The ROYAL CANADIAN DENTAL CORPS Quarterly

VOLUME 10 NUMBER 2 JULY 1969

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The RCDC Quarterly

Published by authority of Brigadier-General BP Kearney, MBE, CD, QHDS

This publication serves as a means for the exchange of ideas, experiences and information within the Royal Canadian Dental Corps. Views and opinions expressed are those of the authors and are not necessarily those of the Director General of Dental Services or the Department of National Defence.

Subscription Rates

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

Director General of Dental Services
Canadian Forces Headquarters
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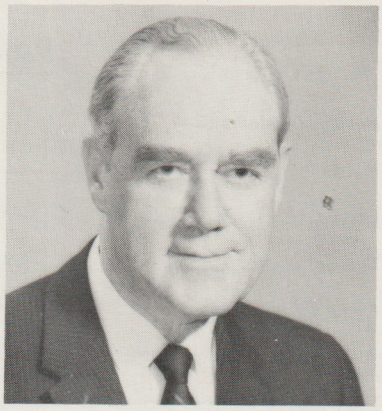
Ottawa 4, Ontario

Cover Photograph

CPL GN Challenger RCDC displays his military and musical talent as General JV Allard, Chief of the Defence Staff inspects Canadian Forces personnel in Cyprus.



ORAL DIAGNOSIS AND RADIOGRAPHY

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In the current practice of dentistry probably the two most neglected areas are history taking and quality oral radiographs. It is not so much the fact that these areas were deficient in the undergraduate curriculum as that they drift into a de-emphasized category in the office of the busy practitioner.

Someone once said "never treat a stranger" and this is just another way of stressing the fact that a history should always be obtained. There are many types of questionnaires that the patient can partially or fully complete by check marks. In some offices the dentist prefers to discuss the history directly with the patient. In my opinion the first method is a time saver and a preparation for a follow-up discussion with the Doctor. The Dental Hygienist or experienced assistant can help the patient with this preliminary examination. See Figure 1.

Following a history and a thorough clinical examination, it would be reasonable to expect to obtain all the information possible about this patient before finalizing a treatment plan. One of the areas of additional information is the radiographic survey. It is much better to explore with an x-ray rather than with a bur or a scalpel. If a radiological record is not in your possession a complete survey should be done. This consists of a minimum of 20 to 24 films where regular size films are used for the posteriors and interproximal areas, and the narrow (numbers 0 to 1) for the anterior. All areas must be included.

An x-ray is simply a shadow record and it may be of interest to review the rules of shadow casting:

1. The source of light should be as small as possible.
2. The distance from the source of light to object should be as long as possible.
3. The distance from the object to the recording surface should be as short as possible.
4. The object and recording surface should be parallel.
5. The source of light should strike the object and the recording surface at right angles.

After using the short cone for over twenty years and a long cone for the last nineteen years, I am personally convinced there are definite advantages in the use of the extended target-film distance. The paralleling technic is strictly one of film placement.[1] The extended target-film distance gives the operator the necessary latitude to increase the object-film distance in order to place the film in a plane parallel to a line drawn through the long axis of the tooth. With the short cone the object-film distance must be minimal, but the anatomical structure permits contact at the crown and about a 10 mm. object-film distance at the root apex - the specific area where the most accuracy is needed. This can easily be demonstrated by using a perforated bur tray out of a sterilizer or any piece of perforated metal or wire

Patient History and Registration

Personal Information

Name ..... Sex ..... Age ..... Number .....

Birthdate ..... Birthplace ..... Racial origin .....

Marital status ..... Date of Registration .....

Occupation ..... Firm ..... Address ..... Phone .....

Residential address ..... Residence phone .....

Forwarding address (friend or relative) ..... Phone .....

Personal physician ..... Address ..... Phone .....

Personal dentist ..... Address ..... Phone .....

The following questions to be answered by the patient. All information given is confidential.

Dental History

1. What dental condition concerns you at present? .....

.....

2. What is the history of this condition? .....

.....

3. Have you had regular dental examinations (at least annually) in the past? ..... Yes. No.
4. Have you had dental X-rays within the past year? ..... Yes. No.
5. Have you had teeth extracted due to accident, decay or periodontal (gum) disease. Underline which one(s) ..... Yes. No.
6. Have lost teeth been replaced by fixed bridges, partial dentures or full dentures? Underline which one(s) ..... Yes. No.
7. Have these replacements been satisfactory? ..... Yes. No.
8. Have you ever had root fillings? ..... Yes. No.
9. Have you ever had periodontal (gum) treatments? ..... Yes. No.
10. Have you ever had abcessed teeth, sore gums or sore mouth? Underline which one(s) ..... Yes. No.
11. Do you have any habits that may affect your teeth, such as clenching, grinding, nail biting, etc.? ..... Yes. No.
12. Do you maintain good oral hygiene by regular brushing? ..... Yes. No.

    How often? .....
13. Do you try to regulate the intake of sugar in your diet? ..... Yes. No.

    How? .....

Fig. 1

Medical History

1. Have you ever had a serious illness? ..... Yes. No.
2. Are you under the care of a physician now? ..... Yes. No.
3. Have you had a medical examination within the past year? ..... Yes. No.
4. Do you use medicine of any kind regularly? ..... Yes. No.
5. Have you ever had any of the following?
   - (a) Liver conditions ..... Yes. No.
     - Jaundice (yellow skin and eyes) ..... Yes. No.
   - (b) Diabetes (sugar disease) ..... Yes. No.
   - (c) Tuberculosis or any lung condition ..... Yes. No.
   - (d) Venereal disease ..... Yes. No.
   - (e) Heart or blood vessel condition ..... Yes. No.
     - high blood pressure ..... Yes. No.
     - stroke ..... Yes. No.
     - shortness of breath ..... Yes. No.
     - chest pain ..... Yes. No.
     - swollen ankles ..... Yes. No.
   - (f) Nervous conditions ..... Yes. No.
   - (g) Epilepsy ..... Yes. No.
   - (h) Cancer ..... Yes. No.
   - (i) Thyroid conditions ..... Yes. No.
     - experience of nervousness ..... Yes. No.
     - room temperature too warm or too cold compared to other persons ..... Yes. No.
   - (j) Kidney conditions ..... Yes. No.
   - (k) Arthritis ..... Yes. No.
   - (l) Gastro-Intestinal conditions ..... Yes. No.
     - nausea and vomiting ..... Yes. No.
     - altered bowel habits ..... Yes. No.
   - (m) Rheumatic fever ..... Yes. No.
     - if so, was there any damage to heart valves ..... Yes. No.
     - if so, were you confined to bed for a long period ..... Yes. No.
   - (n) Blood disorders ..... Yes. No.
     - anemia ..... Yes. No.
     - easy bruising ..... Yes. No.
     - excessive bleeding following injury, surgery or tooth removal ..... Yes. No.
   - (o) Allergic reactions ..... Yes. No.
     - do you ever have hay fever, asthma, hives or skin rash ..... Yes. No.
     - have any members of your family experienced any of these ..... Yes. No.
     - have you ever had a reaction to a local (dental) anesthetic ..... Yes. No.
     - name and address of dentist .....
     - have you ever had a reaction to
       - aspirin ..... Yes. No.
       - penicillin ..... Yes. No.
       - iodine ..... Yes. No.
       - sulfonamides ..... Yes. No.
       - barbiturates ..... Yes. No.
       - other medicines ..... Yes. No.
6. Have you ever had injury to your face or jaws ..... Yes. No.
7. Have you ever had surgery or X-ray for a tumor, growth, or any other condition in the mouth or on the lips ..... Yes. No.
8. (Women) Are you pregnant ..... Yes. No.
9. Are you on a diet? Physician's orders or self imposed ..... Yes. No.
10. Is there any history of family disease? ..... Yes. No.

Patient's Signature— Checked By—

.....

Fig. 1 (Continued)

screening. Place a film in contact with the metal and expose, then increase the distance between the metal and second film by one centimeter and make a further exposure. Repeat this with a 16" target-film distance. Process and compare the films as to the size and definition of pattern. If you wish to go one step further, place the first two films at an angle as they would be in the mouth in relation to the lingual of the tooth crown and the root in the bisecting angle technic. Place the second film at an increased object-film distance but parellel to the metal and expose the films with a 7" and a 16" target-film distance, process, and compare.

Some of the advantages of the increased target film distance are as follows:

1. Quality definition of image (detail sharpness).
2. More exact relationship of anatomical structures.
3. Accuracy of image in alveolar, periodontal and periapical areas.
4. Less overlapping of the central beam.
5. Reduced secondary radiation.
6. Magnification and distortion reduced to the minimum.

