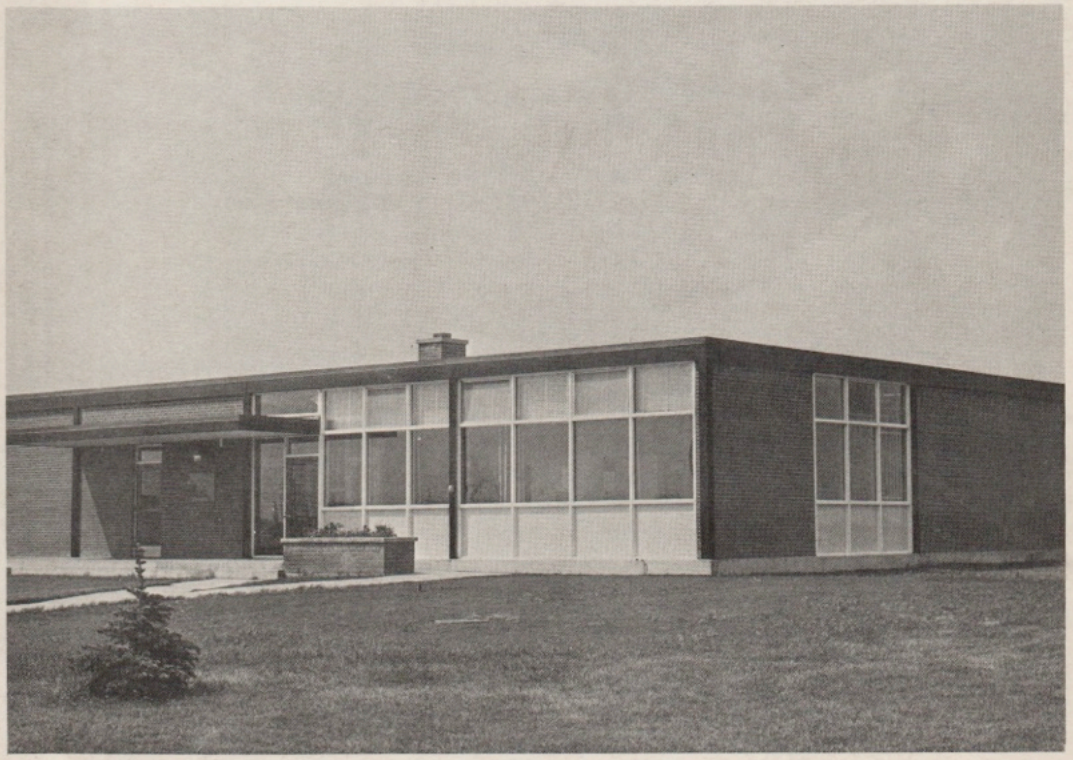
The ROYAL CANADIAN DENTAL CORPS Quarterly



VOLUME 5 NUMBER 2 JULY 1964

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THE RCDC QUARTERLY

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

Editorial Board: Colonel AC Leman
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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.

EDITORIAL

The RCDC Quarterly is a self-supporting publication but depends for its existence on the contributions and goodwill of all members of the Corps. Its primary aims are being achieved in that it enables our personnel to express themselves in writing on subjects which they believe to be in the interest of our profession and our service in Canada's Armed Forces. It is also the only available means by which we are able to keep abreast of current personnel changes which constantly take place throughout our organization. Through its circulation, the RCDC is publicized in many civilian and military installations outside of Canada and is represented in what appears to be a most favourable manner.

If the Quarterly is to continue as a Corps project it must receive the enthusiastic support of all members not only through the nominal annual subscription but by means of well-prepared contributions to the literary content. It is no surprise to the Editorial Board that the units which contribute the most in subscriptions and submissions are those which are the most loyal and outspoken adherents of this effort. It is even less surprising to note that these are the same units which so readily display, under any circumstances, the "esprit de corps" which has set our service at a special level in the Canadian Forces.

Next year the RCDC will celebrate its fiftieth anniversary and in this the Quarterly will play a prominent part. If such is to be the case, then a wholehearted response is expected from all those who form a part of what we like to refer to as "The Corps".

* * * * * * * * * * * *

Cover Photograph

This fine accommodation at Griesbach Barracks, Headquarters Western Command is now occupied by the Quartermaster's Stores Section, No 11 Dental Coy which was formerly located in Calgary. The building was designed and built to house Quartermaster Stores and, hence, provides excellent, modern facilities. From all reports, the move up from Calgary was accomplished smoothly and all members of the staff are commended for their efforts in getting back into business so quickly.

PLANNED SELF-IMPROVEMENT FOR THE DENTAL TECHNICIAN CLINICAL

WO2 HEG Franzgrote

Since 1956 the Royal Canadian Dental Corps has trained dental technicians clinical at the RCDC School and the candidates who have passed these courses in dental hygiene have, in the meantime, proven their value as highly trained auxiliaries. When the clinical technician completes his first comprehensive course he has gained a wealth of new knowledge and skills, and a desire to help his fellow man through his newly developed capabilities. He has also found a new sense of value through contact with the complex world of the medical-dental sciences.

As in any other field, his learning is by no means complete and one may ask:

1. Where will the dental technician clinical go from here?

2. How should he adapt himself to keep up with new developments and the constantly changing situations of Service life?

3. How can he keep abreast with new attitudes, theories and practices which are the result of research in all specialties of dentistry, particularly as they apply to dental health education? and

4. How best can he become proficient in the use of other technical and professional media which may be utilized in dental health education?

The clinical technician in the RCDC holds at least a senior NCO rank and is committed to an important role within the sphere of dental public health. To assist the dental officer in this demanding task he must be a leader and, as a leader, he should look for ways and means to better himself. Leadership is an art which requires self-expression. Basic rules and formulae may be used as guides, to convert knowledge into techniques. There comes a time, however, when the techniques are mastered and personal characteristics and self-acquired knowledge must be blended in, thus leading to self-expression. Perfection in leadership, as in any art, is never achieved. There is always room for improvement. The management engineers of the RCAF Air Defence Command put it this way:

> "The idea of perfection can be conjured in the minds of men, but it is an illusive something which we

never quite capture. Perhaps this is good, for it offers a challenge which few can resist accepting. So the search for perfection never ends and from this search comes an infinite stream of improvements and amendments. Such is progress."

Techniques of leadership as applied to dental health education must reflect changing times, variations in customs, and differences in the ideals, fads, and trends of the community. Furthermore, applied research in psychology, sociology, and related fields render invalid some of the previously accepted techniques and a change is needed.

The word "change" means different things to different people but, for the most part, is met with negative emotions such as resentment, fear or discomfort. This fact can be one of the greatest obstacles to health education. There is always resistance to change, unless the positively oriented and receptive mental level or mood of any particular group is reached, and unless the practical application of our teaching is understood. This applies to different conditions of life in the Armed Forces - in the field, in the air, at sea, or at the home base. It applies, similarly, to all groups of tradesmen and to their particular working conditions. To speak "their language" one must know about the people concerned and their work, social problems and living habits. This can only be accomplished by grasping every opportunity to meet and get to know new arrivals and other Servicemen whom one has not met before. Of equal importance in this regard is the need for the dental health educator to strive continuously toward self-improvement. Methods for self-improvement include increasing his academic learning and extensive reading. Observation and the informal study of interesting subjects which relate to the field of dental public health will also prove valuable. There are readily available countless opportunities for self-development. Books have been written on the subject, and millions of dollars have been spent by government and industry in the development of specialists and leaders in this field. Courses are also available, often without charge.

Before embarking on any program of self-improvement, however, one should turn his thoughts inward and take stock of himself. He should analyse his weak and strong points and consider the following three requisites of success: the desire to improve; the demonstration of wisdom in selecting proper actions; and the allotment of time necessary to work toward improvement. The desire must come from within, the wisdom must be developed, and the time must be planned.

One of the most convenient ways of keeping up with current events is by daily newspaper. The ability to scan the columns for lines of value, and to use them as ideas in one's work is a step in the right direction. Of equal importance is the development of a critical eye to discover useful expressions and opinions. Facility in this regard is a valuable asset in sifting through the jungle of less important news, space-fillers, and persuasive advertising. Magazines or journals can serve as guides to the philosophy and

practice of the pursuit of happiness and can lead to an understanding of the thoughts of other groups, professions and occupations, each of which consider their cause and work essential.

Dental health education competes directly with a great number of idealistic and commercial ideas in the struggle for influence over the human mind and the clinical technician should gain insight into the workings and media of other organizations by studying their techniques. With this knowledge he then can improve on his own methods. He should never forget that he has a trump over some of his competitors in other fields. Dental health is designed for a healthier and better life, and the only requirement is the listener's initiative and interest in himself. On the other hand, the clinical technician should present his material sincerely and with no ulterior or gainful motive.

