The ROYAL CANADIAN DENTAL CORPS Quarterly

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The RCDC Quarterly

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Cover Photograph

BGEN BP Kearney, Director General of Dental Services accompanied by 2LT DK MacKenzie, Parade Commander and CAPT R Peebles inspects 3rd Phase DOTP candidates.

Front Row - Right to Left - 2LTs RW Rix, OW Donald, LR Holland

More DOTP photographs on pages 25 and 26.

ST APOLLONIA

Virgin and Martyr
Patron Saint of Dentists

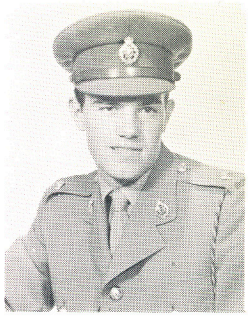
In 1967 the dental officers of 4 Fd Dent Coy acquired this early Baroque painting of St Apollonia which they have presented to the Royal Canadian Dental Corps. The donors were:

LCOL LA Richardson
MAJ MN Deyette
MAJ RJ Paturel
MAJ DR O'Hara
CAPT (now MAJ) GW Hill
CAPT (now MAJ) AN Swanzey
CAPT H Griesbach
CAPT GR Nye
CAPT HS Wood
CAPT JRC Bellerose
CAPT RM Depledge
CAPT RJ Shirkey

St Apollonia, an aged deaconess, was seized by the heathen populace of Alexandria in AD 249 during the reign of the Emperor Philip. After knocking out her teeth the mob threatened to cast her into the fire unless she denied her faith. She threw herself into the flames to convince her persecutors that her sacrifice was perfectly voluntary.

We find churches and altars dedicated to the honor of St Apollonia in most parts of the Western World but she is not venerated in any Oriental church, though she was martyred in Alexandria.

St Apollonia, whose birthday is celebrated on the 9th of February, is invoked against toothache and all dental diseases and is shown in art with a pair of pincers holding a tooth or with a golden tooth suspended on her necklace.



THE DEVELOPMENT OF FLUORIDATION

2 LT GPF Greenacre

Many years ago, epidemiology studies reported that inhabitants of certain areas had a remarkably reduced caries incidence. This was early in the nineteenth century, long before "Crest". Some medical investigators suggested this was due to some specific factor in their water supply. However, it took almost one hundred years to subsequently explain the concept of fluoridation and to begin applying it as a public health measure. The following are some of the most important dates in the development of this concept:

1874 - surprisingly enough, one European doctor was said to have recommended potassium fluoride lozenges for children and expectant mothers as early as 1874. However, whether this was done for the fluoride or potassium content is not ascertainable.

1890 - two researchers, Dr Creckton-Brown and Dr Michel, both expressed a belief that fluoride might be of value in dental health.

1900 - an American Army doctor, Dr J Eager, stationed in Venice, Italy, wrote home describing different dental conditions to his friends in the United States Public Health Service. He mentioned the blackened teeth of Chiaie's disease in northern Italy. Apparently, this was locally attributed to having drunk, during infancy, water that had been "charged under pressure with volcanic fumes". Moreover, he noted that most young Italians in central Italy had surprisingly strong healthy teeth.

1920 - once again, the harmful effects of fluoride were observed. At Johns Hopkins University, Dr EV McCollum administered fluoride in a concentration of 250 ppm to rats. The results were disastrous.

1900-1931 - during this period of time, several studies were conducted on the mineral content of water and the dental implications. One man suggested that it was the complete lack of fluoride that caused weakened enamel. More significantly, Dr FS McKay theorized in 1929 that mottled enamel and a higher caries resistance were due to the relative concentration of fluoride in drinking water. This widely read publication provided a great stimulus for subsequent experiments.

1931 - three almost simultaneous experiments demonstrated that the sole cause of discoloured teeth was the concentration of fluoride in the water.

1930-1945 - for fifteen years, Dr H Trendley Dean devoted himself to researching areas in North American to evaluate the optimum fluoride level for water supplies. In 1944, he published his "study of twenty-one cities" which recommended that communities should increase or reduce the fluoride content in their drinking water to 1 ppm to develop healthier caries-resistant teeth. By late 1944, he had encouraged Dr WH Tucker to become the first municipal health commissioner to authorize the design and construction of a town fluoridation project.

1945 - certain communities, Brantford, Ontario; Newburgh, New York and Grand Rapids, Michigan, adjusted the fluoride content of their water supplies by using fluoride salts fed by an automatic mechanical apparatus.

SYSTEMIC FLUORIDES

A variety of consumable forms of fluorides has been suggested in areas where there is not a piped water supply. For example:

In Geneva, Switzerland, school children were given chewable tablets containing one milligram of fluoride on a daily basis. Results showed a 30-50% decrease in diseased, missing, or filled teeth.

In Sweden, health officials have experimented with fluoridating bread for rural areas.

Some people have suggested fluoridated rice for Asian countries. Also there have been similar ideas for fluorides in milk and even in sugar.

However, there have been several setbacks in developing the "ideal" systemic fluoride for underdeveloped countries and rural areas: the correct dosage is hard to calculate due to international differences in the diet; also expense is a factor for many governments (i.e. tablets, milk, sugar). Finally, there is the technical problem of finding a method to combine a fluoride with a food product while keeping the ions in a shelf-stable yet potentially active form. Fluoridated salt may prove to be the closest we can get as an ideal systemic fluoride.

Research for an ideal rural systemic fluoride has suggested that fluoridated salt is the simplest, safest, and most inexpensive method yet developed. A dosage of 300 mg. "F"/kg. salt has been suggested after studying ethnic and age differences in salt consumption. This allows for a maximum pre-eruptive period intake of 5 g. salt/day and a maximum post-eruptive intake of 25g./day. Finally, experiments have shown that when tricalcium phosphate is added to table salt containing either calcium fluoride or sodium fluoride, the product is both shelf-stable and potentially reactive in the human body.

At present in four isolated Andes villages in Columbia, dental health officials are conducting an experiment to compare the relative efficiency of salt and water fluoridation. This is being financed by the USPHS and may prove someday to be classic reference material. One village receives fluoridated water, one table salt with Ca (F), another salt with NaF, and the fourth will act as a control. Also, a close watch is being kept on the health of the hard and soft tissues in these people by taking x-rays of the metacarpophalangeal joints and blood and urine analysis. So far, the experiment has had enthusiastic cooperation from all the people involved. One observer, impressed by the ingenuity of this experiment, commented:

"North Americans pioneered fluoridated water; Sweden developed fluoridated bread, and now Columbia is leading the way to fluoridated salt. - Will France fluoridate wine?".

TOPICAL FLUORIDES

As the concept of preventative dentistry evolved it became apparent that the use of systemic fluorides was only half of the fluoridation story. Only recently have the additional preventative effects of topical fluorides been fully realized. Several forms of topical fluorides have been developed:

Dentifrices

Currently, most fluoride toothpastes show a 20-30% reduction in caries, but it is hoped to improve them by increasing the number of reactive fluoride ions. Initially, the problem of maintaining ion activity with long shelf-life had to be overcome before going on to the market. At present, researchers are trying to solve the problem of a slow diffusion rate into enamel and ion inactivation due to complex formation and water binding.

Mouth Washes

A 10 ml solution of .05% NaF daily or a 10 ml solution of .2% NaF weekly has proven to be equally effective in reducing caries. The method used depends on individual preferences. Both tooth brushing and the use of a fluoride mouth wash are part of the US Navy's new experimental dental health programme.

Prophylaxis and Polishing

Fluoride preparations are recommended for prophylaxis on patients with a high caries index. Further, it is claimed by some that polishing procedures wear away the fluoride rich surface layers of enamel. It is advisable to prevent this if possible and a NaF-pumice preparation is now available commercially.

In general, the use of topicals depends on the attitudes of the dentist. This reminds me of a story I heard recently. Apparently, one dentist advises his patients when they leave his town that - "if you want to make sure you are choosing one of the top dentists in your new town - try phoning up the local dental supply company and find out which man uses the most topical fluorides".