The tubehead can now be obtained with a built-in long cone that projects no further than the short cone from the head of the machine. If the space around the operator's chair was the limiting factor, this is now the same for the short or long cone apparatus.[2]

The radiograph should display fine detail, good photographic quality and minimum image distortion. These films should be mounted in proper orientation and examined with a viewbox having an even intensity of light. The exclusion of all light except that coming through the films, and the use of a magnifying glass permits the viewer a greater opportunity of noting the detail of every portion of each film. Further illumination through the use of a bright spot viewer where a single film can be examined by a more intense light sometimes brings out aspects that can be missed or do not appear as definite in the full film mount.

Higher kilovoltage will result in longer scale contrast of the image. This means more greys (gradations between black and white). These intermediary greys are needed in order to study in detail the variable densities through which the rays have passed and therefore are of diagnostic value.

Attention should be given to four rules of interpretation:

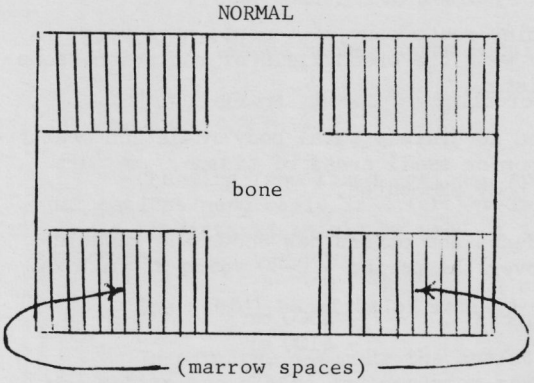
1. The area to be examined must be shown completely with anatomical and technical accuracy and with two or more views.
2. The films must show all the boundaries of a suspicious area with normal bone showing beyond.
3. The interpreter must be familiar with all anatomical landmarks and with the various conditions both pathogenic and nonpathogenic that may produce roentgenographic shadows.
4. A complete evaluation of all teeth and edentulous areas is required regardless of whether or not clinical abnormalities are shown.

In oral radiology in order to have the maximum quality of film detail shadows of small individual areas must be examined separately. The oral cavity is one of the particular locations in the body where anatomy of teeth and associated bone is located on a curve. Lateral and antero-posterior extraoral films result in super-impositions and distortions. Panoramic films result in marked distortions although a gross overall survey type of film of this type will give preliminary information.[3&4] The only technic to date that gives minute detail of teeth, pulp chamber, proximal caries, calculus, alveolar crest, periodontal space, and proximal bone is that of using a number of small intraoral films. More than two teeth are seldom in maximum focus at any single exposure, therefore a complete intraoral survey consists of 20 to 24 films if each tooth, or area where a tooth should be, is to appear in two aspects. For

detailed information of the temporomandibular joint, ramus, or maxillary sinus the lateral and anterio-posterior extraoral views are required.

The reflections of bone changes are the direct result of the degree of mineralization of bone. There is a simultaneous interplay between bone formation and bone resorption. Throughout life, there is more or less an equal balance of osteogenesis and bone resorption. The normal stimuli to the osteoblasts are the stresses and strains to which the area is subjected and when examining osseous tissues it is well to keep in mind the constant change, balance or imbalance corresponding to health or disease. Wolfe's law stated that the number and shape of trabeculae in a given area are dependent on the stresses and strains in that area.

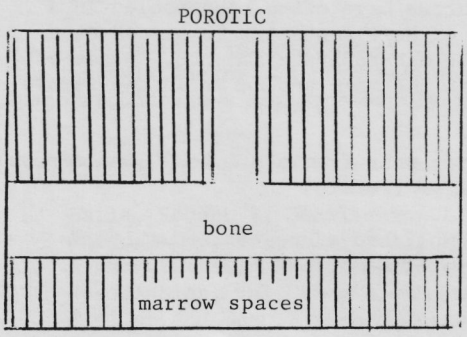
It might be pertinent to consider four broad classifications of types of alveolar bone and illustrate with diagrams:



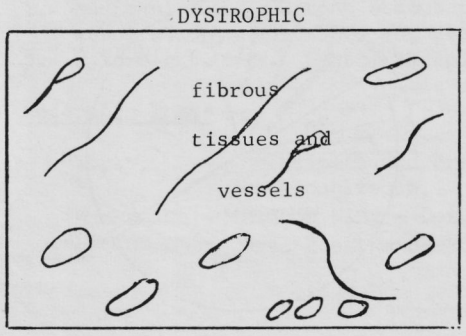
a. Normal (within normal limits) - "average number of trabeculae" per given unit, and average thickness of the cortical plates of the dental ridges and alveoli.

Trabeculae - supporting bone; medullary bone; spongiosa; spongy bone.

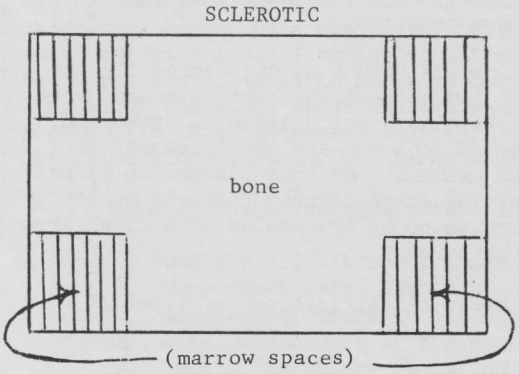
Cortical plates - the cortex; corticalis; compact bone; lamina dura.



b. Osteoporosis (porotic or porous bone) a "decrease in size and number" of trabeculae with an increase in the size of the marrow spaces; also, the corticalis is diminished and may be scanty or missing lining the alveoli. Osteoporosis does not necessarily mean a loss of mineral content; although naturally it is expected that a rarefaction and demineralization of the osseous tissues does precede the loss of these structures.



c. Osteodystrophic (a malnutrition) "the supporting bone either never formed typically, or a degeneration has occurred with a resulting replacement with a very vascular type of fibrous tissue". In extreme cases, the corticalis of the alveoli disappears with a formation of pseudo cysts (brown tumors), and hypercementosis. With the hypercementosis the teeth become ankylosed and concresence may occur.



d. Osteosclerosis (sclerotic bone - a hypercalcification; bone whorls; eburnated bone; marble bone); "an increase in the size and density of the supporting bone with a decrease or obliteration of the marrow spaces". Due usually to inflammation, infectious processes, trauma, or systemic disturbances - i.e. endocrinopathies.

Through the newspaper or popular magazine route many statements have been published that alarm the public; some dealing with the broad field of radiation, some specifically writing about radiation in dentistry.

To my knowledge, no one has yet related accurately total body radiation measurements to amounts of radiation received by exposing small areas of tissue. We must differentiate between local tissue and total body exposures.

Studies by the American Academy of Science and others has shown the genetic or gonadal amounts of radiation accumulated over the period - 0-30 years as follows:

Natural background sources	- 4000 mr
Man-made	- 4100 mr
Dental	- 100 mr
Fallout	100 mr - 400 mr

The radiation from medical and dental sources have often been pooled in a single figure - eg 4500 mr for a 30 yr period. - Here dentistry is placed at a distinct disadvantage due to the failure to state the separate amounts. A set of dental films (20) will yield approximately 1 mr in the male and .14 mr in the female by way of gonadal dose.[5]

One full radiographic survey per person per year from age 4 to 30 would result in a total gonadal dose of 26 mr (male) and 3.64 mr (female)

Since 1957 the dental profession has accomplished a greater reduction in exposure amounts of radiation than any other major category of man-made x-ray.

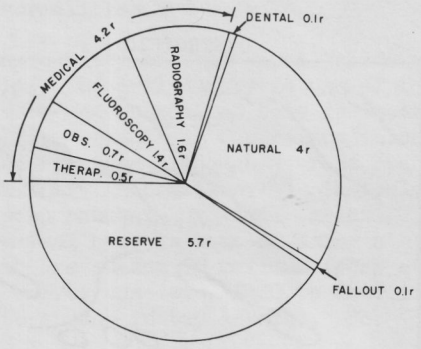
One intraoral survey - yields less radiation than:

1/160 annual dose in medicine

1/1000 annual dose from natural sources

1/4 dose due to fallout

1/3 dose due to building materials



The reduction of radiation in intraoral films has been obtained through:

1. High speed films
2. Improved beam shielding
3. Reduction of beam size
4. Adequate filtration
5. Minimum exposure time, plus maximum development
6. High kilovoltage
7. Open ended cone
8. Proper technic to avoid retakes
9. A leaded rubber apron should be used

The greatest amount of reduction (80%) has been the result of the adjusted film speed.