The multitude of ideas and impressions that influence us every day is staggering, and the ability of the human brain to store all this information is equally amazing. This fact should be exploited. Newspapers, radio and television are of great value in the accumulation of knowledge. Talking to people at the chair, in the messes and elsewhere elicits additional information and insight.

In considering methods of communication, one should not forget other informative services which may be used to advantage by the clinical technician. The Canadian and American Dental Associations publish lists of dental health education material. Certain life insurance companies issue informative publications while other Service and civilian organizations distribute interesting and thought provoking newsletters. These often provide further references to good reading, films and other media. Examples of these are the monthly letters of most banks, which may be obtained free of charge. Ticonium's TIC Magazine, Dental Radiography and Photography by the Eastman Kodak Company, The Management News Letter of the RCAF Air Defence Command are also recommended. Furthermore, the RCDC Quarterly and the Journals of many Dental Associations are available at every clinic.

Additional valuable aids will be found in the lists of the Queen's Printer which publishes a great variety of materials. The US Government Printing Office offers a similar service, selling official books, pamphelts, and brochures on a number of subjects and these are well worth the price.

For a very small outlay or no cost at all, any clinical technician can undertake an extensive program of education and self-improvement through which new interests will be aroused and misconceptions cleared up. By this means a more objective and effective dental health presentation may be offered.

Editor's note:

The following two articles serve as a summary of the Cogswell Technique of Controlled Tooth Division as presented at the recurring seminars conducted by Wilton W. Cogswell Sr., for the Dental Services Division of the U.S.A.F. Defence Command. Certain portions of the original manuscript for each article have been deleted to avoid duplication. Line drawings used in both articles were prepared by Major EJ Small.

PRE-OPERATIVE ASSESSMENT OF THE MANDIBULAR THIRD MOLAR

Lt Col IR Pierce, CD, DDS

The surgical removal of mandibular third molars is frequently undertaken by the general practitioner with some apprehension lest complications arise with which he is unable to cope. Such self-doubts often arise from lack of a precise technique to cover all exigencies, a lack which is easily understood in view of the limited training received in such techniques during undergraduate study. It does not follow, however, that only those who undertake extensive post-graduate work should attempt to remove impacted mandibular third molars. An appreciation of the fundamentals involved and strict adherence to certain principles of diagnosis and surgery will promote self-confidence, which in turn will reduce the number of unfortunate sequilae.

The prime objective in the removal of any mandibular third molar is not merely to remove the tooth but to remove it atraumatically. The mandibular third molar, unlike the rest of the normal dentition, often occurs in such a position that it cannot be dislodged by the pressure of forceps without causing undue damage to the adjacent anatomic features which include:

1. the second molar and its investing tissues;
2. the lateral pharyngeal space and the body of the ramus;
3. the lingual alveolar plate and lingual nerve; and
4. the mandibular canal with its contents.

Pre-operative assessment therefore is most necessary to eliminate or minimize trauma and the post-operative sequilae of pain swelling, paresthesia and shock.

Surgical problems may result from three variable factors:

1. the form of the tooth;
2. the position of the tooth; and
3. the form of the investing tissues.

Tooth form and position should be carefully noted pre-operatively and an adequate radiograph taken to determine the number of roots, their curvature, the possible presence of an

inter-root bone latch, and the relationship of the roots to the mandibular canal.

The controlled tooth division technique is based on mechanical principles and hence it is mandatory to observe the relationship of the third molar to the second molar; i.e. whether the third molar position is vertical, mesioangular, distoangular, horizontal or buccolingual horizontal, and whether the relationship is crown to crown, crown to cemento-enamel junction, or crown to root.

Perhaps the most significant surgical problem is accessibility, which is governed by the anatomy of the investing bone and its associated soft tissues. Cogswell (1) notes: "There are three basic classifications of the ramus based on the mesiodistal relation of the anterior border of the ramus to the distal surface of the second molar regardless of the third molar or its position in the retromolar area."

In the schematic drawings, Figures 1, 2 and 3, these classifications of the ramus are shown in lateral views. It should be noted that the relationship between the curvature of the mandibular canal and the anterior border of the ramus remains constant in all three basic classifications, producing a more abrupt curvature of the canal as the ramus advances mesially.

Class I Ramus (Fig 1)

The anterior border of the ramus is in the extreme distal position in its relation to the distal surface of the second molar. The third molar is fully erupted, lies completely within the body of the mandible and is in normal relation and contact with the second molar. The mandibular nerve is well below the root apices of the third molar and it is also slightly to the buccal.

Class II Ramus (Fig 2)

The anterior border of the ramus is advanced mesially. The third molar is in a more buccal position and is partly within the body of the ramus. The crown of the third molar in this position will be partly covered by bone. The mandibular nerve is close to the root apices of the third molar but is usually in a slightly buccal position.

Class III Ramus (Fig 3)

The anterior border of the ramus is in the most advanced position with respect to the distal margin of the second molar. The third molar is entirely within the body of the ramus and is completely covered by bone. In order to remain within the body of the bone, the tooth, is markedly toward the buccal and the mandibular canal often creates a groove in the roots of the third molar.

From observations of several thousand mandibles, Cogswell notes that 6 percent of all rami are in the Class I position, 80 percent in Class II, and 14 percent in Class III.

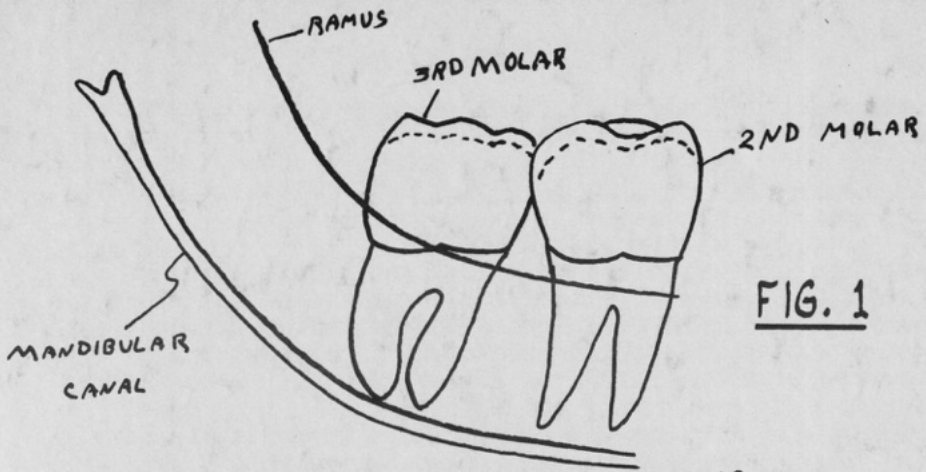


FIG. 1

CLASS I RAMUS

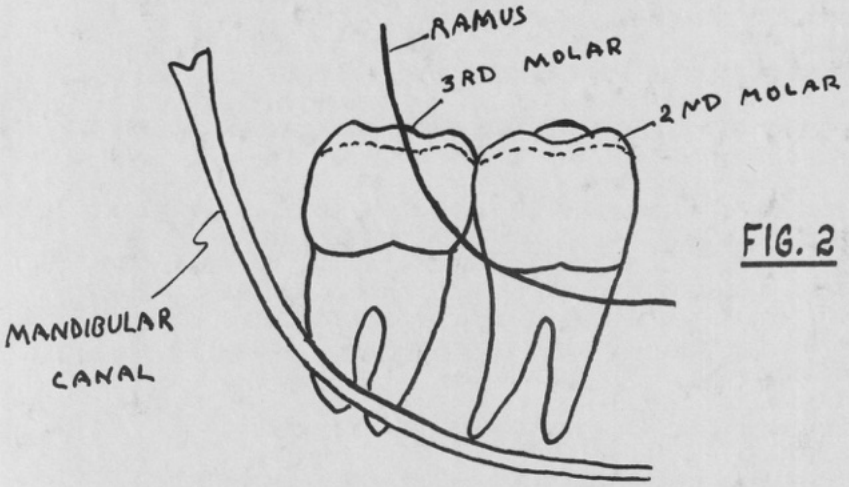


FIG. 2

CLASS II RAMUS

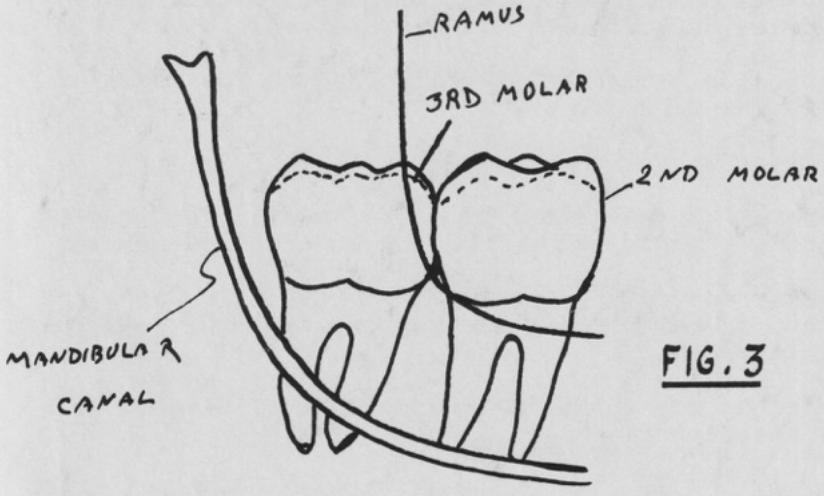


FIG. 3

CLASS III RAMUS

As was mentioned previously, an adequate pre-operative radiograph is of the utmost importance for a rational diagnosis. Many radiographs of the mandibular third molar produce inaccurate images of the area, thus causing surgical difficulties. The following radiographic technique is recommended:

1. Adjust the patient's head high and well back so that the occlusal plane of the open mandible is in a horizontal position. This position causes the tongue and sublingual tissues to relax and fall low in the floor of the mouth.