Within the profession, one of the most significant consequences of fluoridation is the great impetus it gave to developing the philosophy of PREVENTATIVE DENTISTRY. In many areas of the world, a rapid utilization of these concepts is desperately needed to help offset the acute shortage of dental health personnel and the steady increase in dental disease.

PRINCIPLES OF FLUORIDES

Systemic

A concentration of fluoride of .8-1.2 ppm in drinking water is calculated to be within safe limits for even the greatest consumer of water. It is claimed that the permanent teeth will only derive the full benefits from systemic fluoridation if started before the age of two years. However, after the age of nine, no ill effects can be seen in people drinking water containing up to 15 ppm F. Also, it seems that the only tissues adversely affected within this range of 1.2-15 ppm are the teeth. Apparently, tooth mottling is the most sensitive reaction of the body to fluoride levels even slightly above 1.2 ppm.

When an individual drinks fluoridated water containing 1 ppm F, during his pre-eruptive years the body develops an increase of 300 ppm F concentration in surface enamel. The fluoro-apatite crystal so formed is larger and more perfectly shaped. Also, there is less carbonate incorporated into the crystal. This fluoro-apatite becomes concentrated in the outer enamel areas and any subsequent recalcification areas. Thus a denser, less soluble and more caries resistant tooth is formed.

All the oceans and a lot of fresh-water areas are naturally fluoridated. For aeons tooth-bearing creatures of the seas have benefited from fluoridation. Since many biologists have compared man's extra-cellular fluid to sea-water (i.e. physiological saline .7% NaCl), it might be possible to carry this comparison one step further. It is probable that as sea-animals evolved to land, they lost the benefits of having their hard-tissue-forming cells exposed to an extracellular environment containing fluorides. Perhaps this would be a good argument for profluoridationists regarding the physiological and psychological benefits of fluorides. Recently, Soviet scientists have said that fluorides tend to decrease the deposition of strontium 90 in hard tissue - "one group had 25% less strontium 90!" At Harvard, researchers have theorized that fluorides tend to help keep calcium deposited in hard tissue and prevent calcium accumulation in the soft tissues. Thus, it has been indicated that there is less osteoporosis and hardening of the arteries in fluoridated areas.

Topical

There are some differences in the actions of topical fluorides which have to exert their influences by an "outside-in" route. First of all, topical fluorides are much more highly concentrated. Further, the effectiveness of their action depends on several factors:

a. other fluoride sources
b. the caries index of the patient
c. the frequency of application
d. patient cooperation

More specifically, topical fluorides have a much greater effect on smooth surfaces than on pits and fissures. Other researchers have postulated that the presence of fluoride in dental plaque makes an oral environment unsuitable for the proliferation of lactobacillus acidophilus. Thus, it can be surmised that post-eruptive fluorides are just as important in maintaining caries resistance as pre-eruptive fluorides are for inducing this condition.

SOCIO-POLITICAL ASPECTS OR THE BATTLE OF TOOTH OR CONSEQUENCES

Every year, fluoridation is alternately condemned and recommended, shelved and reviewed, and discussed and cussed. The main problem is that in many cases, we simply have been unable to transfer known scientific concepts into practical simple terminology. Essentially, a communications midwife is needed to relieve the scientist of his labour pains and deliver the information to the public. I believe that the Universities should make up a larger part of this communications link.

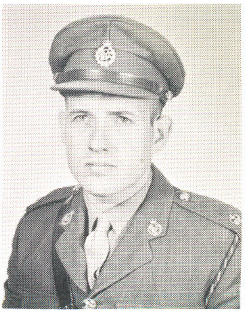
In many unsuccessful fluoridation campaigns, the problems have been a lack of proper preparation and a poor presentation. Often, the profluoridationists tried to go too far too fast and succeeded only in frustrating themselves and arousing public suspicion. Nevertheless, when some of the arguments against fluoridation (i.e. mass indication with rat poison; communist plots; it is against God's will, etc.) are prepared with the presented facts, it becomes hard to believe that man is a rational animal. It seems that humans respond more to "how" the fluoridation campaign was conducted, than to "what" was presented. Lately, many referendums have been won by simply using the right publicity, for instance, some dental associations have made cash offers of "$1,000.00 for anyone who can prove that their health was adversely affected by fluorides properly administered"; various gimmicks and jingles have helped too in the promotion of this health measure.

Politically, it is very interesting to note that the more democratic a country the harder it has been to start fluoridation. Californians annually reject fluorides in their drinking water, while Puerto Rico is 93% fluoridated. Similar acceptance is found in most totalitarian states. In summary, it seems that the two factors of "how" and "where" are very important to the success of a fluoridation campaign.

In Canada, 25% of our population has fluoridated water. As Dr PC Staples mentioned recently in Montreal - "Never was so much public health gained for so little". Yet Quebec makes up only 6% of all Canadians receiving these benefits. More specifically, Montreal remains one of the last major Canadian cities without fluoridation. All past attempts have failed to produce action from the authorities. Unfortunately, most of the local dentists are apathetic towards further attempts and some are even in opposition. All this in spite of the fact that there are higher standards of practice and higher incomes for dentists in fluoridated areas. Nevertheless, some of this conservatism is understandable when the past history of local fluoridation efforts is considered.

* Editor's Note

There are 13 references which are available on request.



COMMENTS ON OCCLUSION IN THE CONSTRUCTION OF COMPLETE DENTURES

MAJ GDV Dippel, DDS

One of the most important steps in complete denture construction is the development of occlusion. Unfortunately, this procedure is often neglected by the dentist and relegated to the laboratory technician.

This article presents some current thoughts regarding occlusion for complete dentures in general and in particular recommends the employment of monoplane occlusion, outlining reasons for its use and the technique employed.

WHAT IS MONOPLANE OCCLUSION?

Monoplane occlusion may be described as an occlusion without a compensating curve. Either cusped or cuspless teeth may be used.

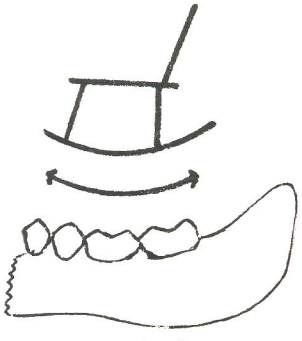


Fig 1

Unfortunately, it is common practice to use a full complement of posterior teeth when constructing complete dentures and in many cases the last molar encroaches on the "lower molar slope". In these situations an exaggerated compensating curve is developed causing the denture to rock like a rocking chair against the lower ridge. The resulting denture instability produces adverse stresses on the residual ridge. A reduction in the number of posterior teeth permitting elimination of the compensating curve, will help to limit this action.

DEVELOPING MONOPLANE OCCLUSION

a. Articulator

In order to develop a monoplane occlusion it is necessary to use an articulator with a flat incisal guidance table. The Hanau Model H2 satisfies this requirement. The Model H has a curved incisal guidance table and cannot be used in this technique because it builds in a fixed compensating curve, however, a conversion kit is available to change the cup-like incisal table to the required flat plane.

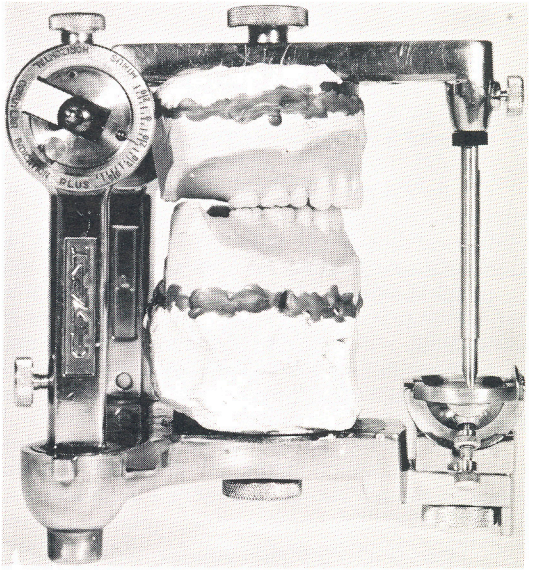


Fig 2

Records

Great care must be taken in making the centric record as accuracy is paramount at this stage. The face bow is used to mount the maxillary cast on the articulator in the usual manner and the mandibular cast is mounted using the centric record. The teeth are then set in centric relation and the rims are transferred back to the patient. The accuracy of the articulator mounting is confirmed by use of plaster check bites. At least two coinciding check bites are necessary to verify the centric record. If this record is not verified in this manner a remount of the lower cast is necessary. Protrusive records are then made to establish the condylar element readings.

c. Incisal Guidance

This is the only factor requiring a setting on the articulator which can be arbitrarily determined by the operator. When developing monoplane occlusion the incisal table is set at zero degrees.

d. Cusp Height

Cusp height or cusp rise is determined by the condylar guidance and incisal guidance. In this case the incisal guidance is set at zero degrees and the condylar guidance readings are variable as determined by the protrusive record. Cusp height may be determined by averaging the difference between the incisal and condylar guidance readings. If by this calculation the cusp height is 15°, the stock tooth selected would be a 20° posterior (closest to 15°) and the difference of 5° reduced to attain anterior posterior balance. The lateral cuspal inclination of the so called 20° posterior tooth is actually 17°. The required reduction of the lateral cusp rise will vary as the cusp rise will be greater as it approaches the condyle and less as it approaches the incisal guidance table.