Changing from fixed periodic surveys to radiographic examination on an individual patient need basis is a further important factor. The taking of radiographs should be dictated solely by need of the patient and not be an automatic or period exercise.

The useful benefits of radiation should not be sacrificed to mass hysteria.

In summary, assuming the operator is aware of the principles of radiation protection the controlled use of x-rays is an essential part of oral diagnosis. The facts about dental radiology should be properly explained to the patient and to the public.

Complete information of the oral cavity and related anatomy cannot be obtained by a single survey. A combination of the intraoral, anterio-posterior, lateral and panographic views may each supply important information.

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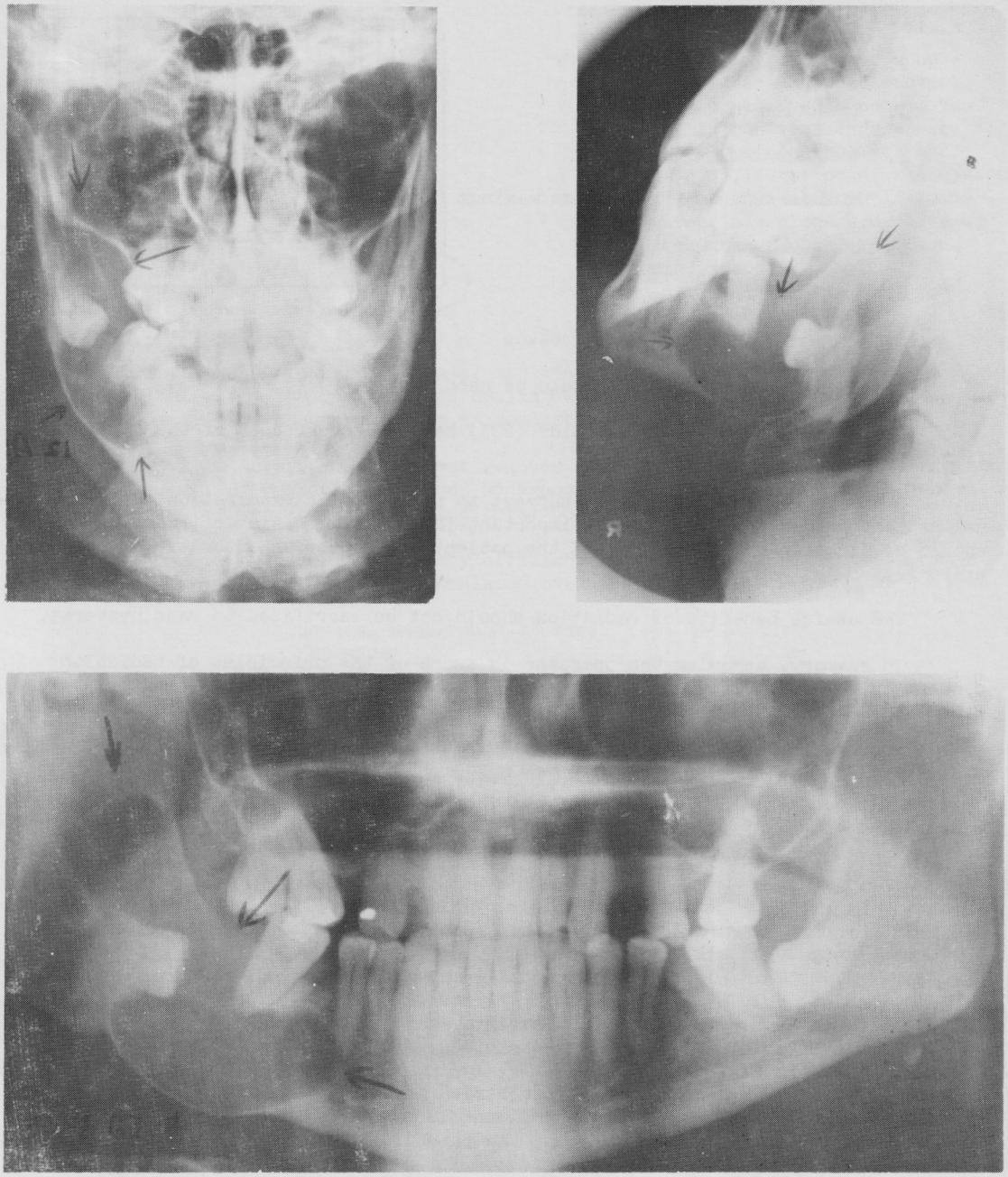
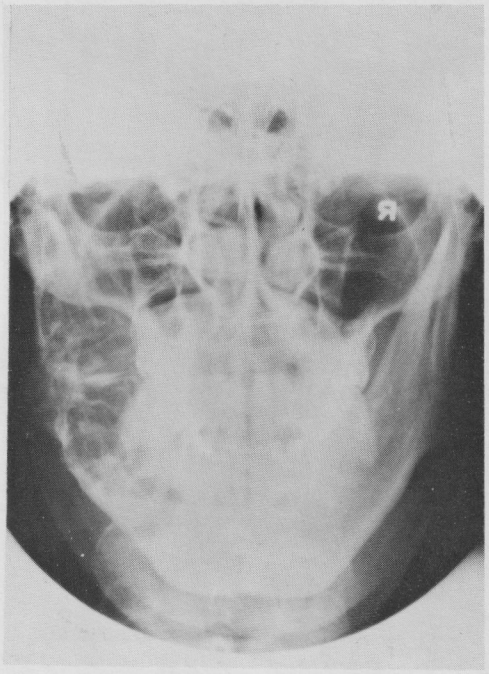
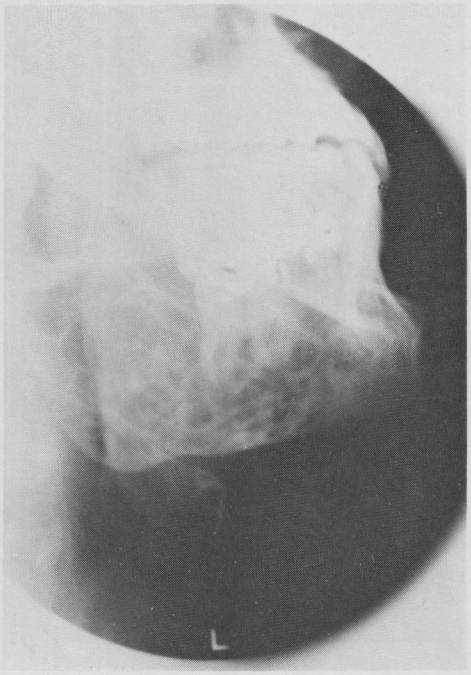


Fig. 2

Extension of cyst involving mandible and ramus best shown in (Tomograph) panographic film.