2. Place the film packet so that the upper edge is at least five millimeters above and parallel to the occlusal plane of the first and second molars. For a patient with a Class I ramus the film packet usually can be placed easily; with a Class II or Class III ramus it is necessary to contour the distal portion of the film packet to conform to the curvature of the throat laterally.

3. The anterior border of the film packet must bisect the mesial root of the first molar.

4. The angle of exposure is directed at right angles to the film packet on the horizontal plane of the cusps of the first molar and directly through the contact area of the first and second molars. The anticipated position of the impacted third molar must be ignored if a true diagnostic image is to be obtained.

The radiograph has diagnostic value only if:

1. there is no overlap at the contact area of the first and second molars;

2. the buccal and lingual cusps of the first and second molars are superimposed exactly upon each other; and

3. the anterior border of the film bisects the mesial root of the first molar.

Summary

1. Pre-operative assessment is a fundamental requirement in the atraumatic removal of the lower third molar.

2. The major anatomic factors of the retromolar area and a method of classifying the various types of rami have been presented.

3. A technique for obtaining radiographs of diagnostic value has been described.

THE COGSWELL TECHNIQUE OF CONTROLLED TOOTH DIVISION IN THE REMOVAL OF THE IMPACTED THIRD MOLAR

Major EJ Small, CD, BA, BSc, DDS

Although the details of the Cogswell technique are specific for the impacted mandibular third molar, the principles involved are valid for any tooth whether impacted or not. The removal of the third molar is treated as a surgical problem to be considered in four distinct phases:

1. Classification;
2. Pre-operative Diagnosis and Planning;
3. Division and Removal; and
4. Post-operative Considerations.

(Editor's Note - The first two phases have been dealt with by Lt Col Pierce in his article which will be found on page five of this issue.)

Division and Removal

Raising the flap (Fig 4)

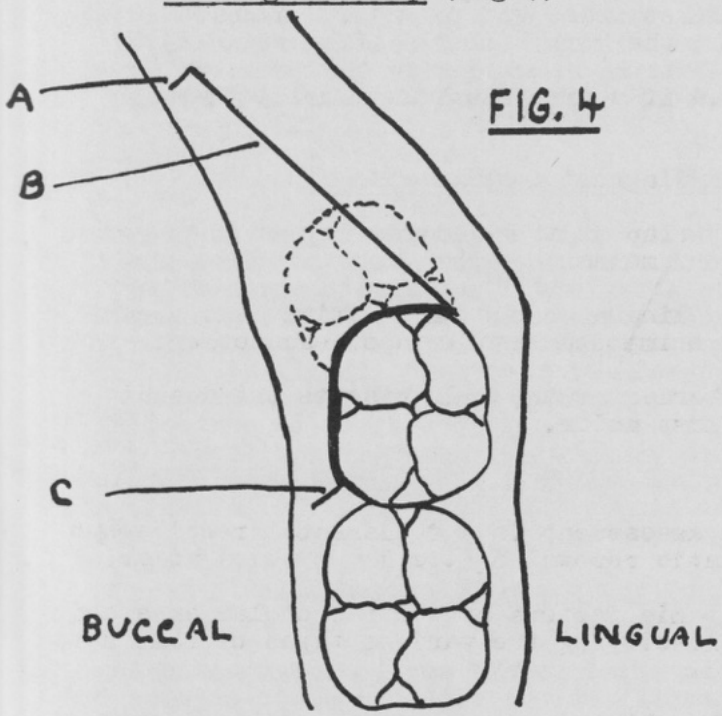


FIG. 4

Regardless of the classification of the impaction, all flap incisions are begun at the disto-lingual corner of the second molar and carried for a distance of one and one half crown lengths toward the buccal, crossing the investing bone of the mandible or ramus at a slight angle. A short right angled incision is then made toward the buccal at the end of the first incision, and finally, another short buccal incision is made at the mesial corner of the second molar to help in retracting the flap.

B - 1ST INCISION

A, C - SHORT BUCCAL INCISIONS

The reflection of the flap is made with a sharp chisel, not the periosteal elevator. The gingival tissue around the second molar is separated from the bone to the origin of the first incision, making sure to sever all the periosteum. The tissue on the lingual side of the incision is disturbed as little as possible - just enough to raise the lingual point of the flap and sever the fibrous attachment of the retromolar pad.

Exposing the crown

The flap is then retracted gently toward the buccal, and the bone overlying the crown is removed by making a series of perforations with a bone bur, placed according to the contour of the crown and connected by a sharp chisel or a cross-cut fissure bur. The lid thus formed is lifted free and the margins trimmed. The whole of the superior surface of the crown must be visible to a point slightly distal to the cemento-enamel junction, where the first cut in controlled tooth division is made.

Effect of exposing the crown of an impacted tooth in this manner

A young tooth has a developmental space around the crown, and the walls of the socket are composed of vascular bone which bleeds readily and heals rapidly when the tooth is removed. In older patients the developmental space loses its vascularity and becomes calcified around the crown of the tooth, gradually including the disto-lingual portion of the crown. Because of the denseness of bone, bleeding is limited and healing retarded. When the surface of this bone is removed with the bone bur, however, a bleeding wall is produced which hastens the healing process.

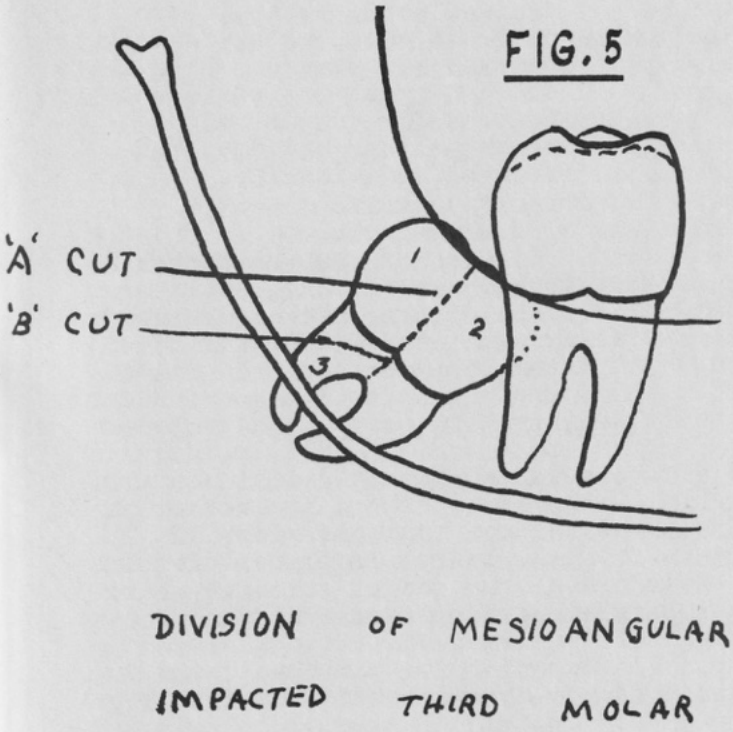
Surgical complications from use of excessive force

Practically any tooth can be dislodged if one is prepared to use sufficient force or to remove enough bone to allow the tooth to be pried from its position. Such treatment, however, may cause compression of the mandibular canal, injuring or even severing the mandibular nerve. There is also the danger of perforation of the lingual wall of the ramus; injury to the cancellous bone of the ramus; or even the loss of the second molar. All of these occurrences can be prevented by controlled division of the tooth which permits its removal by finger pressure alone. To quote Dr. Cogswell, "We must always bear in mind that we are trying to remove the tooth from the patient, and not the patient from the tooth."

Technique for the removal of the two most common classes of impactions

Although mandibular third molars may be impacted in any direction, they most frequently assume either a mesio-angular or a horizontal position, and these two types will be considered in detail. If there is any doubt concerning the exact classification, the tooth should be treated as a horizontal impaction and removed accordingly.