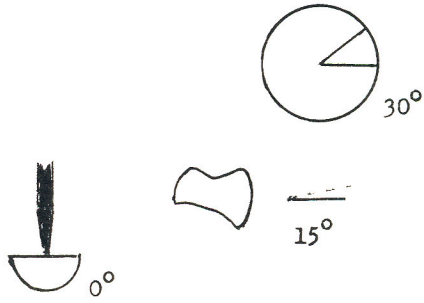


Fig 3

e. Positioning of Teeth

Anteriors

Fig 4

The incisive papilla is perhaps the most constant landmark in the mouth, in that its position remains constant throughout life. The maxillary centrals should be positioned approximately 9 mm anterior to the incisive papilla. Soft tissue relationships such as lip line, smile line, face profile and factors such as phonetics and age, all play a role in the positioning of anterior teeth.

There should be no contact between maxillary and mandibular anterior teeth in centric or any other excursion and the incisors should be set directly over the ridge to prevent adverse tipping stresses. Patients should be warned regarding the loss of incising power and be taught to incise in the cuspid - bicuspid area rather than in the incisor area. They should also be encouraged to break food into smaller pieces before placing it in the mouth to minimize the necessity for incising.

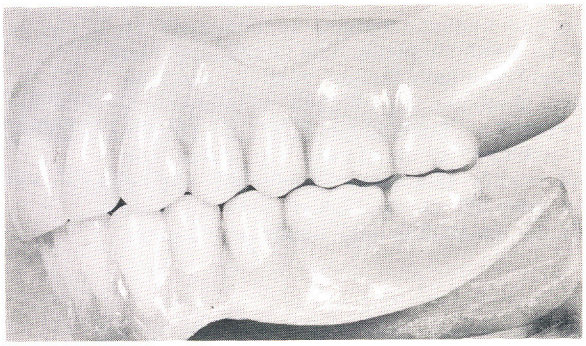


Fig 5 illustrates a case with a large discrepancy between the arches. The lower anteriors are set off the ridge and tilted labially to bring upper and lower anteriors in contact in centric relation. This is a common fault in complete upper and lower dentures.

Fig 5

Fig 6 illustrates the same case set up with monoplane occlusion and no contact anteriorly. The following points should also be noted in this set-up:

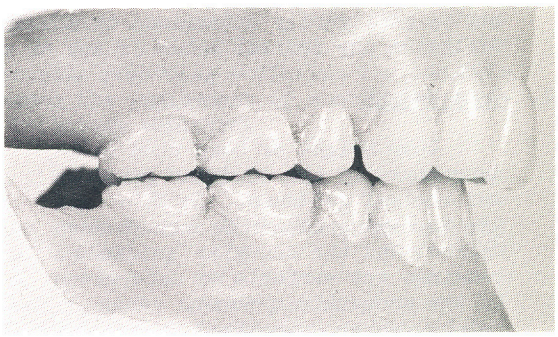


Fig 6

a. buccal cusps not in contact,
b. reduced number of posterior teeth,
c. diastema between cuspid and bicuspid to permit proper cusp to fossa relationship,
d. there would be contact between the anterior teeth in exaggerated protrusive and lateral movements; however, an overbite can be allowed because of the great discrepancy between anterior portions of the maxillary and mandibular ridges. Ideally a monoplance occlusion should provide minimal clearance and no contact of anterior teeth in protrusive and lateral excursions.

Posteriors

1. In order to minimize tipping forces the lower posterior teeth are set directly over the crest of the ridge.

2. The height of the occlusal plane posteriorly is established at a level 1/3 to 1/2 the height of the retromolar pad. When making occlusal records, the patient is seated in an upright position with the plane of occlusion established parallel to the floor. The face bow record will then usually position the case on the articulator with the plane of occlusion parallel to the lower member of the articulator. This in effect provides a third plane of reference in mounting the case.

3. In order to avoid placing teeth over the lower molar slope (thus avoiding the rocking chair effect), it may be necessary to reduce the number of posterior teeth. Two bicuspids and one molar or one bicuspid and two molars may be used.

4. Diastemata should be created if required to obtain proper cusp to fossa relationship when positioning maxillary posterior teeth.

5. The buccal-lingual width of posterior teeth may be reduced in order to reduce the food table, thereby lessening stress on a resorbed residual ridge.

Balancing

6. The final balance prior to the insertion of dentures can only be properly

achieved by remounting the processed dentures on an articulator before they are removed from the cast.

The maxillary buccal cusps are ground until the lingual maxillary cusps maintain the only contact in all excursions. The action of the maxillary lingual cusp against the opposing fossa creates a mortar and pestle effect. (See figure 7)

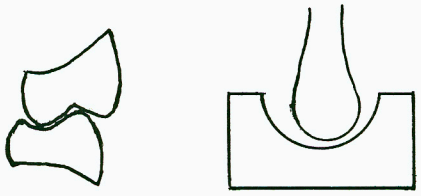


Fig 7

Fig 8

During selective grinding once centric relationship has been developed the lingual cusps of the upper (centric holding cusps) or the central fossa of the lower must not be ground or the centric relation will be destroyed. Grinding will be limited primarily to the inner inclines of the mandibular buccal cusps. While grinding these inclines it must be noted that these inclines are not just ground to the point of uniform balancing contacts but are ground in such a manner that the incisal pin does not leave the flat incisal guidance table.

Polishing

7. When finishing dentures, it is important to guard against excessive polishing of teeth which will destroy the balance attained by selective grinding.

SUMMARY

The objective to be gained by adhering to the suggestions in this article regarding occlusion in complete dentures is the attainment of denture stability which will help to preserve the remaining tissue. In many cases patients can wear dentures which have been made in the conventional fashion for long periods without serious bone loss; however, it is obvious that in a large percentage of cases much of the residual ridge is lost.

Typical lower ridge after twenty years of wearing dentures.

Fig 9

It is very difficult to forecast the amount of bone loss which will occur. Therefore, although the technique described is designed primarily for older denture wearers, there is strong evidence that its employment will also greatly benefit younger patients.

ACKNOWLEDGEMENT

The author recently attended a course in Complete Denture Prosthesis at the Naval Dental School of the National Naval Medical Center in Bethesda and this article is based on ideas and information gained while on course.

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TOPICAL ANAESTHESIA

MAJ JW Jolly, CD, DDS

As a result of a recent dental stores investigation, the value of topical anaesthesia in many minor dental procedures has become more apparent to the writer. The method of use and benefits are set out below, as well as information concerning the packaging, stability and patient acceptance of the anaesthetic studied in the investigation.

The topical anaesthetic used was Xylocaine Flavoured Spray, which is packed in a 62.5 gm container providing about 600 metered sprays of 10 mg each. This spray has a long shelf life and retained full potency over the six month test period. The manufacturer claims the shelf life to be three years. Under normal usage, one container should last between six months and one year.

This spray produces topical anaesthesia of good depth and approximately fifteen minutes duration on oral mucous membranes. The spray is applied to the desired area, allowed one to two minutes to produce anaesthesia and then the dental procedure may be carried out.

The apprehensive patient is well known to us all. The use of this spray is beneficial, both physiologically and psychologically for this type of patient when applied prior to injection of local anaesthetic.