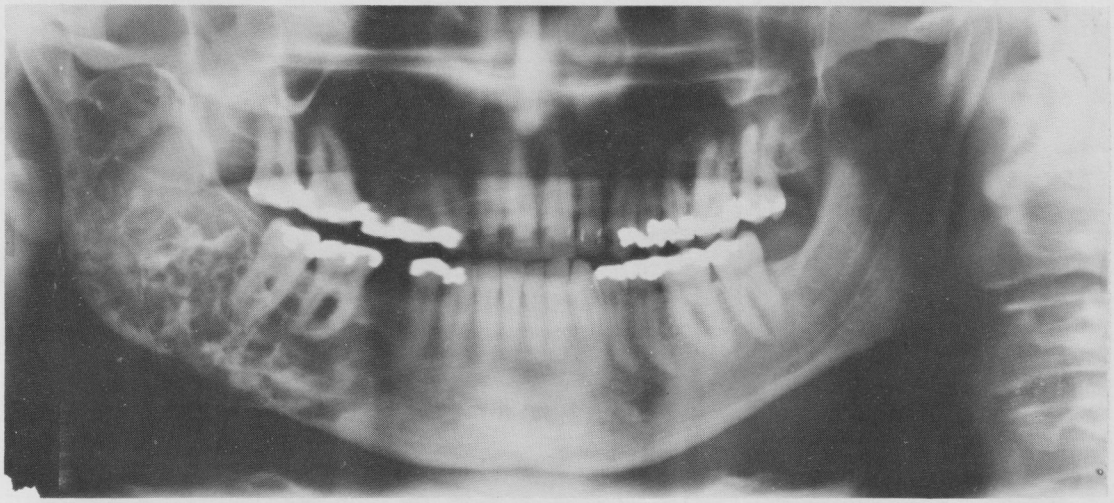
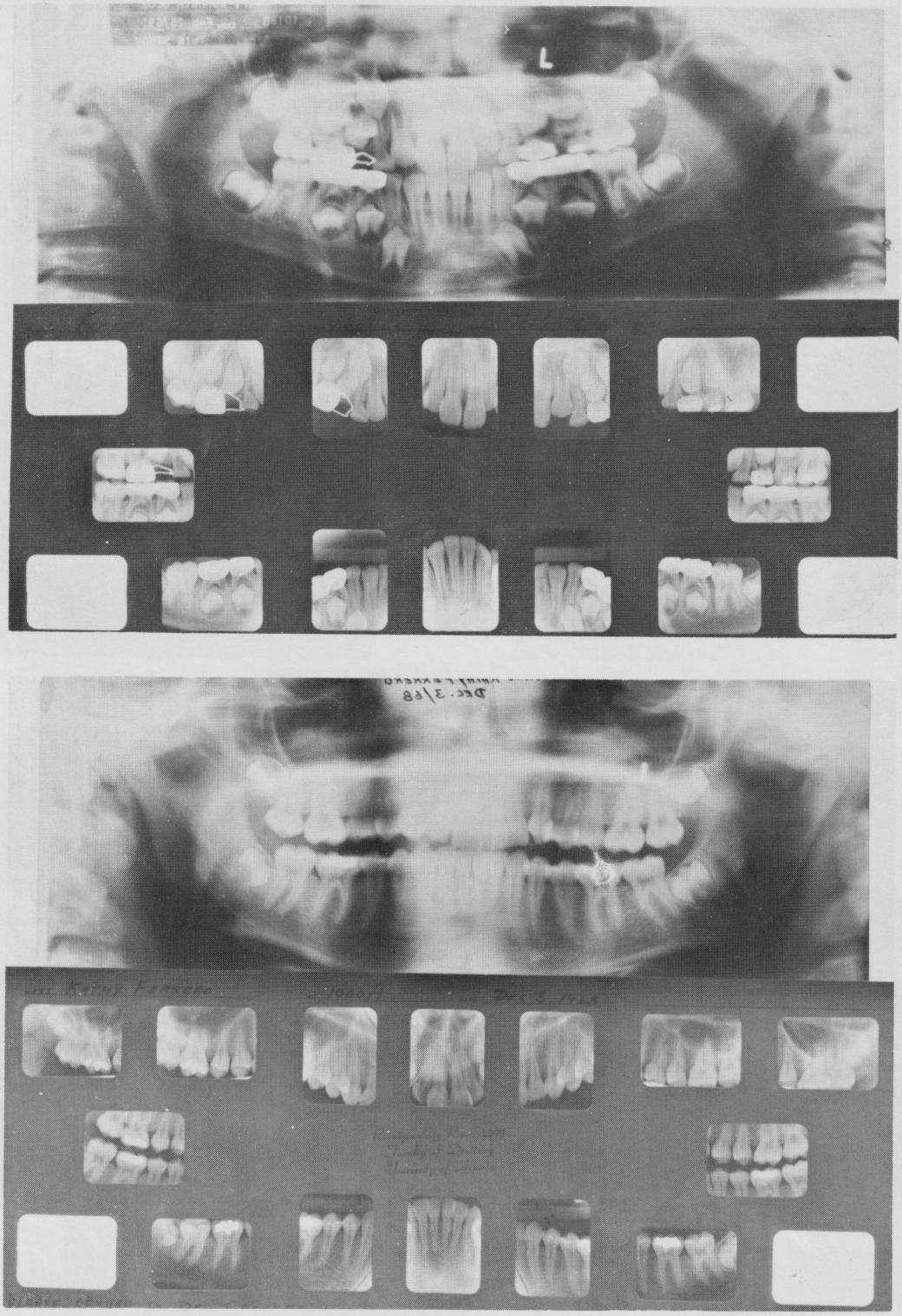


Fig. 3

Extension of fibrous dysplasia involving ramus and mandible best shown in panographic film.



Figs. 4 & 5

Demonstrate distortions in panographic view that are more correctly oriented in the periapical.

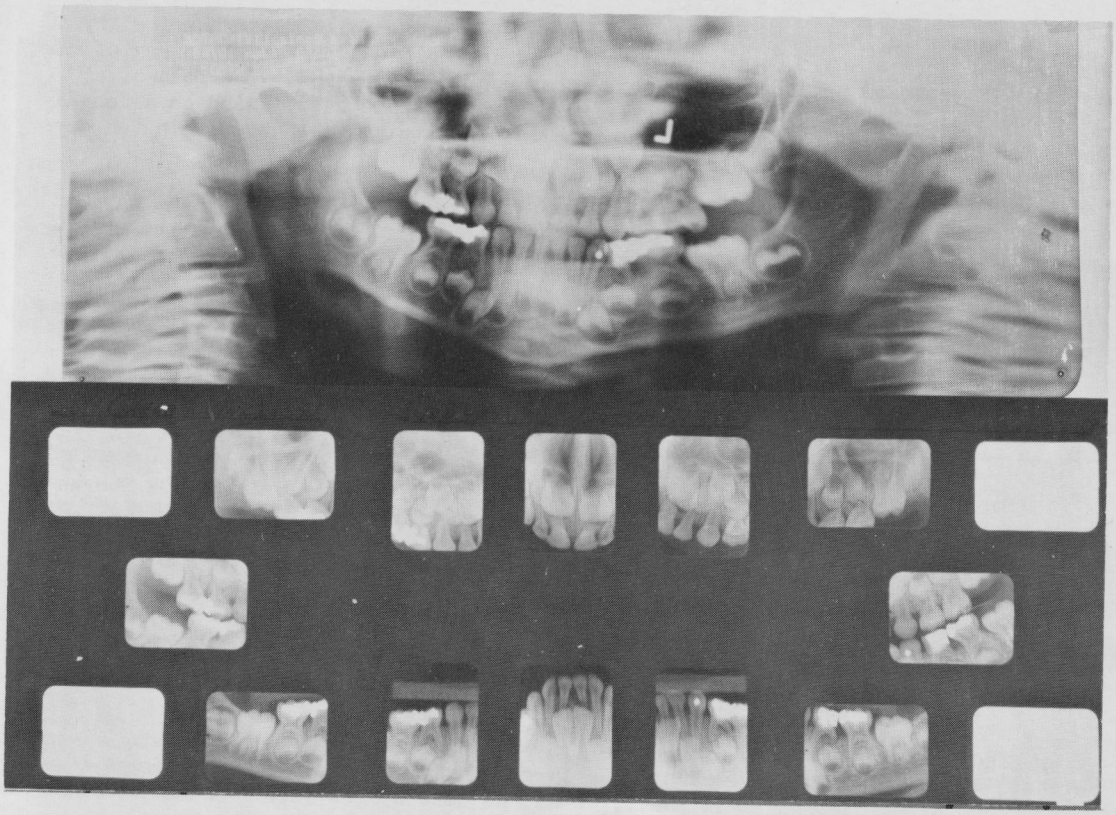
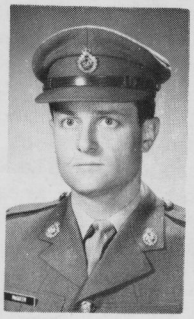


Fig. 6

Demonstrate distortions in panographic view that are more correctly oriented in the periapical.



THE CANVAS CLINIC

Major PR McQueen, DDS

The helicopter eased over the trees, landed in the clearing and discharged six wounded men on stretchers. The wounded were taken into a large tent where two medical officers quickly scanned the tags tied to each casualty. "This one will be a priority one, I think we had better get him to the OR first."

These were simulated cases, part of the Trial Field Hospital Exercise conducted at CFB Kingston during May-June 1969.

The only logical sequel to the purchase of a semi-mobile field hospital by the Canadian Forces would be to evaluate it. This logic was prevalent in May of 1969, when the 71 tents of the hospital were erected near CFB Kingston. The role of a field hospital is to provide emergency war surgery, in this case, based on a ten day holding policy, ie, if the patient cannot be returned to active duty within ten days he must be prepared for evacuation to Canada.

The hospital had 100 beds and a staff of 141 and was self-sufficient as the twenty-four hour drone of the diesel generators attested. For two weeks the provision of hydro, water, rations, quarters, mosquitoes and rain was the responsibility of the Trial Field Hospital. For two weeks CPL Paul Timmers and the author participated in the exercise as members of the dental detachment. This article describes the how, when and why of our participation.

The Canadian Forces Medical Service indicated need for a dental detachment in the field hospital, it was accepted as an opportunity to determine the role of the RCDC in such an establishment and to evaluate dental equipment under field conditions.