Division and removal of the mesioangular impacted mandibular third molar (Fig 5)



DIVISION OF MESIOANGULAR IMPACTED THIRD MOLAR

The first division ("A" cut) is made by cutting through the crown in the long axis from buccal to lingual almost to the bifurcation of the root. Care must be exercised to avoid entering the bone on the lingual surface. The tooth is then divided with the flat blade elevator. Although the distal portion of the tooth may appear to be free, it must not be levered out at this time. Instead, a transverse cut is made downward and lingually through the distal root. ("B" cut) Avoid penetration of the lingual bone. Normally, the distal section of the crown may now be lifted out with ease. If it resists moderate pressure, however, it should be divided mesiodistally and removed in sections.

After removing the distal half of the crown, the mesial half with its attached root is moved upward and distally until the cemento-enamel junction of the mesial surface of the tooth can be seen. Sometimes this portion will come out easily with the flat blade but it may be necessary to put in a traction point with a bone bur and remove it with the round tip elevator. The distal root may now be moved mesially and taken out with the pick, putting in a traction point if required.

Division and removal of the horizontal impacted mandibular third molar (Fig 6)

In the removal of the horizontal impacted third molar, the "A" cut must extend through the crown bucco-lingually in such a manner that the crown portion will be shorter mesiodistally at the base than at the superior surface. The crown is separated from the root with the flat blade, and the "B" cut made through the crown mesiodistally. When this is done the crown is divided with the flat blade, and the lingual half moved upward. A space is thus created for the buccal half, which is then removed.

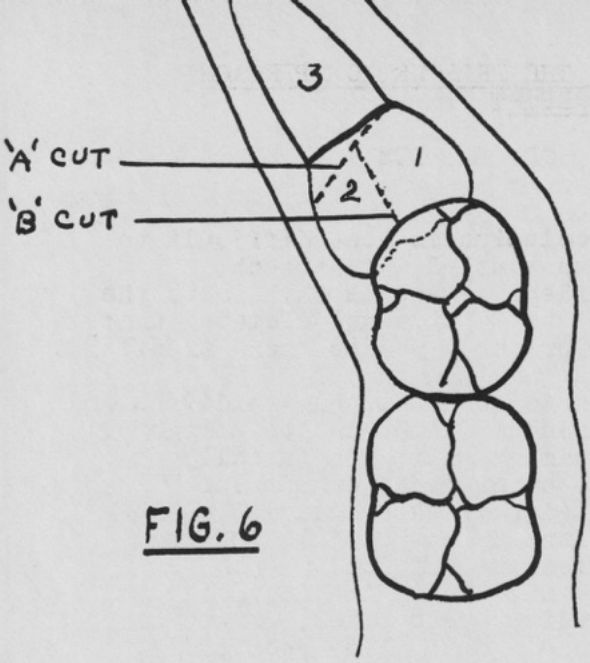


FIG. 6

DIVISION OF HORIZONTAL IMPACTED THIRD MOLAR

The developmental membrane should be cleared with a curette to provide greater visibility, and a traction point placed in the superior portion of the exposed root. Often there is only one root, which is brought forward and upward. When there are two roots the resistance is felt, a "C" cut is made to separate them and they are removed individually.

As soon as the tooth has been removed, all cystic or developmental tissue is removed from the socket, the fibrous ends of bone are made smooth, and operative debris is flushed out with warm normal saline solution. A post-operative radiograph will indicate whether or not the socket is clear. In the Cogswell technique, no packing is placed in the socket but an opening is made for irrigation and drainage by cutting away a triangular portion of the retromolar pad immediately distal to the second molar. After the flap is replaced and sutured into position, the socket is irrigated through this opening with 0.5% tincture of metaphen.

If the tissue at the distobuccal corner of the second molar is hypertrophic, this gingival margin should be trimmed away to provide a new tissue attachment.

Post-Operative Considerations

Before leaving the clinic the patient should be provided with analgesic tablets and also an ice-pack to hold against the mandible for fifteen minutes to control swelling. He should be instructed to restrict his food to fluids for the next twenty-four hours and to return the following day for observation.

Summary

An outline of the Cogswell technique of controlled division and removal of the impacted mandibular third molar is presented under the general headings of classification, pre-operative diagnosis and planning, controlled division and removal, and post-operative considerations. Two classes of impaction, the mesioangular and the horizontal are considered in some detail.

THE PROGNATHIS MANDIBLE - THE PROSTHETIC APPROACH
A CASE REPORT

Major LE Kelly, CD, BA, DDS

The typical Class III malocclusion is most difficult to treat successfully particularly when coupled with speech, masticatory and psychological disorders. Despite this fact, the relatively high incidence (from 0.5 to 2 per cent) dictates that the general practitioner should be prepared to recommend treatment.

True mandibular prognathism is an idiopathic condition and heredity is considered to be a prominent factor in its etiology. It should not be confused with instances where congenitally underdeveloped maxillas demonstrate an apparent mandibular prognathism. Caldwell (1) has stated that hyperactivity of the growth centers in the condyles is largely responsible for the condition, while Pascoe (2) has noted the difficulty in determining the true etiology which may lie in the aberration of any of the following factors: heredity, endocrines, growth of the cranial tissue, appositional bone growth, bone resorption, alveolar process development and functional activity.

There are many appracohes to the treatment of mandibular prognathism. Most writers suggest orthodontic procedures as the first step and, if these do not provide a functional and aesthetically pleasing result, surgery becomes the treatment of choice. Since Hullihen pioneered surgical correction for mal-relation of the mandible in 1848, a number of surgical approaches have been developed which involve both the ascending ramus and the body of the mandible. Open and closed surgery using both intra- and extra-oral approaches have been recommended. With the exception of the Kostecka Gigli saw technique, these are all lengthy, major surgical procedures and which, together with the difficulty of obtaining the services of a specialist, often means that the only person available to deal with the problem is the general dental practitioner. Sometimes, prosthetic appliances may be the treatment of choice. In the prognathis series by Derby, Chatwin and Duff (3), three of seventeen cases were corrected to acceptable aesthetic and functional limits without surgical intervention by means of complete dentures with flat occlusal planes. The case reported here considers the fabrication of cast metal framework overlay in the treatment of a young soldier.

Report of Case

The patient, a 21 year old serviceman, had a severe mandibular prognathism (Figs 1 and 2). He had been subjected to a great deal of barrack room kidding and was extremely self-conscious and sensitive about his deformity. Financial considerations had precluded surgical intervention as a civilian and Service commitments made this type of treatment impractical. Intra-oral examination revealed that the mandibular incisors protruded 12 mm beyond the maxillary incisors. The oral hygiene was excellent.