In the surgical field, good topical anaesthesia permits the removal of sutures, loose bone spicules and loose residual roots to be accomplished painlessly. When a tooth has fractured during extraction and the exposed pulp is sensitive this spray is very effective as a desensitizing agent, thus allowing the extraction to be completed with a minimum of discomfort to the patient.

In operative dentistry, topical anaesthesia is useful when placing matrix bands subgingivally in unanaesthetized areas or when rubber dam clamps are liable to impinge on the gingival tissues.

In periodontia, application of the topical spray to the gingival sulcus permits deep sub-gingival scaling with a minimum of pain. This anaesthetic also appears

to reduce gingival bleeding to some extent thus improving visibility during deep scaling procedures.

The spray is useful as an analgesic for denture adjustments when sore spots or ulcerations are present. It is particularly beneficial when making adjustments to immediate dentures in the first few days after insertion.

The gagging patient is a source of frustration to the dental operator, particularly during prosthetic and radiographic procedures. Application of this convenient anaesthetic spray to the posterior portion of the palate permits impressions to be made or film packets to be placed with much less discomfort to the patient. The improved prosthetic and radiographic results and the saving in time, materials and frustration are probably the greatest benefits derived from its use.

Most patients, particularly the apprehensive ones, accepted the use of the topical anaesthetic spray well. The majority commented on its effectiveness in reducing the discomfort of the minor procedures detailed above. Some patients commented on the relatively pleasant flavour of the spray.

SUMMARY

The usefulness of a topical anaesthetic spray in a number of minor dental procedures has been outlined.

The value of topical anaesthesia to the dental operator, in time and materials saved and improved results gained, and to the patient, in lessened discomfort, has been demonstrated.

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REIMPLANTATION - A TECHNIQUE FOR DEFERRING THE LOSS OF POSTERIOR TEETH

MAJ AL Kelland, CD, BA BEd, DDS

In a military dental practice there are certain positive indications for reimplantation of teeth that otherwise would be lost. Many, or indeed most of our patients are young, healthy individuals whose reparative powers are at their best. Since this is so, the favorable prognosis of the following technique promises a very rewarding experience both for the dental surgeon and the patient.

General

Advantages of reimplanting posterior teeth

1. Maintains the integrity of the dental arch where prosthetic replacement of a single tooth is not contemplated.
2. Defers the necessity of prosthetic replacement.
3. Satisfies the patient who desires to retain his own teeth as long as possible.
4. Offers the most complete dental care possible for our military personnel.
5. Reduces the dental officer and laboratory technician working time by eliminating the necessity of constructing a fixed bridge replacement.

Indications for reimplantation of posterior teeth

1. Teeth for which conservative endodontic treatment is not feasible because of instrumentation difficulties.
2. Teeth which are chronically abscessed.
3. Teeth for which conservative treatment by root canal and subsequent apicoectomy are not indicated.
4. Teeth where the time required for conservative treatment is not available.

Contra-indications for reimplantation of posterior teeth

1. Acutely abscessed teeth.
2. Teeth which fracture during extraction.
3. Teeth whose roots must be sectioned before extraction.
4. Teeth with advanced periodontal involvement.
5. Uncooperative patients or those not available for post operative treatment.

Technique for Reimplantation

Employ an "Aseptic" Technique

1. All instruments must be sterile.
2. Prepare the gingival crevice and local operating area with a suitable topical antiseptic (metaphen, merthiolate or Zephiran).
3. Give patient 1/150 gr. atropine sulphate one hour before the operation.

Extraction Technique

1. Perform the extraction as atraumatically as possible. It is better to lay a flap and remove a controlled amount of buccal bone than to fracture the crown of the tooth or an excessive amount of buccal plate.
2. Curette the extraction socket free of any debris and place sterile gauze over the wound. Have the patient close on the gauze until the tooth is ready for reimplantation.

Endodontic Treatment

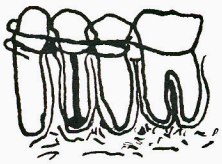
1. The endodontic instrumentation and treatment of the tooth is accomplished in the hand and can be completed from both ends of the tooth, if necessary. It is important to keep the root area from drying out, by wrapping it in a sterile saline soaked sponge.
2. The root tips should be amputated with a disc before filling the canals. This facilitates the reimplantation of the tooth into the socket.
3. The canals are enlarged, sterilized and filled by employing any suitable endodontic technique.
4. The tooth is then placed in a Zephiran Chloride aqueous solution (1:1000) for 15 minutes before replantation into its socket.
5. If difficulty is encountered in reinserting the tooth into its socket, have the patient bite it into place by applying the pressure of his occlusion on a tongue depressor placed on the reimplanted tooth.

Stabilization Procedure (Fig 1)

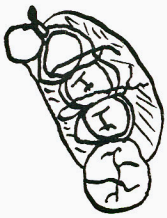
1. The reimplanted tooth is stabilized by splinting it to the adjacent tooth with 24 gauge ligature wire.
2. Sutures may be inserted through the interdental papillae if necessary for good tissue adaptation.
3. A periodontal pack may be placed around the tooth to keep the gingival crevice free from saliva and food debris until initial healing of the tis-

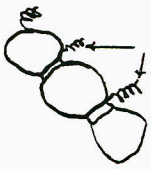
sue has occurred.

WIRE SPLINT TECHNIQUE



1st wire around three teeth





2nd and 3rd interdental wires

Fig 1

Post Operative Treatment

1. Post operative pain is usually negligible; however, it is always wise to prescribe an analgesic and an antiseptic mouth wash.
2. Antibiotics need not be employed and should be used discriminately.
3. Have the patient return in 24 hours to check on the stability of the wire splint and occlusion.
4. Remove sutures and periodontal pack in approximately five days.
5. Make a weekly check of the wire splint and remove it in four weeks.
6. Extract the tooth if an acute infection should occur.

Prognosis

1. The common result of reimplanted teeth is the resorption of the roots with replacement of the dental tissue by bone.
2. A successful replant can last as long as 20 years.
3. If the replant survives five years in the patient's mouth, it is considered a successful replant.

THE LAST DAYS OF THE RCDC IN WHITEHORSE

CAPT JJ Erskine, DDS

The history of the Royal Canadian Dental Corps on the Alaska Highway spans the twenty-two year period from April 1954 to July 1, 1968. Colonel (now Brigadier-General) Kearney's article in the January 1965 issue of the RCDC Quarterly covered the period from 1946 until the Northwest Highway System was handed over to the Department of Public Works on April 1, 1964 and this article is concerned with the period from April 1964 to the recent closure of CFS Whitehorse and, with it, No 6 Dental Clinic.

In early 1943 the Northwest Staging Route was established with Whitehorse as a Staging Unit. This route was a joint effort of the United States Army Air Force and the Royal Canadian Air Force to supply the defenders of Alaska, and was used as the ferry route for lend-lease aircraft enroute to Russia. In 1944 Northwest Air Command was formed, part of which was No 5 Staging Unit, later renamed RCAF Station Whitehorse. A lodger unit, No 5 Radio Unit, was the prime employer so consequently in 1966 the station became CFS Whitehorse under command of Canadian Forces Supplementary Radio System.

The staff of No 6 Dental Clinic in the spring of 1964 consisted of Captain GA Johnson, Sergeant RL Thornton and Mrs Olga Johnson. Captain Johnson had the unique experience at this time of helping to found the Yukon Dental Association. There were four charter members and each received a moose hide certificate of registration.

Clinic personnel passed the summer and early fall in much the same manner as their predecessors by hunting, fishing and becoming involved in the community. During this period, the pedo-ortho component of the clinic practice grew, and Sergeant Thornton started night classes at the Vocational School in welding, presumably to help him to solder retainers. Around Christmas time trouble was experienced with the heating pipes and Sergeant Thornton's newly acquired skills were put to use in thawing them out.

The winter of 1965 passed slowly, broken only by a brief flurry of annual madness, the Sourdough Rendezvous. This mid-winter carnival is designed to keep the natives from getting too involved in their own problems and to let them have a little fun during that long cold night they call winter. During this time, Sergeant Thornton, who had taken up painting, managed to sell several of his oils which he had entered in the Rendezvous exhibit.