For the dental detachment, the exercise began in early May at the QM Stores where we signed out clothing, field, summer, combat, for the purpose of:

A few days later the clinic tent was set up and ditched. A tent was employed in lieu of the dental van since air portability was a prerequisite of the field hospital. The small size of the tent was its liability as can be seen from the photos. The inadaquacies were obvious in terms of negotiable floor space and in the wide swings of temperature during intermittent sunshine. The second problem was corrected after a fly canvas was improvised.

The tent was provided with three 110 volt outlets. All water and stove gas were delivered daily in Jerry cans. The larger tents were heated with Hermann-Nelsons, however, ours being so small, we had no heat source save a 60 watt bulb. Consequently the temperatures ranged from 32°F to 95°F.

The key dental equipment was the Encore Console and Compressor. After correction of a few minor problems the Encore was a reliable and easy unit to operate. It would be my choice for any dental field work in the future. One photo shows the compressor located behind the tent -- this is to reduce the noise it creates.

Prior to this exercise, my last encounter with the folding field dental chair was at the Corps School in CFB Borden, as a part of phase three training. This versatile and unstable metal monster did not win me over. I would rather switch than fight. I know it fits into that trunk but.....

The recently acquired Philips Oralix, a portable 110 volt 7 ma x-ray unit was a pleasure to use. It requires ten minutes to set up or take down and fits compactly in a metal chest as the photos show. The quality and definition of processed films were comparable with those by installed x-ray units in static clinics. During the exercise the area was visited by a radiation survey team who performed a check on the Oralix. The survey indicated a well designed unit with a well collimated beam which satisfied safety regulations.

Various other dental items were employed and evaluated, such as the field light, the operating headlight etc, but they are not new to field conditions and are written up elsewhere.

Of interest was the processing of exposed dental x-ray film, while the CFMS radiology section processed wet films for us in 16 minutes, we set the developer fixer tank up in a corner of the tent and tried creating a mini darkroom inside a plastic garbage bag. Curiously enough after some effort the results were acceptable, offering testimony to improvisation based on imagination, adhesive tape, wire, pliers and necessity.

There's always a first time for a greenhorn in the field, mine was finding an officers mess operating in the forest. An old abandoned house was opened and "decorated" to serve as a joint officers and Senior NCO mess.

It was only two and a half weeks but we learned and enjoyed. Finally all the tents folded and with them the people. There is only the memorable élan of the Trial Field Hospital which remains --- Those were the days my friend. Dulce bellum inexpertis.

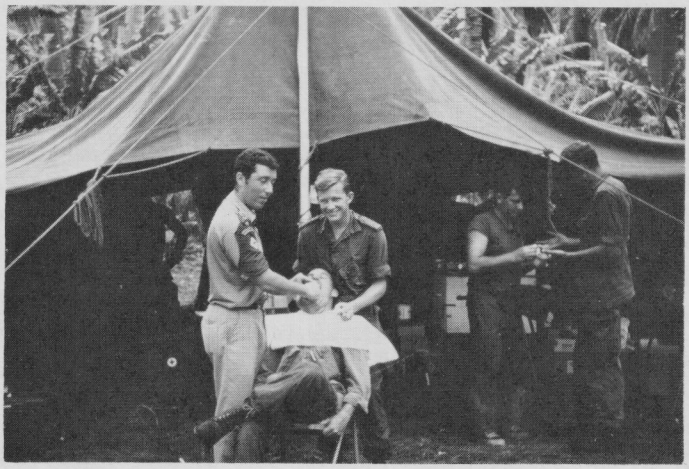
Top Left - Helicopter brings in casualties

Top Right - Wounded are treated and sorted

Center Left - Oralix and patient in position

Center Right - Encore compressor and tent

Bottom - The canvas clinic



EXERCISE NIMROD CAPER

Captain CW Kearns, DDS

The snow was falling and March was coming in like a lion, when the dental detachment of Private John Allain and I left our homes in CFB Petawawa to join the main task force group from the 2nd Battalion RCR in London, Ontario, for Exercise "Nimrod Caper", to be conducted in Jamaica 1 Mar-23 Mar 69. At 0600 hours, Thursday, 6 March we departed via Yukon Aircraft from London on a 6 hour flight, landing in 85 degree temperature at Palisadoes Airport, Kingston, Jamaica. From Kingston we were shuttled, via Buffalo Aircraft, 30 miles across the mountainous jungle terrain of Jamaica to the main base camp at Ken Jones on the northern shore -- very near the luxury resort area of Port Antonio!

After settling in camp, we established liaison with the dentists of the Jamaican Defence Force at Up Park Camp in Kingston. They graciously offered to provide the use of their facilities for any patients who could not be handled under emergency field conditions. We were later to make use of this offer on three occasions. These cases also provided an opportunity to have a look at Kingston.

The types of dental emergencies which can be expected on an exercise such as this included the usual toothaches and fractured anteriors. The latter are almost inevitable, when 600 Canadian soldiers are given a weekend pass in Montego Bay at the same time as 400 American sailors are let loose from the aircraft carrier USS Saratoga.

In spite of some interesting dentistry, we were not overworked, and thereby, had the opportunity to see a large part of the 190 mile long, 40 mile wide island. I spent an interesting weekend driving the length of the island. The tour included an overnight stop at Ocho Rios and a visit to the Jamaican Playboy Club, along with numerous swims in Montego Bay.

The standard of dental health among the natives of Jamaica is very low. Decay is rampant, as sugar constitutes a mainstay of the local diet. It is not unusual to see people strolling along, gnawing on a three-foot length of sugar cane. I had the opportunity to help out a few of the "locals" with their toothache problems. There is one dentist in the area of 50,000 people surrounding Port Antonio. He is a young competant Jamaican, who was trained at the University of Edinburough and is now on a commitment to the Jamaican Government. All dentists are foreign trained either in Britain, USA, or a few in Canada. As one can image, the type of dental work done consists mainly of surgery and hospital work. One sees a lot of anterior gold work which is still a status symbol in Jamaica. The average income of a dentist is probably one-third of what he would earn in Canada but this is easily compensated for by the low cost of living (one would expect to have at least a maid and a housekeeper). Numerous Canadian servicemen have retired to the northern coast.

It was truly enjoyable to be picking bananas, coconuts, mangoes and other tropical fruit from the local vegetation, while Canada was in the throes of cool March weather!

SPLINTING: AN AID TO PERIODONTAL TREATMENT

Major CM Mason, DDS

When periodontal treatment is started before extensive damage has occurred, most cases will fully respond to the prescribed therapy. Natural repair processes often heal the tissues; bone and soft tissues will frequently regenerate and provide support for loosened teeth, which then become stabilized in their alveoli. Scaling, curettage, and selective tooth grinding are adequate for removing primary sources of trauma, and surgery eliminates infected and useless tissues. However, many cases occur in which the remaining bone and periodontal membrane are inadequate to resist the pressure to which the teeth are subjected. Repair processes are not fully consummated because the forces and stresses interfere with healing. In many such cases, however, repair will occur if the affected teeth are stabilized and immobilized, the pressures reduced, and the various torques eliminated. Dental splints may be used successfully for this purpose.

Fixed splints may be either provisional or final, as the condition and case may indicate, and there is a wide variety of materials and types of splints available. These will be discussed later.

One might now wonder what value a provisional splint has, especially in cases where it is felt that a final or permanent splint will be required eventually. Some of the values or indications for provisional splints are:

1. Permit the operator to do periodontal surgery under conditions of immobilization, stabilization, and function, and thereby prevent interference with repair, which might occur if the teeth were loose.

2. Provide a method of evaluating the reaction of the periodontal tissues to other therapy, and of those teeth whose prognosis is guarded.

3. Prevent shifting and drifting of teeth during other periodontal treatment.

Prior to discussing the treatment planning and selection of the type of splint to be used, the sequence of fixed splinting in relation to other phases of treatment should be briefly mentioned.

The first phase of treatment should be scaling, curettage and home care instruction. Some occlusal adjustment can also be done by means of selective tooth grinding. A more definitive selective grinding may not be necessary if extensive splinting is planned for both arches, because occlusal balance will be obtained by creating proper relationship between opposing and adjoining castings and pontics. Extraction of hopeless teeth is done after the gross inflammatory processes have been reduced by the scaling and curettage procedures, followed by insertion of provisional fixed splints. During the period that provisional splints are being worn, further periodontal surgery, curettage and selective grinding can be done. Periodontal tissues are checked after the splint has been worn for several months. The case may require additional therapy and should be checked again several months later.

Final fixed splints are inserted after all inflammatory and granulomatous tissue including the periodontal pockets has been eliminated. The alveolar bone should

show repair by regeneration of bone which will appear denser at crestal areas. All irregular bone edges should have disappeared during the wearing of the provisional splints. The architectural form of the gingiva should also have been restored before insertion of final fixed splints.