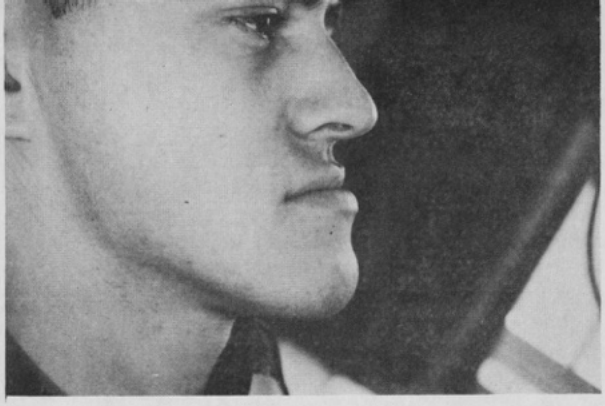


Fig 1

Profile Before Treatment

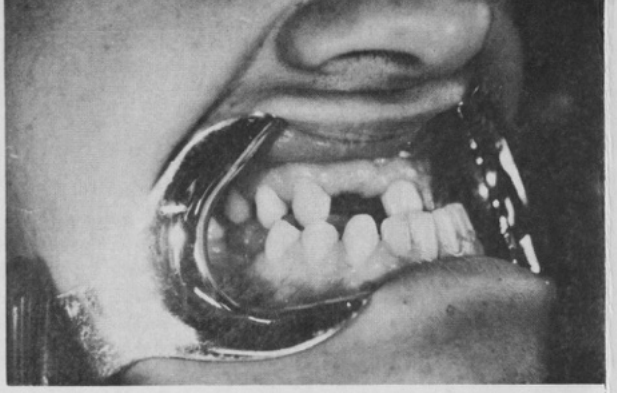


Fig 2

Occlusion Before Treatment

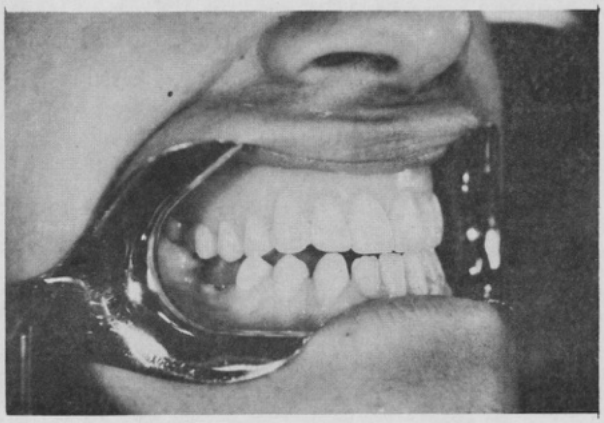


Fig 3

Temporary Acrylic Denture

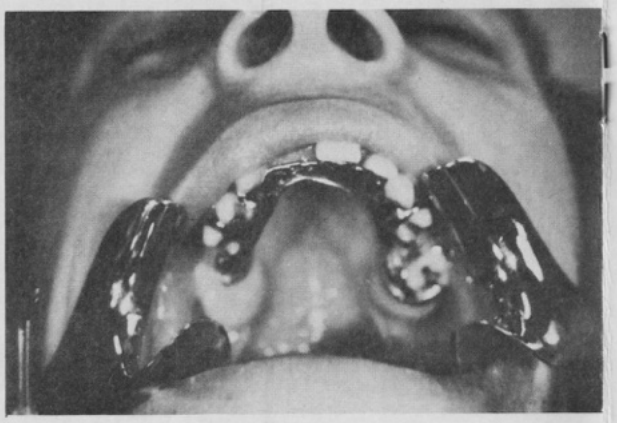


Fig 4

Ticonium Framework

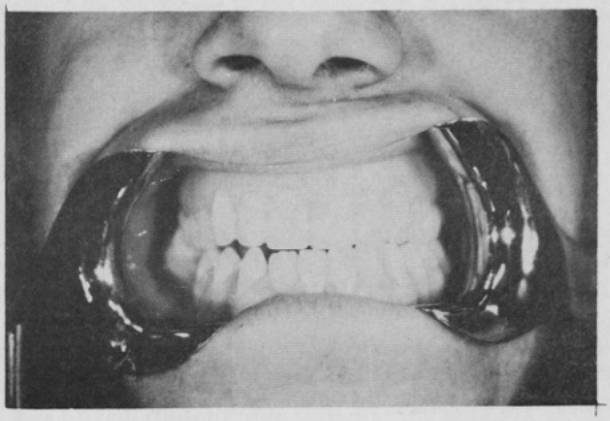


Fig 5

Ticonium Denture Inserted

Fig 6

Profile with Denture

$\frac{7621|58}{76|6}$ were missing and in centric occlusion, only $\frac{3|35}{54|56}$ were in contact. Fortunately he had a long upper lip and a large vestibule in the maxillary anterior area.

It was decided to open the bite 8 to 10 mm by means of a maxillary denture with the anterior teeth set forward of his own and with a slight overbite. A temporary acrylic denture was made. The patient responded well and, following insertion of the appliance (Fig 3), made a remarkable transition. After approximately six weeks, a ticonium framework was fabricated and a new appliance was made with an open palate. In general, the aesthetics and bite of the acrylic denture were duplicated although the maxillary teeth in the right posterior region were placed somewhat more to the buccal (Compare Fig 3 with Fig 5). The laboratory technique for each of these dentures was as follows:

1. The maxillary teeth on the model were blocked out and a path of insertion was established with a surveyor.
2. The model was duplicated and both upper and lower models were mounted on a Hanau articulator.
3. The upper masticating surfaces were brought into occlusion by means of built out wax and teeth and a biting plane with a slight overbite was established. It is to be noted (Fig 2) that the patient previously had contact in the anterior region only in the cuspid area.

Post insertion results are shown in Figs 5 and 6

The patient has noted a pronounced increase in the efficiency of mastication. He lost little duty time during treatment, has experienced minimal inconvenience and is very satisfied with the results. His mental attitude is greatly improved and he is no longer the subject of ridicule. Because the long upper lip allows the lips to remain closed at rest, the patient has not become a mouth breather as might be expected with the insertion of this bulky appliance. After six months, the tissue tone is excellent and, as a result of his good oral hygiene, no caries have developed and the prognosis is good. Since no family heredity was reported, it is considered that the under-development of the facial aspect of the maxilla may have been due to the development of the anterior teeth in linguo-version: indeed, it is this writer's opinion that the patient has developed a pseudo-prognathism.

Summary

The prognathis problem is discussed from the general practitioner's point of view and the prosthetic appliance used in one instance is described. Motivation and rigid oral hygiene are cardinal factors in this approach to the successful treatment of prognathism.

References

(1) Kruger, C.C., ed. Textbook of oral surgery. St. Louis, Mosby, 1959. 573 p. (p. 429).
(2) Pascoe, J.J., Hayward, J.R., and Costich, E.R. Mandibular prognathism: its etiology and a classification. J. Oral Surg., Anesth. and Hosp. Dent. Serv. 18:21-4, Jan. 1960.
(3) Derby, A.C., et al. Personal communication. July 1963.

EFFECTIVE WRITING

Lt Col DH Hillier, CD, DDS, MPH

Professional polish is not to be expected from non-professional writers but it is reasonable to anticipate a degree of competancy and evidence of care in the work of those who aspire to be read. It matters little whether the manuscript is unsolicited or requested; similarly, it makes little difference whether it bears the author's name or is cloaked in the anonymity of a submission from unit headquarters. Whatever one writes should be written to the best of one's ability.

A mediocre standard of writing may simply evolve from a lack of experience in the art but frequently reflects a total disregard for objective evaluation by the author of what he has produced. Craddock (1) has delineated effective writing succinctly by saying:

> "It seems that two moods contribute to effective writing. They might be described as the inspirational or subjective, and the critical or objective. Write in the first mood; revise in the second."

Adherence to this maxim will prove of inestimable value in improving the readability of prose.

Composition should not be started until the subject has been well defined and the main points to be made are either firmly in mind, or better yet, put on paper as paragraph headings. From such a framework, the article should be composed as quickly as possible while the "inspirational mood" remains fresh. It is suggested that this draft should be put away for a while and returned to later with as objective a mind as can be assumed. On re-reading, the form and substance of the work should receive the following type of evaluation:

Form

1. Does each paragraph contain the presentation and development of only one thought or, on the other hand, is there an artificial division where the content of two paragraphs should rightly be contained in one?

2. Is there redundancy?

3. Is the choice of words varied, interesting and precise? Restrict the use of "pet" expressions - those words or phrases which appear so frequently that they become monotonous and lose their effectiveness.

4. Is there an over-abundance of adjectives and adverbs? Each of these should be assessed to determine whether or not they add to the forcefulness of the word or phrase they modify. "Very, most, quite" and other such modifiers seldom strengthen an adjective or adverb and should be used sparingly.

5. Are all the sentences of relatively equal length? If so, the reader will become bored. To maintain interest, not only sentences but also paragraphs should be of varying length and complexity.

Substance

1. Is each sentence pertinent to the subject and is there a logical progression of ideas?

2. Are there gaps in the sequence; is there presumption that the reader is able to bridge these gaps where, indeed, he may not have sufficient knowledge of the subject to do so?

3. Alternately, is there more detail than is required by the anticipated readership?

4. Does the opening paragraph contain the germ of all that follows and is the closing paragraph the essence of what has gone before?

Adoption of questions such as these will elicit others of equal value in the production of acceptable prose.

One cannot easily be objective concerning his own writing and it follows, therefore, that the neophyte should seek constructive criticism from someone who can and will evaluate a proposed submission for him. If the comment reflects only satisfaction with the paper then it is necessary to look elsewhere, for only the ego is served by such non-specific evaluation. As experience is gained, the facility for subjective and objective writing is sharpened, the number of re-writes is reduced and more acceptable composition ensues. Books on creative writing will provide inspiration and direction but competancy is won only through experience and the development of a capacity to critically evaluate one's own work.

Effective writing presumes a knowledge of a subject and a desire to be read. It entails a methodical and wholehearted effort and thrives on adherence to certain basic rules, on a sense of style, critical appraisal and on experience. With so much to be read it is presumptuous to expect anyone to devote his attention to something that is less than the best possible effort of the writer.

Reference
(1) Craddock, F.W. Dental writing. Bristol, Wright, 1962. 90 p. (p.15).

Fellows Of The International College Of Dentists

Colonel IAL Millar, Deputy Director General of Dental Services and Colonel BP Kearney, Command Dental Officer, Western Command were recently inducted as Fellows of the International College of Dentists. These Fellowships were awarded in appreciation of their contriubtions to arts, sciences and general welfare of the dental profession.

Seen following the ceremony, which took place in Edmonton on the 27th of June 1964 are: (Left to Right) Colonel IAL Millar, Colonel GB Shillington (Retired), Mrs Kearney, Brigadier KM Baird, Mrs Shillington and Colonel BP Kearney.