By June the ice was gone on the lower lakes and a change-over of personnel was imminent. Captain George Johnson and Sergeant Thornton, were posted and only the DO was replaced. Full circle from 1946; back to one DO and an assistant.

Major JI Gordon arrived in August of 1965. The Major's trip up the Highway is noted in his progress report: "...lost one tire, wheel rim, and one headlight with assorted nicks and marks on the windshield." I'm sure that story has a faintly familiar ring to anyone who has driven that gravelled trail.

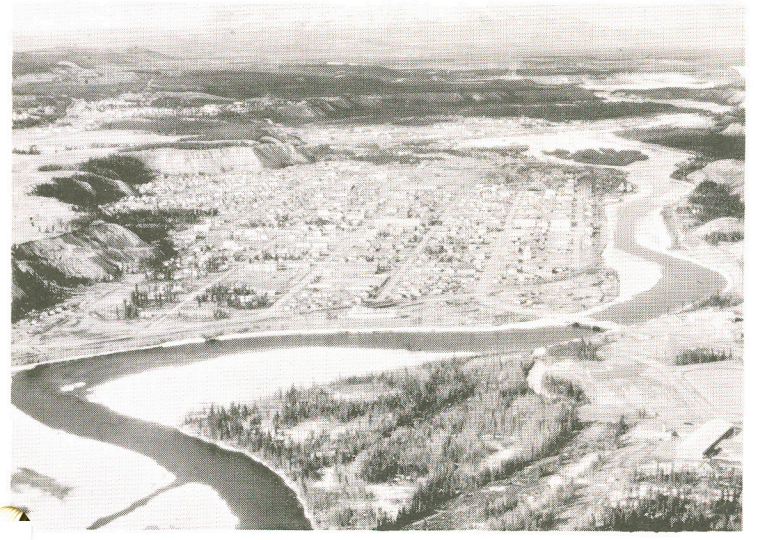
By October there was snow on the ground and the temperature was averaging twelve below zero. Major Gordon passed the winter working and curling and, right on

home in January, the pipes froze again. Another three days of Sourdough Rendezvous brought a noticeable increase in moustaches on the station. As the Major said: "It is a long, long winter."

Major Gordon was relieved by Captain MB Kricken in June 66 and Captain Kricken's score on the Highway was three flat tires.

With the arrival of Captain Kricken and amid rumors of the station closure the practice in No 6 Clinic settled into its final phase.

In August 1966 the laboratory equipment was returned to QM 11 Coy during a visit by Captain Hunter.



Whitehorse and the Yukon River.

January of 1967 was noteworthy in that the heating pipes did not freeze, however, the unit went U/S. Ah well. During this winter, Captain Kricken played goal for the Air Force Kodiak hockey team and he must have been a pretty good goalie because they won the Commercial League championship (for the last time).

In May 1967 Colonel GC Evans, Commanding Officer of 11 Dental Unit visited Whitehorse and inspected the facilities. There is no official record of whether or not he caught any fish.

The end of July 1967 saw the final change-over in Dental Officers on the Highway with Captain T Erskine replacing Captain Kricken. On Captain Erskine's maiden fishing trip on Discovery Day, August 17 his only catch was the head of a previously caught and cleaned fish. On the way home he got a rock through his windshield and two flat tires - with only one spare in the trunk. The station CO and the SSupO, who were in convoy with Captain Erskine, tried to comfort him but were laughing so hard they were of little help.

In September Mrs Olga Johnson terminated her long employment to accept a more permanent position with the Territorial Government. This situation was fairly common at this time as the civilians knew the station was closing and were naturally seeking permanent employment elsewhere. We were sorry to see Olga go.

Private Rich North arrived in October to take up duties as DA. Shortly thereafter he attempted his trade test, passed and was promoted to Corporal.

Christmas was heralded by that fine old Whitehorse ritual, the Christmas Tree Hunt. Trees were gathered for wives of men away at Alert and for the various messes and halls. The efforts of the choppers were greatly aided by large jugs of hot "Yukon tea" provided by the Sergeants Mess.

The last New Years Levees were frantic affairs and the new year promised to be one long social event as it was fairly firm now that the station was closing July first.

Colonel GC Evans made his final visit to Whitehorse in January 1968 and in February the Commander of CFSRS confirmed that we would be out of Whitehorse on July 1, 1968.

Spring was an exciting time with a surge of bonspiels and a multitude of farewell parties and dinners. The people of Whitehorse did everything possible to show the servicemen how much their contributions to the community were appreciated and in May a parade was held in Whitehorse to commemorate the departure of the RCAF from the territory.

With all the confusion attending station closure, clinic closure, postings, leave and goodbyes, June passed very quickly. MWO Conkey arrived from Edmonton to remove the units and to enjoy one last look at the Yukon where he had served in 1949. No 6 Clinic was now officially closed.

Thus, a little over twenty-two years after Captain JA Allan arrived aboard DC 3 'Gravel Gertie', the RCDC left the Yukon. There was no ceremony. Captain Erskine merely turned over the building keys and inventory, said a few goodbyes and swung out on the Alaska Highway to join the dusty caravan south.

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GOOSE BAY - THE FINAL CHAPTER

LCOL RA Fell, CD, DDS

The Canadian Forces were pulled out of Goose Bay and the Base and its operation was turned over to the Department of Transportation on 1 Aug 67.

In December 66, the Base Commander, Group Captain RFM Walker, called all section heads together and announced that the Base would be turned over to the Department of Transport. Each section was to prepare a phased shut-down program to be incorporated into the base program and so planned that no essential service would be lost to the personnel who would be last to leave. Consideration had also to be given to the crating and shipping of a vast weight of equipment and supplies.

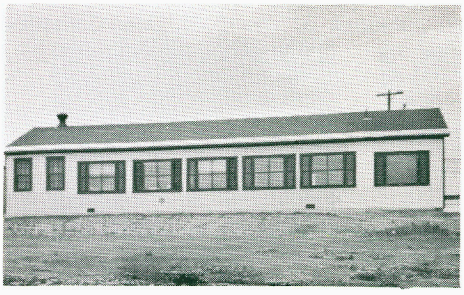
At this time, Dec 66, the clinic had two operating bays with LCOL Fell and CAPT Dippel, and a dental laboratory with CPL Mitrikas. There were three dental assistants, CPL Patterson (RCAF), CPL Russell and CPL Wormington. The technician clinical position had been left vacant when MWO Tapp left in Aug 66.

The first phase of the shut-down was completed on 22 Feb 67 when all dental equipment associated with the third operating bay plus other non-essential clinic equipment was shipped out.

In May 67 arrangements were made with the USAF to provide dental care for a group of RCAF personnel who were to remain until DOT had trained men for Air Traffic Control and the small administrative unit that would remain to support these men. Treatment also had to be arranged for the RAF Detachment. In addition, the RCDC would send up a dental team on periodic visits. This team would provide its own dental supplies and instruments but would be allowed the use of a completely equipped operating bay in the USAF clinic.

In the course of destroying old dental records an unpaid civilian account was discovered in the amount of $56.00. The patient advised us that she would be unable to pay her debt before our deadline but promised to send the money by mail. We had to accept her word. It was with considerable satisfaction that we found in researching for this report that the bill had been paid. There are some honest people left in the world.

In late July all remaining equipment and personnel were gone. The RCAF Inventory of Building 82 was turned over to DOT and CPL Russell locked the door. LCOL Fell, CPL Russell and CPL Ritchie boarded the outgoing plane on 28 Jul 67. We have heard that DOT will use the building for living quarters.



Above - Goose Bay Dental Clinic 1967

Right - The last of the RCDC - CAPT Dippel, PTE Paquet, CPL Russel, CPL Ritchie, LCOL Fell

Two visiting teams have since returned to the Goose. The first in Dec of 67 consisted of MAJ Gordon and SGT Hill; the second in Jul of 68 consisted of CAPT Berthiaume, CPL Olinik and WO DeBlois.

The Dental Clinic at Goose Bay has been the responsibility of 15 Dental Unit since 1951. Commanding Officers have been, in turn, LCOL PR LaSalle, LCOL CW McCrary, COL TL Marsh, LCOL JG Butler, COL RB Jackson and COL CM Cornish.