EXAMINATION AND TREATMENT PLANNING FOR FIXED SPLINTS

Before prescription can be made and operative interference is started, the findings from the clinical, radiographic, and study cast examinations should be carefully studied and analyzed. From this it can be decided how many teeth are to be used for abutments; the crown to root ratios and leverage factors; the inclinations of the teeth and how this may influence the paralleling of abutment preparations. Determination of the number of hopeless teeth should also be made in the planning of treatment and then indicated for extraction so as to avoid their use as abutments. The various clinical and radiographic pathological findings are also established and correlated in the treatment plan.

CLINICAL SURVEY

The main considerations in respect to the clinical survey or examination of the patient must be:

1. Anatomical and Clinical Crown Length

   Usually the clinical crown will be long enough to retain the castings because of bone resorption which has led to gingival recession. If the clinical crown is short and there is little periodontal involvement, gingival resection may be required to expose more crown. The form of the clinical crown and its position in relation to adjoining and opposing teeth will determine whether a full, three-quarter or three-surface casting is to be used.

2. Mobility of the Teeth

   The grade of mobility helps decide if splinting is necessary and will be a guide in determining prognosis. An apico-occlusal movement indicates greater periodontal involvement than bucco-lingual mobility. The former would indicate a poorer risk as an abutment tooth, but not necessarily a hopeless prognosis.

3. Position, Shape and Depth of Pockets

   Teeth with deep periodontal pockets will require stabilization by splinting, because of increased leverage due to a longer clinical crown. Prognosis is better when roots are long and big, than in cases where roots are short and thin with equivalent pocket depth. This is so because large roots have more bone and periodontal attachment than small roots. Teeth requiring splinting generally have a poor prognosis if the pockets around them are circumferential or circuitous and deep.

4. Position of Teeth in the Arches

   Malaligned teeth may not permit seating of the castings without including cast key and key-way interlocking attachments. This type of device should not be used between the last abutment tooth in the splint and the adjoining one, especially if they are loose, as movement of them may occur during mandibular excursions.

5. Number of Teeth to be Splinted

   It is preferable, wherever possible, to have no fewer than two sets of

double abutment teeth on both sides of the pontics. In all instances, over splinting is preferred to under splinting. An example would be where mobility is detected in several maxillary anterior teeth. All incisors, cuspids and bicuspids should preferably be splinted together on both sides. If only the six anteriors were splinted here, there would be a tendency during movements of the mandible to force the six anteriors, along with the splint, in a labial direction.

6. Occlusion

If clamping, grinding and attritional factors are present, they should be corrected where possible. As mentioned previously, a definitive selective grinding may not have to be done if prematurities can be eliminated in the fabrication of the splints.

7. Edentulous Areas

Finally, the condition and shape of the saddle areas and the vitality of abutment teeth must be carefully determined prior to treatment.

RADIOGRAPHIC SURVEY

The width of periodontal spaces should be evaluated and correlated to the depth of the pockets as previously measured. Radiographs allow us to analyze the length, shape and number of roots of teeth being considered as abutments, etc. The amount and nature of bone loss and the distribution of bone loss can be ascertained from radiographs. Size and shape of pulp chambers can be determined with radiographs and thus help to decrease the danger of pulp exposure in the preparation of teeth to receive full crown castings.

STUDY CAST SURVEY

Plunger cusps, facets, steep incline planes, etc will be more apparent on study casts since the translucency of enamel, wet with saliva, tends to distort the contour of the occlusal surfaces.

The lingual occlusal relationship can only be seen on study casts. This will disclose anatomical abnormalities of teeth which otherwise could be overlooked.

The axis of preparation of tooth abutments, as well as guide preparations, can be done on study casts.

To this point the three main surveys to be undertaken in the examination and treatment planning have been considered. It is also essential to consider the emotional and physical state of the patient. Some patients, because of their temperament and nervous patterns, would not be desirable subjects for the necessary procedures. An attempt to determine the pain and emotional threshold is desirable. The limitations imposed by the physical health and age of the patient are considerations which the operator must pre-determine through the medical history and consultation with the physician when indicated. If a patient is chronically ill, splinting should be delayed until the health is improved. The impact on patients' emotions when they hear that many or all teeth have to be extracted must also be evaluated before such a diagnosis is made evident.

The patient's attitude toward operative procedures must also be considered. Patients may be reluctant to accept splints of any kind, which are unsightly or unattractive in appearance. Others may be reluctant to accept extensive fixed splinting because of fear of having teeth ground for abutments. They are fearful that the abutment teeth may be seriously damaged. The various things that may occur during the operative procedures, such as pulp death or exposure, should be explained to the patient. The possible loss of teeth that will occur if splinting is not performed

should also be explained. There are, of course, many other concerns and questions patients will have regarding these procedures and extreme care must be taken in this respect to avoid misunderstandings.

SUMMARY

The basic fundamentals in considering splinting as an aid to periodontal treatment have been briefly covered. The necessity of a sound diagnosis and treatment plan, and the relation and sequence of splinting to other periodontal treatment has been pointed out. Detailed preparation and construction of the splints has not been considered but many types of splints which are available, have been mentioned.

* Editor's Note

This paper was presented while Major Mason was on course at CFDSS in CFB Borden.

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The RCDC News

Honors and Awards

COL GR Covey and COL LG Craigie received Fellowships in the International College of Dentists at a ceremony on 9 July 1969 at the Canadian Dental Association Convention in Montreal presided over by Dr JA Fortier, President of the Canadian Section of the International College of Dentists.

Promotion

Canadian Forces Headquarters recently announced the promotion to LCOL of MAJ JMA Donely.

A graduate of the University of Toronto, LCOL Donely has been on the instructional staff at the Canadian Forces Dental Service School in Base Borden for the last four years.

LCOL Donely has been posted to Canadian Forces Base Cornwallis where he will command the recruit treatment facility.

Division News

CWO Jones Retires

CWO Al Jones retired after almost 30 years service. He will continue to make his home in Ottawa. He was presented with a golf bag on May 26 at a party in his honor and has subsequently put it to good use.

CWO Jim Taylor, Al's replacement, is making his presence felt and has already been signed up for the Division golf team.

CFDSS

by MWO HJG Franzgrote
and 2LT JCRM Chagnon

Armed Forces Day Base Borden 14 Jun 69

The CFDSS provided a dental display for Armed Forces Day which included our Field role using the dental vans and field equipment as well as a static display of our modern clinical equipment. The display consisted of three main themes:

1. An audio visual display from Ontario Dental Association dealing with dental health;
2. A section devoted to the recruitment of dental personnel; and
3. A display for the fabrication and fitting of mouth guards for a Base football team.

Course personnel (DOTP Phase III and DENT THR PL 6) aided staff in manning the displays.

Entraînement

Le 9 juin, l'école dentaire de la Base des Forces Canadiennes de Borden accueillait trente-cinq étudiants des différentes facultés dentaires canadiennes. Ces jeunes officiers y passeront environ deux mois afin d'y suivre leur troisième et dernière phase d'entraînement qui comprend entre autres quelques notions sur l'organisation et l'administration des forces armées en général ainsi que du corps dentaire, un entraînement au travail d'équipe en clinique, une semaine à Meaford, Ontario, et une semaine à Washington DC.

Comme par les années passées l'enthousiasme ne manque pas au sein de ce groupe. Peut-être que quelques-uns des lecteurs se souviendront d'avoir vu un char d'assault sortant de l'ordinaire par ses multiples couleurs s'ils étaient de passage au camp l'été dernier! If faudrait alors s'attendre qu'après la graduation du mois d'août, quelque chose d'inattendu survienne une fois de plus, surtout que pour la majorité d'entre nous, ce sera la dernière occasion de laisser notre marque sur la base de Borden. Donc, il va de soi que nous n'y manquerons sûrement pas.

Special Qualifications

LCOL PS Sills has successfully passed the examinations for certification by the American Board of Prosthodontics and is now a Diplomate of the Board.

MWO Hans Franzgrote was admitted to the board examination in dental hygiene of the Royal College of Dental Surgeons of Ontario, June 16-17, conducted at the University of Toronto, passed successfully and is the first male dental hygienist with a RDH certification in Canada. History was made by the CFDSS.

Top Student

CPL Marie Grandchamp of No 25 Clinic Griesbach Barracks in Edmonton attended the PL 3 course for dental assistants and was the outstanding candidate.