Major Wright To Attend Course At Walter Reed

As was mentioned in the last issue, a vacancy is being held for an RCDC officer on the 44 week course in Advanced Theory and Science of Dental Practice at the United States Army Institute of Dental Research at Washington D.C. Nominated to attend this course is Major JJN Wright of RCAF Station Clinton, who will proceed to Washington in September.

Capt Woodcock

It was with deep sorrow that the death of Captain GR Woodcock on the 6th of July 1964 will be learned by his many friends in the Corps.

The year following his retirement in 1960, Capt Woodcock was employed by the University of Alberta Dental Faculty and subsequently was on Continuous Army Callout on the staff at Headquarters Western Command. He is survived by his wife and four children.

DIRECTORATE NEWS

Board Of Governors Meeting

Brigadier KM Baird,a member of The Board of Governors of the Canadian Dental Association, attended the Annual Board Meeting in Edmonton, Alberta.

While in Edmonton Brigadier Baird also attended the joint convention of the Canadian Dental Association and the Alberta Dental Association.

Summer Concentration

Colonel IAL Millar visited Camp Gagetown, NB 13-15 Jul 64 as an Army Headquarters observer during the Regular Force Summer Concentration.

ODA Convention

Colonel AC Leman represented the DGDS at the Ontario Dental Association Convention in Toronto 10-13 May 64.

Major Brusso to London, England

Major AW Brusso, Senior Procurement Officer, visited the Medical Directorate War Office, London, England to attend the annual meeting of the Standing Working Group for Table of Medical Equivalents.

Major Harrington Attends Conferences

Major WH Harrington took part in a Management Training Symposium at CASC Kingston, Ontario 17-19 June 1964. During the period 27-30 July 1964 he attended a symposium on "Applied Preventive Dentistry" held at the US Army Institute of Dental Research, Washington, D.C.

Editorial Board Changes

Lt Col DH Hillier has been posted to 11 Dental Coy for service in Edmonton and will be replaced on the Board by Major WH Harrington. Lt Col Hillier has put a great deal of time and effort into the production of the Quarterly in the past few years and his absence will be acutely felt by the new Editorial Board.

Sports

Sgt Semple and Cpl Buncombe tried out for the D Pers Baseball team and are now regulars as Shortstop and Outfielder respectively.

WO 1 Jones, Ssgts Roberts and Smallshaw have been regular participants in the AHQ Golf Tournaments. In the last two outings Ssgt Smallshaw has been a winner (Class "C", Third Low Net).

11 DENT COY NEWS

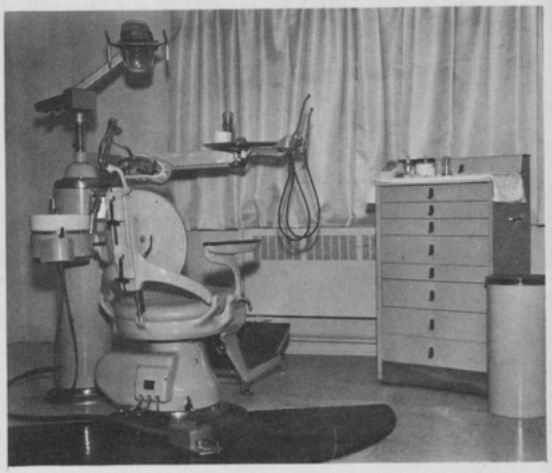
Annual Conventions - CDA and ADA

The Canadian Dental Association meetings held in conjunction with the annual meeting of the Alberta Dental Association, took place in Edmonton 29 Jun to 1 Jul 64. Brig Baird and Col Millar attended from the Directorate. In addition to local residents, the Corps was represented by Lt Col Pierce from Esquimalt, Major Jolly from Calgary, Major Hinch and Capt Hill from Cold Lake, Capt Kamachi from Chilliwack and Capt Mason from Penhold. Major Jolly presented a highly interesting and informative table clinic on "Dowel Crowns".

Cold Lake Clinic Officially Opened

The new dental clinic at RCAF Station Cold Lake, was officially opened by Brigadier Baird on 23 Jun 64. Shown attending the ceremony are: (Left to Right) Cpl Hardy, Sgt Fox, Cpl Neill, Major Hinch, Col Kearney, Brig Baird, Capt McRae, LAW Wood, Capt Hunter, LAW Crevier, Capt Walls, Cpl Giacobbo, Capt Hill, Capt Chernesky and Ssgt Shand.

To demonstrate the excellent facilities provided in the new clinic, one of the operating rooms in shown in the accompanying photograph.

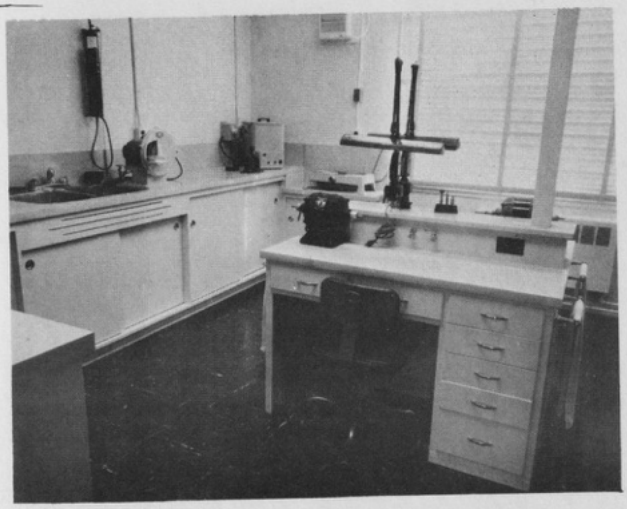


13 DENT COY NEWS

CDO to Europe

Colonel AT Roger, representing the DGDS, carried out the annual inspection of overseas units in May. Col Roger visited all clinics of 4 Fd Dent Coy and 35 Fd Dent Unit and interviewed personnel. He also made a liaison visit to Canadian Joint Staff in London and to the Headquarters of the RADC. Mrs Roger accompanied Col Roger on portions of the trip and they were able to enjoy a short period of annual leave touring Italy.

New Clinic



The laboratory of the newly occupied dental clinic at RCAF Station Clinton.

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14 DENT COY NEWS

Lt Col Anglin to Command

Lt Col WW Anglin will assume command of 14 Coy following a two year tour of duty in "La Belle Province" at RCAF Station St Jean.

Appointments

The services of Lt Col LA Richardson have been loaned to the Faculty of Dentistry, University of Manitoba where he will be employed in the Prosthetic Department for the academic year 1964/65.

Posting Party

The annual posting party, held in RCAF accommodation on 19 Jun 64 was well attended by unit personnel. Presentations were made to Col RB Jackson, Capt GJ Moore and Ssgt AJA MacFarlane who have left the unit and carry with them our best wishes.

15 DENT COY NEWS

Personnel of 15 Dent Coy

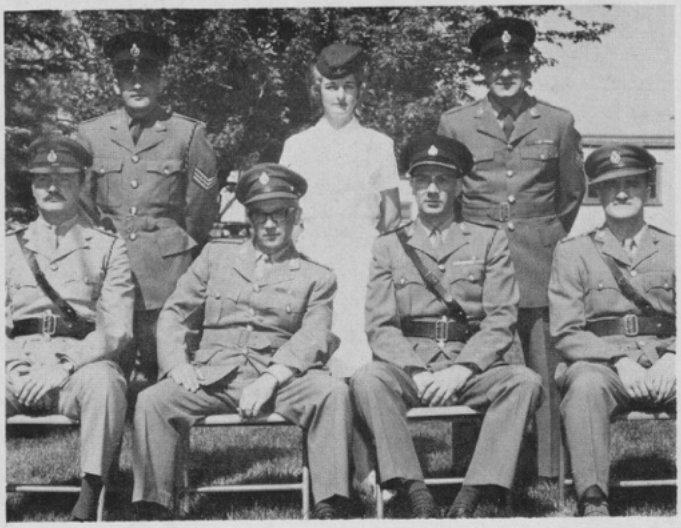
No 8 Dental Clinic,
Camp Valcartier, PQ

Front Row (L to R)

Miss Georgette Haggie, Major JL Masse, Major JD Bourque, Miss Fleurette Parent.

Second Row (L to R)

Corporals MD Longford, JR Pouliot, C Lachance, WO 2 R Fortin, Sgt TH Southin.



No 9 Dental Clinic, RCAF Station, St Jean, PQ

Front Row (L to R)

Capt PS Wade, Major PH Guevremont, Lt Col WW Anglin, Capt JR Senechal.

Second Row (L to R)

Sgt JM Chayer, LAW MYC Lachance, Ssgt GH Couture.

Farewell Party for Lt Col Butler

Thirty members of 15 Dent Coy assembled at 25 COD Longue Pointe on the evening of 10 Jul to honour Lt Col JG Butler, who, after three years as unit CO, has been posted to HMCS Cornwallis. Lt Col WW Anglin presented the guest of honour with a farewell gift on behalf of the personnel of the unit. We sincerely wish Lt Col Butler the very best in his new appointment as Senior Clinician of 12 Dental Company.