The following names and dates should be added to those compiled by LCOL JM Smith in his report in the RCDC Quarterly of Apr 66:

1961 - SGT T Hussey(second tour)
1964 - MWO M Tapp (second tour)
1965 - SGT E Borden, CPL R Wormington
1966 - LCOL R Fell (second tour), CPL L Russell, CPL W Mitrikas, SGT M Tremblay, CPL Anderson, SGT D'Avigon (second tour)
1967 - CPL Burns, CPL Gapmann, CPL Ritchie, PTE J Paquet

RCAF Assistants - AW Babish, CPL Maklitz, CPL Scarborough, CPL Patterson

* Editor's Note

Appologies are extended to veterans of service in Goose Bay whose contributions have not been acknowledged. Space limitations and lack of detailed records makes it impossible to adequately describe the part played by many others who have had short tours of duty at "Robert Michelin's Berry Patch".

SIXTH ANNUAL RCDC GOLF TOURNAMENT

On 20-21 Sep 68 the RCDC School again hosted the annual RCDC Golf Tournament at the Circled Pine Golf Club CFB Borden. A record turnout of 101 eager golfers representing all RCDC units in Canada participated in the two day event. The Officers' Trophy for team play was won by the RCDC School team and various individuals won 23 other prizes.

On the final evening over 120 members of the Corps attended the banquet and presentation of prizes and awards.

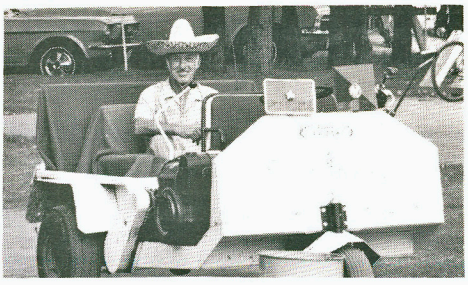
Everyone had a wonderful time and the staff members of the RCDC School received many well deserved compliments for a job well done.

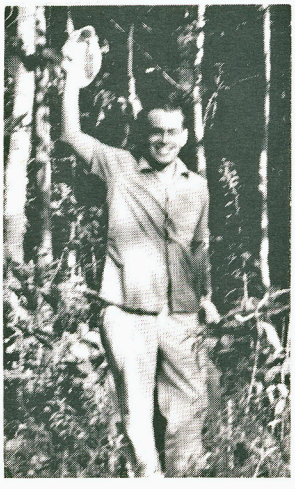
Top Left - BGEN BP Kearney presents the RCDC(R) Officer's Trophy for team competition to winning team from the RCDC School.
L to R - CWO Tom Batten, (BGEN Kearney) COL LG Craigie and CPL John Clint.

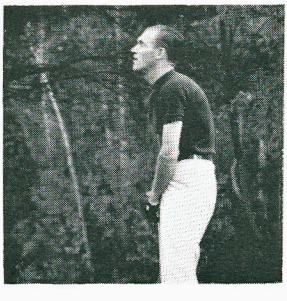
Top Right - BGEN BP Kearney presents the KM Baird Trophy for tournament low gross for for 36 holes to CWO Tom Batten whose score was 164.

Bottom Left - COL Covey presents the GR Covey Trophy for low gross for 18 holes to CAPT DA Devine. His score - 80.

Bottom Right - MAJ Henry Marion presents the prize for tournament low net (147) to BGEN BP Kearney.







Some of the action - SIXTH ANNUAL RCDC TOURNAMENT - 1968

Division News

Visits and Inspections

BGEN BP Kearney and Major Chatwin visited the three Service Colleges in Victoria, Kingston and St Jean, PQ to introduce the preventive dentistry program instituted this year for the Cadets.

Major Chatwin visited the recruit training centres in St Jean and Cornwallis as well as CFB Gagetown to introduce the preventive dentistry program instituted this year for new recruits.

LCOL Fletcher travelled to London England in September to attend a cataloguing meeting and then visited the European Bases to review the dental stores procedures.

LCOL Pierce visited the RCDC School prior to the DOTP Graduation ceremonies to interview the cadets.

Postings

SGT Ken Shergold left the Division on posting to the Canadian Air Borne Regiment in Edmonton. He can be certain that he is missed since no replacement was provided.

11 Dent Unit

In Memorium

The many friends of WO2 Bill Powers (retired) will be saddened to learn of his death on 9 Aug 68 in Victoria. The Corps was represented at his funeral by CWO Greco and WO Storms.

Sports

Golf

This Unit was represented by five golfers and one non-golfer at the recent RCDC Annual Golf Tournament and they did not return empty handed. Our total haul of prizes was "one golf ball".

SGT Walker RS won the Tournament low net in the Labour Day Weekend Tournament held at Namao.

Swimming

CAPT Rosengart contributed to the success of CFS Holberg in capturing second place in the "100-hr swim" which is an annual competition held by radar stations across Canada. He completed the 12 mile maximum allowed per man within the specified time.

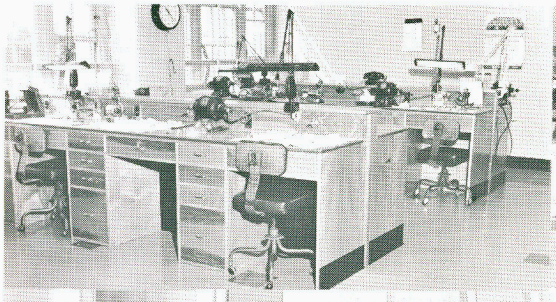
Hunting

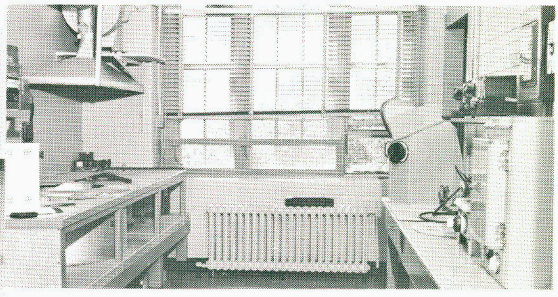
With all the hunting and fishing success of personnel throughout the unit, the meat departments of local groceterias should suffer a marked reduction in sales this winter. CAPT Walls and CPL Clifton of Esquimalt claim 35 pounds of salmon taken during a morning's fishing. CAPT Dunnigan and CPL North took time out from a heavy workload at Alsask for goose shooting and SGT Looker of CFB Penhold reports a 12 lb Jack. The most fortunate sportsmen, or at least the best story tellers, are based at Cold Lake, where CWO Daw claims a deer, moose and four grouse. Not to be out-done, CAPT Pankratz during the same month scored a moose, a deer and 6 grouse. However, the laurels go to COL Evans for activities ensuring success in stocking the larder. He recently contributed 64 lbs of King Crab (legs only) to local deep freezers by purchasing them on a recent liaison visit to CFB Comox via Kodiak Alaska.

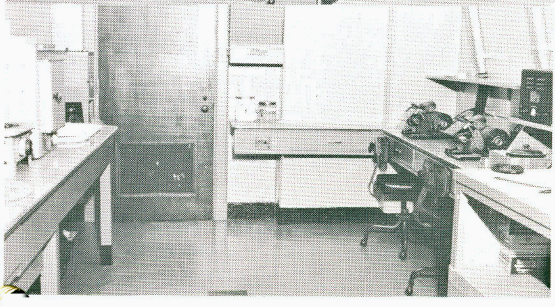
12 Dent Unit

Accommodation

Central Laboratory CFB Halifax







The laboratory in Stadacona, so well known to a great number of RCDC personnel has finally been renovated. A great deal of credit should go to Major Franklin and MWO Laurence for the planning and assistance given the local CE staff.

Sports

CPL Mason was a member of the Zone 7 Softball Team which competed in the Canadian Forces playdown in Winnipeg.

CAPT Cragg was the runner-up in the Zone 8 tennis tournament held at CFB Greenwood 15-16 Aug 68.

Wings Parade

Major Cobb pins a Radio Navigators Wing on his son LT Thomas R Cobb during graduation ceremonies at the Air Navigation School in Winnipeg.