Visits

Twelve dentists undertaking graduate studies towards the DPH diploma at the University of Toronto and two of the University staff members, Dr AM Hunt, Professor of Public Health Dentistry and Director of post-graduate Dental Education, and Dr Roger Ellis, visited the CFDSS on April 18 and had the opportunity to observe armed forces preventive dentistry methods, and the employment and work of the Canadian Forces auxiliary dental personnel.

MWO J Sadler explains the trades progression of military dental auxiliaries to Dr Roger Ellis and Professor AM Hunt of the University of Toronto who accompanied the DDPH graduate students.

MAJ Bill Susser is presently completing his studies in dental public health with this group.

Guest Lectures

COL LG Craigie and LCOL AG Andrews attended the 10th Annual Canadian Forces Medical Service Clinical Conference at the Canadian Forces Hospital in Kingston, Ont. 24-25 April where LCOL Andrews presented a paper "The Dental Officer In The Team Concept Management of Maxillo - Facial Injuries."

From Kingston LCOL Andrews continued on to Ottawa where he again presented papers to the "Ottawa Dental Study Club".

Training

LCOL AG Andrews will leave the CFDSS to undertake graduate studies in dental surgery at the Doctors Hospital in Toronto.

MAJ Henry Marion is leaving for the University of Montreal to commence graduate studies in Orthodontics on August 5th. He will be well remembered in the Base Borden community for his charitable work and will certainly be missed at this school. A Bientot, MAJ Marion.

Special Course

CAPT DW Pettigrew attended the workshop on hypnosis by the American Society of Clinical Hypnosis, 18-21 April in the Royal York Hotel Toronto.

The dental Equipment Maintenance Technician Course (DEMT PL 4) started 12 Apr 69 and lasts for six months at the CFDS School. It is the first course of its kind to be conducted at the CFDSS. Instructors are MWO Bill Morris, SGT Bill Parker, CPLs Pete Nadeau and John Clint. CAPT Dave Cartwright supervises and directs the training.

CAPT DD Robertson Retires

CAPT Robertson, better known as "Robbie" to all his confreres is leaving the service after 27 years. "Robbie" was born in Niagara Falls, Ont. He joined the service in 1942 and served five years in the Dental Corps attached to the RCAF. Going overseas in 1942, he served in England and the Continent. Robbie was released in 1945 and rejoined in 1947 and served in Gagetown, Camp Borden, Ottawa, Germany and was posted to the CFDSS in 1966 and commissioned in the rank of CAPT from WO1 as Laboratory Officer. Robbie, throughout his career, served 11 years at the School and imparted his knowledge and ability to the Lab Technician Trade, training hundreds of technicians from the embryonic PL 3 course through the advanced trade courses.

His wife, Glenda, and sons David and Alec will accompany him to London, Ont where his new duties will be Laboratory Superviser at the University of Western Ont.

It's a civilian gain and a military loss, but we know that we'll see Robbie and his wonderful wife again at the CFDS Golf and Curling Tournaments and many other social functions. All success in your future endeavours, Robbie, and everyone in the CFDS wishes you "Bon Voyage".

1 Dent Unit

A "brush-in" was held at 1 Dent Det on 5 Jun 69. This "brush-in" was conducted by WO Frot in conjunction with Dr D Bell, of the Reserves. A total of 16 militia recruits between the ages of 14 and 17 were present.

MAJ Turcotte attended the annual CFMS Clinical Conference held at CFH Kingston, 24-25 Apr 69.

A party was held at the Airmen's Club, CFB Rockcliffe to bid farewell to CAPT Strom and SGT Hill on their retirement from the Armed Forces. They were presented with attache cases by the Unit.

On 27 May 1 Dent Det held a going away party for MWO Fediuk, CPL Mahlitz and CPL White.

Sports

On 6 Jun a "fishing derby" was held by this Unit. CAPT Stirling won the prize trophy for the largest fish caught (this one didn't get away) awarded by Labatts. SGT Schmelzle was the runner-up. LCOL Harrington, his son and SGT Hill also won prizes. Richard Harrington won the "GRAND AWARD" a radio. 18 members of the Unit participated.

11 Dent Unit

by MWO RD McHugh

Special Events

BGEN BP Kearney was a visitor during the month of May. He attended the British Columbia Dental Association Convention held in Vancouver BC from 14-17 May. Accompanied by COL Evans he visited the West Coast dental facilities.

MAJ JVP Chatwin from Dental Services Division Ottawa accompanied by LCOL DH Hillier conducted Preventive Dentistry demonstrations at CFB Comox, CFB Chilliwack and CFB Esquimalt during the period 5 to 12 May 69.

Recent farewells were said to CAPT WH Dunnigan CFB Edmonton; CAPT MG McRae CFB Comox; and CAPT JWC Walls of HMC Dockyard. These gentlemen have completed their five year term of service and will now take up private practice. CAPT Dunnigan will hang out his shingle in Edmonton, CAPT McRae has set up shop in Courtenay BC and CAPT Walls is located in Abbotsford, BC. We wish the Good Doctors well in private practice.

A get-together of personnel from the Calgary Dental Detachments at Camp Sarcee and Curry Barracks to honour MWO Stan Madge on his retirement was held in the CFB Calgary SGT's Mess on 2 May. A presentation was made to MWO Madge at that time. In the evening a party was held at the home of Mrs Sisson that also included the wives who gathered to say farewell to Stan and his wife.

A farewell party was held 23 May for WO Glen Storms who was released at CFB Esquimalt on 2 Jun 69. A retirement gift was presented on behalf of the staff of clinics in the area by LCOL HR Kettyls.

A party was held in Unit QM Stores Edmonton on Friday 30 Jun 69 to say "farewell" to CAPT WH Dunnigan, WO Chuck White and PTE Maxine Roseberry who are leaving the service. WO White is retiring after 26 years service and has accepted a position with Simpsons-Sears in Edmonton. PTE Maxine Roseberry is leaving the service on the 26 Jul to marry CPL NG Jones in Saskatoon, Sask on the 6th of Sep 69. They will reside in Cornwallis where CPL Jones is employed as a dental assistant.

Sports

CAPT KHE Rosengart, Detachment CFS Holberg received an Air Defence Command Sports Achievement Award for completion of a 12 mile swim.

The following story comes out of Cold Lake. Recently LCOL RB Jackson and MWO Earl McFadden decided to do a little after supper fishing. At approximately 1800 hrs they pushed off from shore in their small fishing vessel. In a very few minutes LCOL Jackson hooked his first big one, weighing 22 lbs. Before you could say Bob's your uncle, he had another one on his line, this only 18 lbs. In rapid succession he had hooked five more weighing 15, 11, 11, 9 and 8 lbs. Earl was not idle either. His four weighed 13 lbs, 11 lbs and two eight pounders. All in all their total catch weighed 134 lbs. All this took less than an hour as they returned to shore at 1845 hrs, a little weary but with a story to tell to anyone who would listen. All this may sound a little "fishy", but as Phil Harris says in his song, "It's true, because we know the soldiers".

12 Dent Unit

by SGT GR Jennings

The RCDC in Sea Element Role

In order that those unfortunate individuals who live "inland" in this country of ours might be enlightened about the happenings out here on the Eastern Shore, the following is recorded.

Negotiations were started in late April to provide dental treatment on board the destroyer escort HMCS Restigouche. CAPT Harry Amos and SGT Glen Jennings joined the ship in time to enjoy the "all expenses paid" trip to Montreal, Trois Rivieres

Rimouski and Quebec City for the period 5-25 May 69. The team, incidentally, turned out a creditable amount of treatment with little or no difficulty. A good time was had by all and the crew of the Restigouche welcomed our people like long lost friends and were very hospitable. The possibility of sending teams with other destroyers is now under active investigation. Anyone wishing such a trip should apply early through normal channels.

Civilian Dental Assistants

This unit was requested by the Nova Scotia Institute of Technology to help in the training of dental assistants. Prior to graduation the students do a period of practical instruction. Three teams of two girls each worked for two week periods from 21 April through to 30 May at the Stadacona clinic.

13 Dent Unit

by SGT ES Beattie

Honors and Awards

CAPT VO Bergland was presented the 1st clasp to his CD by COL RHG Cunningham on 25 Jun 69. The official date of the award, however, is 7 Dec 67.

Marriages

CPL PR Coss, on temporary duty from the Dental clinic, CFB Clinton to CFS Moosonee for six months from Dec 68 to Jun 69, climaxed his stay at CFS Moosonee by marrying Miss Charleen Pineault on 23 May 69. Miss Pineault was a school teacher with the Moose Factory Board of Education.

Retirements

LCOL RA Fell with COL RHG Cunningham presenting a silver tray on behalf of 13 Dental Unit personnel to MAJ PL Falkner on his retirement from the service.