Change of Command

Colonel RB Jackson assumes command of 15 Dent Coy from Lt Col JG Butler on 8 Jul 64.

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RCDC SCHOOL NEWS

Exchange Postings with US Army

Major PS Sills has left for a two year tour of duty at Walter Reed Army Medical Centre in Washington D.C. Major DH Newell of the US Army Dental Corps has arrived in Camp Borden and will serve on the instructional staff of the RCDC School for a like period.

Liaison Visit by Col Budge

Colonel Clare T Budge, Director Department of Dental Science, Medical Field Service School, Fort Sam Houston, Texas made his third liaison visit to the RCDC School during May. He accompanied Colonel LA Potter, Assistant Commandant of MFSS who visited the CFMSTC.

During the visit, the Commandant and Officers of the RCDC School presented Col Budge with a framed RCDC Crest, as a token of the esteem with which this officer is held by the staff of the School. The occasion is represented in this photograph of: (Left to Right) Lt Col RE Brown, Capt RH Crowson, Lt Col DH Protheroe, Colonel Budge, Major WH Murray, Capt DG Cartwright, Colonel GR Covey, Major PS Sills, Lt Col JW Turner, Major JM Smith, Lt Col WR Thompson and Capt CA Casterton.

HQ Personnel During Col Roger's Visit

Colonel AT Roger visited 4 CIBG for the period 12-17 May to inspect dental facilities and interview 4 Fd Dent Coy personnel.

Front Row (L to R): Sgt SD Posyluzny, Pte LE Wannamker, Ssgt TW Sullivan, WO 2 DW Riddell, Pte EW Moore;

Second Row: Sgt EV Tanner, Col AT Roger, Lt Col G MacDougall, Capt FC Arpin.

Professional Meetings Held

Two Dental Professional Meetings were held in this area during recent months, the first being at the British Military Hospital Renteln while the final meeting of the season was held at Sennelager.

On the latter occasion, the attendance was encouraging as seen by the photograph. Only certain officers are identified as: Front Row (L to R): 1st Capt H Bruner US Army Dental Corps, 4th Lt Col AJL Wheatley RADC, 5th Col James RADC, 7th Lt Col G MacDougall RCDC, 8th Lt Col Elliott RADC; Back Row: 5th Capt FC Arpin RCDC, 6th Major JF Eadon RCDC, 7th Major WR Collier RCDC, 8th Major JVP Chatwin RCDC, 14th Major RH Headley RCDC, 15th Major LA Reynolds RCDC, 16th Major G Smith RADC.

35 FD DENT UNIT NEWS

Accommodation

It's "business as usual" at Unit Headquarters even though painters have all but aken over our offices. Painting was started on 22 June and the finished product, as exemplified by several of the rooms, makes burning eyes and strong odours almost worthwhile.

Sports

In most sports, a high score denotes a good game. This does not hold true for golf, however, as demonstrated by Lt Col Craigie and Capt Van Ryssel whose "rather" high scores failed to help the cause of the Air Division Headquarters team during the annual Air Division Golf Tournament held at Baden-Baden in late June. The tournament was won by No 3 Wing.

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CBU(UNEF) NEWS

"Canada Day" in Middle East

Seventeen Canadian radio and television personalities provided some much appreciated "home-brew" entertainment as the 900 Canadian soldiers in Egypt's Sinai Desert played host to their sister contingents of UNEF at a special version of "Canada Day". Carol Ann Balmer "Miss Canada 1964", Gordie Tapp, Bert Niosi and the other performers gave a one-hour show which was followed by a Canadian film feature and food to fit the occasion, including hot-dogs and popcorn.

Personnel

We feel that this detachment has long since ceased to be a "fledgling" outpost of the Corps, and to prove the point we present our "honour roll" of those officers who have toured the Sinai Strip.

As Majors:

Major	PS	Sills	Lt Col	HR	Kettyls
Lt Col	G	MacDougall	Major	JCE	McDonald
Major	DJ	Carmichael	Major	EJC	Small
Major	AL	Kelland	Major	RJK	Pyne
Major	TC	Gaudet			

As Captains:

Major	JJN	Wright	Capt	FC	Buschlen	(Released)
Major	LA	Reynolds	Capt	JS	Davis	(Released)
Capt	FC	Arpin	Capt	DE	Williams	(Released)
Major	JOL	Bourget	Capt	RDH	Bunt	(Released)
Capt	RJ	Paturel	Capt	MDG	Conrad	(Released)
Major	BA	Gaudet	Capt	R	Lanthier	(Released)
Major	JLY	Cyrenne	Capt	RG	Perry	(Released)
Capt	PAA	Dailyde	Capt	KN	Munroe	(Released)

WELCOME TO THE CORPS

Congratulations are extended to the twenty-three graduates who have recently been promoted to the rank of Captain and who are now employed at the following locations:

Capt	RWC	Adams	- NDHQ Clinic, Ottawa
Capt	DJM	Boston	- RCAF Stn, Greenwood
Capt	RW	Chernesky	- RCAF Stn, Cold Lake
Capt	RH	Crowson	- RCDC School
Capt	GDV	Dippel	- RCAF Stn, Goose Bay
Capt	WH	Dunnigan	- Calgary Garrison
Capt	N	Goldberg	- HMCS Stadacona
Capt	H	Griesbach	- Camp Petawawa
Capt	MH	Harach	- RCAF Stn, Winnipeg
Capt	JPJ	LaPorte	- Camp Valcartier
Capt	MG	McRae	- RCAF Stn, Comox
Capt	JA	Nattress	- RCAF Stn, Winnipeg
Capt	RFC	Oswin	- RCAF Stn, Namao
Capt	DJAG	Pigeon	- RCAF Stn, St Jean
Capt	GE	Purcell	- Griesbach Barracks
Capt	V	Rausch	- RCDC School
Capt	JR	Robertson	- HMC Dockyard, Halifax
Capt	GR	Rowe	- HMC Dockyard, Halifax
Capt	JO	Strom	- HMC Dockyard, Halifax
Capt	TC	Tervit	- RCAF Stn, Trenton
Capt	JWC	Walls	- RCAF Stn, Cold Lake
Capt	RE	Warren	- RCAF Stn, Clinton
Capt	BH	Weeks	- RCAF Stn, Rockcliffe

A cordial welcome is also extended to the following personnel who have recently joined the Corps:

Pte	GG	Albertson	- HMC Dockyard, Halifax
Pte	WD	Buxton	- Camp Gagetown
Pte	RE	Todd	- 4 Fd Dent Coy
Pte	LE	Wannamker	- 4 Fd Dent Coy
LAW	MJ	Hebert	- RCAF Stn, Goose Bay
Mrs	CN	Colleaux	- Fort Osborne Barracks

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PROMOTIONS

The following Corps personnel are congratulated on their promotions:

WO 1	MB	Fisk	- to Lt
WO 2	TL	Batten	- to WO 1 (SM)
WO 2	RH	Daw	- to WO 1 (SM)
WO 2	H	Thorsson	- to WO 1 (SM)
Ssgt	JS	Wentzell	- to WO 2 (DQMS)
Sgt	JM	Roberts	- to Ssgt
Cpl	JG	MacDonald	- to Sgt
Cpl	GD	Schwarze	- to Sgt
Pte	JAL	Boulianne	- to Cpl
Pte	LJP	Nadeau	- to Cpl
WO 2	ESW	Moore	- to Lt
WO 2	EC	Carpenter	- to WO 1 (TSM)
WO 2	TM	Jackson	- to WO 1 (SM)
Ssgt	AF	Davison	- to WO 2 (DQMS)
Sgt	JP	Carrier	- to Ssgt
Cpl	AH	Green	- to Sgt
Cpl	JG	MacPhee	- to Sgt
Cpl	WL	Wylie	- to Lsgt
Pte	NL	Highfield	- to Cpl

RETIREMENTS AND RELEASES

Capt	JSE	Dorion	Capt	AG	Garden
Capt	RJ	Gillis	Capt	KSM	Mathers
Capt	JJ	Mitchinson	Capt	M	Petryk
Capt	PP	Prud'homme	Capt	JR	Senechal
Capt	WJ	Thomson	Capt	CG	Travis
Capt	LK	Wansbrough	Capt	DA	Warrick
Capt	JB	Wilcock			
WO 2	RWM	Hall	Sgt	JRM	Chayer
Cpl	HW	Anderson	Sgt	MP	Foley (RCAF)
Pte	R	Taillon	LAW	MFE	Audet
LAW	EE	Beaver	AW1	SJD	Clutterbuck
LAW	SD	Fitzpatrick	LAW	DJM	Gagnon
Miss	JL	Blumes			