13 Dent Unit

Retirements

WO Kennedy and MWO Blackmore have retired from the service after long and faithful service. Best wishes are extended to Tiny at University of Western Ontario and Vince in British Columbia.

Special Event

Miss Catherine Kidd, daughter of MWO "Mickey" Kidd of the dental detachment at CFB Trenton, entered a 30 mile walkathon sponsored by the Belleville Kiwanis Club to raise money for the purchase of an intensive heart care unit for the Belleville General Hospital. No 13 Dental Unit personnel at Trenton pledged $5.00 per mile and Catherine completing the walk to earn $150.00 for the Kiwanis.

14 Dent Unit

Accommodation

The unit HQ, clinic, and central laboratory are now comfortably settled in their newly acquired quarters.

Top Left - WO Strubb at work in the Dental Stores
Bottom Left - WO Stewart in the equipment repair station
Top Right - MWO Mann, SGT Roy and CPL Cormie in the bright new Central Laboratory
Bottom Right - Miss Morken preparing one of the operating rooms

Outstanding Jr NCO

CPL Dale was presented with a plaque by LCOL Butcher on behalf of the Commandant of the Combat Arms School at CFB Borden for standing second in a recent Jr NCO course. Major Begin adds his congratulations.

15 Dent Unit

Retirements

Major Gaudet, MWO Arsenault and SGT Hughes were honoured on completion of their service in the Canadian Forces. Major Tom Gaudet is opening a practice in Weymouth, NS. Andy Arsenault will be residing in Shediac, NB and John Hughes in London, Ontario.

Sports

CAPT JLPA Berthiaume has been appointed assistant coach with the CMR Football Team.

Major JFA Marcil won the CFB Valcartier Golf Club Championship and was again a member of the winning team in the Valcartier Zone 6 Golf Championship.

1 Dent Unit

Retirement

A party was held at CFB Rockcliffe on 28 August to bid farewell to SGT "Red" Arnsby who is retiring after 20 years service to take a position at the Faculty of Dentistry, University of Toronto.

Golf

WO Torrens won a prize as the best woman golfer at the RCDC Tournament. PTE Lamontagne won 1st low gross "B" Flight. SGT Hill had the longest drive.

4 Fd Dent Coy

Conferences and Meetings

LCOL Windsor, CAPT Swanzey and CAPT Wood attended the USAREUR Dental Training Conference in Garmisch Germany from 25 to 27 Sep 68.

Major Deyette and CAPT Depledge attended the USAFE Dental Training Conference in Wiesbaden Germany from 11 to 13 Sep 68.

Hospital

Best wishes for a speedy recovery are extended to SGT Schuh who received extensive injuries in a vehicle accident.

Sports

LCOL Windsor has been appointed President of CLFE Curling Club.

35 Fd Dent Unit

Conferences and Meetings

LCOL Protheroe, Majors Cyrenne and MacDonald, and Captains Adams, Boston, Cooper, Fortier, MacKenzie, and Stansfield attended the USAREUR Dental Training conference in Garmisch from 25 to 27 September. LCOL Protheroe presented a paper on Auxiliary Dental Personnel in the RCDC which was well received.

LCOL Protheroe attended the USAFE Dental Training Conference in Wiesbaden Germany from 10 to 13 September.

Sports

LCOL Protheroe and Major Mason participated in the Air Div HQ and 1 Wing Golf Tournament on September 18 and were prize winners. No report was received of what the prizes were awarded for.

Leave

The members of the unit visited many countries of Europe on leave during the summer and returned home full of enthusiasm for the marvellous sights they saw. The most recent attraction has been the Octoberfest in Munich and "Dirndl" and "Leder Hosen" are now the costumes of choice at local parties.

Dent Det Cyprus

Rotation

CAPT Nadeau, SGT Forsyth and CPL Dannyluck have completed their tour in Cyprus with the PPCLI and are being replaced by CAPT Dion, CPL Stanaboug and CPL Bernier who will serve with the 3rd Battalion R22eR.

Entertainment

On 7 Sep 68, local talent produced a brilliant show "Farewell to CML". CPL Dannyluck and his group known as the "T Birds" were the star performers.

DENTAL OFFICER TRAINING PLAN 1968

Graduation Parade

Practical Phase DOTP training was conducted at CFB Borden during the summer culminating in a marching out parade and graduation ceremonies at the RCDC School on 8 Aug 68. BGEN BP Kearney inspected the cadets and took the salute.

Left - BGEN BP Kearney presents Third Phase Honour Cadet Trophy to 2LT JC Steel (University of Alberta).
Top Right - COL LG Craigie presents Second Phase Honour Cadet Trophy to 2LT FVR Jackson (Dalhousie University).
Bottom Right - LCOL AG Andrews presents the Chief Instructor's Trophy to 2LT R Gish (University of Alberta).

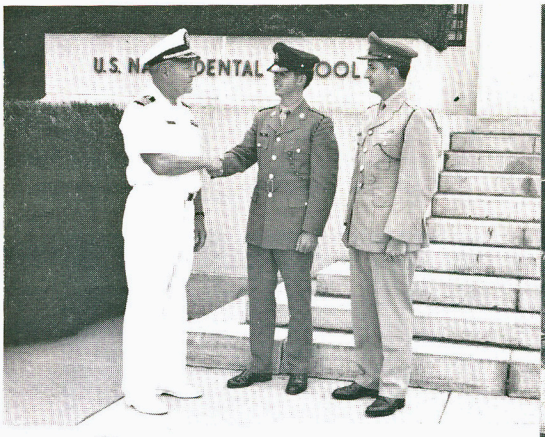
O/Cdt JJJ Lemieux (University of Montreal) was named Honour Cadet, First Practical Phase.

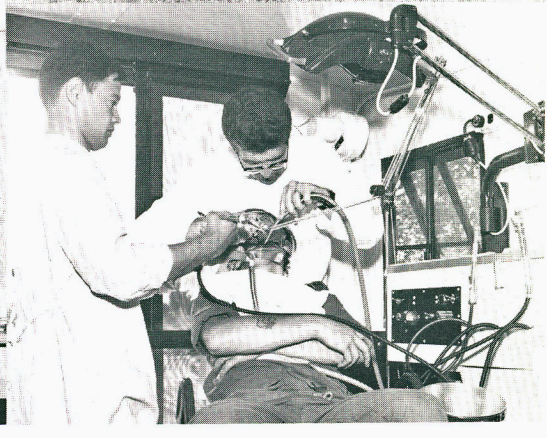
2LT JM Cherun (Dalhousie University) was presented the Third Phase Honour Cadet Runner-up Award.

2LT FR Margetts (University of Alberta) was presented the Second Phase Runner-up Award.

Field Exercise - 3rd Phase DOTP 22-26 Jul 68

A five day field exercise was conducted at Meaford, Ontario, utilizing three mobile dental vans and a lecture room with six operating areas. The candidates worked in pairs and were rotated through all operating positions to gain experience in using field equipment.





Top Left - Third Phase DOTP visit US Naval Dental School

CAPT WC Wohlfarth Jr - Commanding Officer US Naval Dental School, 2LT DB Smith - Third Phase DOTP and MAJ JN Wright RCDC - Tour Conducting Officer.

Top Right - Third Phase DOTP candidates and instructors on a field exercise at Meaford, Ont.

Bottom Left - Clinic manager 2LT DB Smith (U of Toronto) allots patient to 2LT RD Carver (McGill) while CAPT NS Misura looks on.

Bottom Right - 2LT AJ Burns (U of Toronto) treats a patient in a dental van with the assistance of 2LT JSHL Duchesne (U of Montreal).

Familiarization Tour of Military Installations,
Washington, D.C., USA (27 Jul-3 Aug 68)

One of the highlights of Phase 3 DOTP this summer was the Washington tour. The tour began with departure from Base Borden via aircraft to Andrews Airforce Base on 27 Jul 68, under the supervision of the Tour Conducting Officer, Major Jim Wright.

The one-week tour included visits to: Dental activities - Walter Reed Army Medical Center, Institute of Dental Research - National Institutes of Health, and Naval Dental School - National Naval Medical Center. Also, visits were arranged to: The Whitehouse, The Smithsonian Institute, and the US Marine Barracks.