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POSTINGS

Lt Col	WW	Anglin	-	HQ 14 Dent Coy, Winnipeg
Capt	DW	Armstrong	-	RCAF Stn, Gimli
Major	JF	Begin	-	4 Fd Dent Coy
Lt	VO	Bergland	-	HQ 13 Dent Coy, Trenton
Lt Col	JC	Brick	-	35 F Dent Unit
Capt	HW	Brogan	-	RCAF Stn, Greenwood
Major	HG	Bunston	-	RCAF Stn, Goose Bay
Lt Col	NA	Butcher	-	RCAF Stn, Trenton
Lt Col	JG	Butler	-	HMCS Cornwallis
Major	DJ	Carmichael	-	RCAF Stn, Clinton
Capt	HJ	Cashin	-	HMCS Stadacona
Capt	CA	Casterton	-	1 Dent Eqpt Dep
Lt Col	FD	Charman	-	RCAF Stn, St Jean
Lt Col	CM	Cornish	-	1 Dent Det, Ottawa
Lt Col	LG	Craigie	-	DGDS
Capt	MN	Deyette	-	HQ West Ont Area, London
Major	WK	Dickie	-	35 Fd Dent Unit
Major	PE	Fafard	-	HMC Dockyard, Esquimalt
Lt Col	RA	Fell	-	HQ East Ont Area, Kingston
Major	BA	Gaudet	-	35 Fd Dent Unit
Major	TC	Gaudet	-	CBU (UNEF)
Capt	EW	Gazo	-	4 Fd Dent Coy
Major	DDR	Girard	-	25 COD, Longue Pointe
Major	WH	Harrington	-	DGDS
Major	RH	Headley	-	Camp Gagetown
Capt	GW	Hill	-	HQ Sask Area, Regina
Lt Col	DH	Hillier	-	Griesbach Barracks, Edmonton
Capt	IP	Hunter	-	QM Stores Griesbach Bks, Edmonton
Col	RB	Jackson	-	HQ 15 Dent Coy, Montreal
Lt Col	HR	Kettyls	-	HMCS Stadacona
Capt	WR	Kyle	-	Camp Picton
Capt	JPA	Legendre	-	Camp Petawawa
Major	IAC	MacDonald	-	RCAF Stn, Downsview
Major	DJ	MacPhee	-	CFH, Kingston
Capt	NA	McFarlane	-	6 RD, Trenton

Major	VN	McMaster	-	RCAF Stn, Summerside
Capt	CM	Mason	-	RCAF Stn, Penhold
Major	HK	Meisner	-	Fort Churchill
Capt	GJ	Moore	-	HQ 13 Dent Coy, Trenton
Capt	PP	Morin	-	4 Fd Dent Coy
Capt	RJ	Paturel	-	HMCS Shearwater
Lt	RG	Peebles	-	RCDC School
Major	RJK	Pyne	-	RCAF Stn, Comox
Major	MP	Quinn	-	HQ BC Area, Vancouver
Capt	WE	Russell	-	RCAF Stn, St Jean
Capt	MD	Taylor	-	RCAF Stn, Moose Jaw
Major	JJY	Turcotte	-	NDHQ Clinic, Ottawa
Capt	PS	Wade	-	RCAF Stn, Bagotville
Sgt	WJ	Arnsby	-	1 Dent Det, Ottawa
WO 2	AJ	Arsenault	-	25 COD, Longue Pointe
Sgt	LR	Barrett	-	1 Dent Det, Ottawa
Cpl	RS	Black	-	RCAF Stn, North Bay
WO 2	VO	Blackmore	-	RCAF Stn, Downsview
Sgt	LG	Brown	-	15 Dent Coy, Montreal
Cpl	N	Cable	-	Fort Churchill
WO 1	EC	Carpenter	-	1 Dent Eqpt Dep
Ssgt	JP	Carrier	-	RCDC School
Sgt	H	Chamberlain	-	HQ Man Area, Winnipeg
Sgt	CA	Chartier	-	1 Dent Det, Ottawa
Ssgt	MF	Conkey	-	QM Stores Griesbach Bks, Edmonton
WO 2	AF	Davison	-	HQ 15 Dent Coy, Montreal
Sgt	AH	Green	-	CBU (UNEF)
Cpl	BF	Hannah	-	RCAF Stn, Winnipeg
Cpl	B	Hannay	-	CBU (UNEF)
Pte	PE	Harkin	-	RCAF Stn, Greenwood
Cpl	TJ	Herrett	-	CBU (UNEF)
Cpl	NL	Highfield	-	RMC, Kingston
WO 1	TM	Jackson	-	1 Dent Eqpt Dep
Sgt	WA	Jackson	-	Fort Osborne Bks, Winnipeg
Sgt	EA	Jermain	-	HMCS Stadacona
Cpl	RB	Johnson	-	14 Dent Coy, Winnipeg
Sgt	C	Johnston	-	HMCS Naden
Ssgt	VR	Kidd	-	RCAF Stn, Trenton
Sgt	HC	Kirby	-	RCDC School
Sgt	GKW	Libby	-	4 Fd Dent Coy
Ssgt	AJA	MacFarlane	-	HQ 12 Dent Coy, Halifax
Sgt	FK	MacKay	-	HMCS Shearwater
Cpl	PA	McCoy	-	RCAF Stn, Comox
Sgt	HM	McCurdie	-	35 Fd Dent Unit
Sgt	MO	McDonald	-	HMCS Cornwallis
Cpl	RW	McDonald	-	QM Stores Griesbach Bks, Edmonton
Cpl	H	McRae	-	RCAF Stn, Winnipeg
Cpl	OW	Mandrusiak	-	RCAF Stn, North Bay
Sgt	JF	Marchand	-	RCAF Stn, Clinton
Sgt	H	Marckwort	-	Griesbach Bks, Edmonton
Pte	ZWJ	Mitrikas	-	NDHQ Clinic, Ottawa
Sgt	JM	Moore	-	QM Stores Griesbach Bks, Edmonton
WO 2	WD	Morris	-	RCDC School
Sgt	DT	Murley	-	RCAF Stn, Clinton

Cpl	LJP	Nadeau	- HQ 14 Dent Coy, Winnipeg
Cpl	RA	Neill	- RCAF Stn, Cold Lake
Cpl	TR	O'Mara	- HQ West Ont Area, London
Sgt	RH	Palmer	- 1 Dent Eqpt Dep
Cpl	WJ	Parker	- 1 Dent Det, Ottawa
Sgt	DB	Playford	- CFH, Kingston
Sgt	SD	Posyluzny	- HQ 13 Dent Coy, Trenton
WO 2	W	Powers	- Fort Osborne Bks, Winnipeg
Sgt	WS	Richardson	- 1 Dent Det, Ottawa
Ssgt	JM	Roberts	- Pers RCDC, Ottawa
Ssgt	SE	Robertson	- HQ Calgary Garrison
Sgt	G	Sapergia	- RCDC School
Ssgt	KJ	Smallshaw	- HQ 12 Dent Coy, Halifax
Pte	JA	Strasdin	- 1 Dent Eqpt Dep
Sgt	AJ	Tait	- 4 Fd Dent Coy
WO 2	JM	Tapp	- RCAF Stn, Goose Bay
Sgt	GH	Taylor	- RCDC School
Cpl	B	Vandervaart	- DGDS
Cpl	GM	Wadden	- 35 Fd Dent Unit
WO 2	JS	Wentzell	- 1 Dent Eqpt Dep
Ssgt	CR	White	- QM Stores Griesbach Bks, Edmonton
LAW	J	Boucher	- RCAF Stn, St Hubert
LAW	BJ	Larose	- RCAF Stn, St Hubert
LAW	JH	McDonald	- RCAF Stn, Comox

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VITAL STATISTICS

Births To:

Ssgt and Mrs G Shand, RCAF Station, Cold Lake, a son;
Sgt and Mrs DL Fenton, RCAF Station, Winnipeg, a son;
Cpl and Mrs DE Fraser, RCDC School, a daughter;
Cpl and Mrs ADT Gardner, RCDC School, a daughter;
Cpl and Mrs RS Walker, RCDC School, a daughter.

Marriages:

Capt LW Armstrong, RCAF Stn, Gimli, to Ethel Rae Neelands;
Capt PR McQueen, CJATC Rivers, to Melva Jean Barrie;
Cpl NL Highfield, RMC Kingston, to Judith Ann McDonald;
Cpl RE Thompson, RCAF Stn, St Jean, to Nicolle Christopher;
Pte LJP Nadeau, QM 14 Dent Coy, Winnipeg, to Theresa Ann Kotar
LAW MD Cyr, RCAF Stn, St Jean, to LAC W Golimbioski;
LAW C Lachance, RCAF Stn, St Jean, to LAC JRM Daigneault;
LAW JM Stangowitz, RCAF Stn, Trenton, to LAC Mackie.

Deaths:

Our deepest sympathy is extended to:

Brigadier KM Baird, whose mother passed away in early July;
Sgt AW Wilkinson, who suffered the loss of his father.