A series of professional lectures from staff instructors at the Naval Dental

School and Walter Reed Dental Activities were much appreciated and proved invaluable to the hungry minds of our 3rd Phase DOTP.

Among the dignitaries the candidates met were Major General Robert B Shira, Assistant Surgeon General and Chief of US Army Dental Activities and Brig Gen James S Pegg - Director Dental Activities (WRAMC).

At 0900 3 Aug 68, the group departed from Andrews Airforce Base for CFB Borden, very appreciative of all they had seen and heard from the Washington tour. This was certainly an ideal way for these young dental officers to finish their nine-week summer program, and they took fond memories back with them to their respective universities.

Officers Clinical Course (Oral Surgery) 5 Sep-20 Sep

A two-week plus course in Oral Surgery was held at the RCDC School under the skillful direction of LCOL AG Andrews. The six candidates included LCOL WW Anglin (13 Dental Unit), Major NW Brogan (11 Dental Unit), CAPT GS Zwicker (14 Dental Unit), CAPT DC Morgan (13 Dental Unit), CAPT JM Steadman (14 Dental Unit), CAPT JL McNeil (11 Dental Unit). The course provided members with an opportunity to perform exodontia and minor oral surgery with specialized training in clinical procedures.

Retirement

A farewell party was held at the RCDC School to wish "bon voyage" to some of the staff retiring from the Corps. They included Majors "Bill" Murray, "Bob" Bryant, CWO "Tom" Batten, and SGT "Ken" Rothwell. Everyone in the RCDC is sorry to see them go, and wish them the best in their future endeavours.

Dental Liaison Officer Visits RCDC School

Colonel "Bill" Wakefield from the Dental School at San Antonio, Texas, visited the RCDC School as a Liaison Officer of the US Dental Corps. An exchange of ideas on training and preventive dentistry was afforded by his visit. COL Wakefield stayed for the RCDC golf tournament on 20-21 Sep; and was presented with an RCDC plaque by the School Commandant, COL LG Craigie before his departure.

1 Dent Eqpt Dep

The fishermen of the unit report only fair to good results in their search for pickerel.

The depot team entered in the RCDC Golf Tournament unfortunately had to withdraw thereby giving second and third place teams a chance at the top money.

Professional Training

University of Michigan, Ann Arbor, Michigan, USA

MAJ	CL	Gullekson	- Crown and Bridge Prosthesis	-	11-22 Nov 68
CAPT	JAA	Boucher	- Guiding Occlusal Development	-	4-8 Nov 68

Walter Reed Army Medical Centre, Washington, DC, USA

MAJ	LA	Reynolds	- Periodontics 2nd (final) yr of Residency	-	Oct 68-Aug 69
CAPT	IC	Wambera	- Preventive Dentistry	-	14-18 Oct 68

US Naval Dental School Bethesda, Maryland, USA

CAPT	JAAL Carrier	-	Removable Partial Dentures	-	28 Oct- 1 Nov 68
CAPT	DNH Charles	-	Complete Dentures	-	30 Sep- 4 Oct 68
MAJ	JOL Bourget	-	Fixed Partial Dentures	-	23 Sep- 8 Nov 68

Royal Canadian Dental Corp School, CFB Borden

Officers Clinical Course Oral Surgery 4-19 Sep 68
LCOL WW Anglin; MAJ HW Brogan; CAPTs GS Zwicker, DC Morgan, JM Steadman, JL McNeill

Fixed Partial Dentures 3-18 Oct 68
CAPTs EI Gerard, DG Wilson, JW Bergerman, DA Humphreys, JLPA Berthiaume, JLAR Bourcier

Training

Royal Canadian Dental Corp School, CFB Borden

Dental Assistant Pay Level 3 - 7 Oct-6 Dec 68
CPL(AF) Doucet JC, CPL(A) Griffiths JW, CPL(A) Kallman LJ, CPL(A) Langford DT, CPL(AF) MacAulay DA; PTE(AF) Christal DR, PTE(AF)(W) Dumont MML, PTE(A) Hopkins JD

Dental Laboratory Technician Pay Level 5 - 3 Sep-25 Oct 68
CPLs Allen ML, Ayerst HE, Buxton WD, Hope NJ, Gapman HKK, Larouche JA, Peck AH, Todd RE

Dental Laboratory Technician Pay Level 6 - 4 Oct-20 Dec 68
SGTs Hardy DH, O'Mara TR, Pink A, Roy JRR; CPL Mandrusiak OW

No 1 Dental Equipment Depot - CFB Petawawa

Dental Equipment Maintenance Technician Pay Level 5 - 3 Sep-20 Dec 68
CPLs Boulianne JAL, Gratton JRY, Harkin PE, Longford MD, Violette JLA

Canadian Forces Staff School
CAPT FH Harreman

Canadian Forces School of Intelligence and Security

Sr NCO course - 17 Oct-14 Nov 68
CPLs Alkenbrack AM, Atherton JA, Kalmet M, Mitrikas ZW, Olinik MG, White JM

Sr NCO course - 18 Nov-13 Dec 68
CPLs Challenger GN, Heather CSB, McDonald GK, Ritchie JR, Schultz EF, Jack A, Hatcher LR

Welcome to the Corps

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

LT RD Townshend; CPLs Denis MJ, Griffiths JW, Jenereaux WK, CPL(AF) MacAulay DA, CPL(AF)(W) Price EI; PTE(AF) Christal DR, PTE(N) Hebert RL, PTE(N) Nesrallah JW, Shirley E MacDonald, Miss Gail Thorp, Mrs E Powell, Mrs Macklin; CPL(AF) JC Doucet; Mrs D'Amour

Promotions

To MAJ - AN Swanzey
To CAPT - EM Lobb
To OC - CPL KV Hansen - DOTP University of Manitoba
To SGT - Highfield NL
To CPL - Bernier JG, Brophy GL, Craig MJ, Dale JE, George HBM

Retirements and Releases

MAJ RJ Bryant, MAJ TC Gaudet, MAJ WH Murray, MAJ JJL Girard, MAJ AT Hinch; CAPT JG Thompson; CWO TL Batten; MWO Arsenault AJ, MWO Blackmore VO, MWO Kennedy FM; SGT Arnsby WJ, SGT Hughes AJ, SGT Rothwell KS; CPL Deveaux CW, CPL Hansen KV, CPL Thompson RE; PTE(AF)(W) Verret PA; Mr R Avon, Mr R Mills; LCPL Arklie HE; SGT Heard JF; PTE(AF)(W) Lemoine BA; Mrs I Pollock, Mrs F Bussieres, Mrs MH Despres

Vital Statistics

Marriages

PTE(A) Cudmore WG to Miss Darlene Marcia Dowhaniuk, PTE(A) Lambert LA to Miss Anita-Mayer Andrews, PTE(AF)(W) Cook MA to CPL Chapman AW, PTE(AF)(W) Graham RA to RJ Verret; CPL(A) Bosch P to Miss Margaret Caughlin; PTE(AF)(W) Brayton J E to CPL RH Zarudzki, PTE(A) Cloutier JRA to Miss Marie Jeannette Regine

Births

Daughter - CAPT & Mrs JFD Cormier, CAPT & Mrs JW Bergerman, CAPT & Mrs RP Meunier, CAPT & Mrs JD McCallum, CAPT & Mrs V Rausch; CPL & Mrs EJ Schultz, CPL & Mrs JA Larouche

Son - CAPT & Mrs DG Jones, CAPT & Mrs DNH Charles, CAPT & Mrs DE Gibbs; SGT & Mrs B Vandervaart (adopted); CPL & Mrs PJ Armstrong

Bereavement

All members of the Corps extend their deepest sympathy to SGT Dowell of No 12 Dental Unit and CPL Larouche of No 15 Dental Unit on the recent loss of their wives.

Notice

Remember the 7th annual RCDC Bonspiel to be held in Camp Borden 21-22 Feb 69.

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With this edition readers will note a change in the Editorial Board for the RCDC Quarterly. LCOL LA Richardson replaces LCOL G MacDougall.

The Editorial Board wishes to express the appreciation of all readers of the RCDC Quarterly to LCOL G MacDougall for his editorial work during the last three years.