COL RHG Cunningham, presenting a silver tea set to MAJ JD Bourque on his retirement.

MAJ Bourque retired after a career which started with the navy from Feb 1941 until Sep 1945 where he attained the rank of Petty Officer. After his release from the navy he returned to school at Dalhousie University where he graduated in dentistry. He enrolled in the Royal Canadian Dental Corps and was promoted to CAPT in 1951. Since then he has served in Korea and most provinces in Canada. He returned on 13 Jul 69 to Antigonish, Nova Scotia, where he is working for the provincial department of health. Major Bourque will be missed by all who knew him in the Service.

Sports

Headquarters 13 Dental Unit hosted their biennial golf tournament on 20 Jun 69. Fifty-four golfers from Ottawa, Petawawa, Kingston, Toronto, Oakville, London and Clinton competed at the CFB Trenton golf course.

The evening barbecue steak dinner and dance was attended by one hundred and fifteen golfers, non-golfers and ladies. After dinner the trophies donated by Canadian Breweries and Molson's Brewery and the many prizes were awarded to the outstanding few.

In "A" flight - low gross - 1st - SGT Matt Hall (Molson's Trophy)
2nd - SGT Bill Hill
3rd - MAJ Ian MacDonald
4th - CAPT Max Fisk

- low net - 1st - Mr Tom Batten (Cdn Breweries' Trophy)
2nd - CPL Gerry Anderson
3rd - BGEN BP Kearney
4th - CAPT Vern Bergland

In "B" flight - low gross - 1st - Mr Bill Trembley (Molson's Trophy)
2nd - MWO Fred Neeve
3rd - CAPT Tom Ringland
4th - CPL JW Griffith

- low net - 1st - CPL Don MacKay (Cdn Breweries' Trophy)
2nd - MWO Mickey Kidd
3rd - MWO Jack Fraser
4th - MAJ HG Bunston

In "C" flight - low gross - 1st - CAPT DM Hodges (Molson's Trophy)
2nd - WO Gene Raymond
3rd - Mr Jack Trembley
4th - CPL Andy Violette

- low net - 1st - LCOL JM Smith (Cdn Breweries' Trophy and Labatt's prize)
2nd - LT TA Rawlyk
3rd - WO Bud Lunnin
4th - CAPT DB Smith

Mr Bill Trembley, the winner of the Molson's Trophy for 1st low gross in "B" flight, is the son of Mr Jack Trembley, who is the local representative for Canadian Breweries. Thus, Molson's gave a trophy to Canadian Breweries.

14 Dent Unit

Special Events

A noon day luncheon and farewell party was held on 18 Apr 69 for MWO(A)(W) Pat Savage, at which time a presentation was made and best wishes extended from the staff of Headquarters, and Nos 1 and 2 clinics.

The 14 Dental Unit annual posting party was held on 14 Jun 69 at CFB Winnipeg (Westwin) with approximately 80 personnel attending including MAJ and Mrs Gullekson from Moose Jaw; CAPT and Mrs McCallum from Portage la Prairie, and CAPT and Mrs Poy from Gimli. MWO Tapp acted as MC. WO Roberts lined up an excellent musical program

and the food was very good. There were many farewells due to the large number of personnel leaving the unit.

Hobbies

CPL McRae of CFB Portage has added to his large collection of dog show prizes.

Dental Floss

Therapist: - Why didn't you brush your teeth this morning?

Muddy flood control soldier: - "I couldn't Sir, I was up all night patrolling the dikes looking for the Crest!"

15 Dent Unit

by MWO AF Davison

Postings, postings, postings! People come and people go, and those who want to leave stay on forever. A small gathering was held at CFB Montreal to say goodbye to CAPT TM Jackson and wish him happy holidaying on his posting to 35 Field, and to wish LT JP Carrier the best of luck in La Belle Province.

What is a Good Samaritan? If you should ask WO PD Peterson, he might have a few words for you. The story goes that an American tourist had a little trouble with his trailer which somehow became detached from the car on these good Quebec roads. Pete, being an obliging chap, stopped to give him a hand; the trailer somehow objected and slipped and fell, pinning Pete's finger to the ground. Net result - one broken finger - and now the doer of good has two weeks sick leave. What a way to get holidays in the summer.

It is too bad that MAJ JFA Marcil is leaving for a tour in Washington, as he has already started collecting golf trophies by winning the SGTs' Mess trophy at CFB Valcartier. CPL RM Clarke might be aiming to take his place, as he is attending the Quebec Regional playdowns at CFB Valcartier this week.

CAPT JLAR Bourcier and CPL JAN Audet have their summer work cut out for them, as they are at Camp Dubé looking after the Cadets in the summer training camp at Valcartier.

4 Fd Dent Coy

Professional Meetings

A Dental Officers Professional Meeting was held on 14 May 69 in the Canadian Officers Club, Soest, with the program presented by Officers of No 1 and 2 Dental Groups RADC, BAOR. Thirty-five Canadian, British and American Dental Officers were in attendance.

Field Training

June and Sennelager are synonymous in the vocabular ot 4 CMBG. The Sennelager concentration from 6 to 28 Jun this year was unusual in that 4 Fd Dent Coy concentrated in one area as a company rather than with dental sections accompany their units. Most personnel, including base dental personnel, lived in the field for at least one week to carry out qualifications on personal weapons and practical phase of NBCW training - the gas chamber. Many personnel also had the opportunity to throw grenades and fire the M72 rocket launcher.

SGT Schuh maintained his reputation as a marksman - he hit a 4" square on a Tank with the M-72 while his instructor missed completely. Two clinic vans and a lab van were set up to provide dental treatment for the concentration period. This gave everyone an opportunity to become familiar with and use the field equipment.

Several members of the unit also participated in individual training periods on the Sennelager 18 hole range.

D-Day Anniversary

SGT G Sapergia was one of 11 veterans from the Brigade area who attended the ceremonies in Normandy commemorating the invasion that took place there twenty-five years ago on June 6, 1944. SGT Sapergia reports as follows:

"A bus, billets and food were thoughtfully provided by the French Airforce located outside of Caen.

The area was crowded with Canadians. The CBC had eight rooms booked at a hotel situated on the beach were the Regina Rifles had landed.

The beaches, a few Pill-boxes, punctured stone walls, and some pieces of "Mulberry" (the man-made harbour) are there to prove that it wasn't just a dream.

A fly-past by a Lancaster bomber and two Spitfires gave me my biggest thrill. When I was able to inspect the "Lanc" at close quarters, it was a moment flooded with nostalgia.

The coup de grace came when five Canadians, including myself walked into a cafe filled with the local people. They applauded and treated us to a round of drinks."

Sports

Top: Pictures selected by LCOL Windsor and submitted as indicative of the golf skills of the two RCDC units in Europe. (Photos by CPL JEL Frechette)

Left: MAJ Mason receives the prize for low gross score from LCOL Windsor (Photo by SGT A Schuh)

The Annual RCDC Golf Tournament (Europe) was held at the CLFE Golf Course, Fort Anne, on the 2nd of May. 35 Field Dental Unit were well represented and enthusiastically led by LCOL DH Protheroe. A total of 33 golfers participated with 16 golfers from Air Div and 17 from 4 Fd Dent Coy. The sports activity was blessed with reasonably decent weather in the form of scattered cloud and periods of sunshine. The golf tournament was followed by presentation of low gross and net prizes along with a buffet dinner in the club house. MAJ C Mason won the low gross with a score of 83.

Leave

PTE Bamford (RCASC) spent 36 days on leave to and in Australia. Having received word that his mother, whom he had not seen for 22 years, was seriously ill, an indulgence flight was arranged through the auspices of the RAF. The journey to Adelaide, with stopovers in England, Singapore and Darwin was speedy and uneventful. The return trip was considerably slower with numerous stops including 8 days in Singapore. The staff of No 1 Clinic are now busy attempting to discover the secret of throwing a boomerang. The only results to date have been broken windows. Mrs Bamford's health has improved following the visit of her wayward son.

35 Fd Dent Unit

by SGT DT Moran

CO Presents Paper

LCOL Protheroe visited Ramstein AFB on 18 Apr 69 and presented a paper on the RCDC Preventive Program to the West German Armed Forces Dental Society.

Preventive Centre Established

A Preventive Dentistry Centre was opened on 24 Jun in the building occupied by unit headquarters.

WO Lowery, the unit therapist, is working full time in the centre, and dental officers and assistants from 1 Wing clinic are staffing it on a roster basis. Field equipment is being used and Phase 1 preventive procedures only are being performed.

Zweibrucken Clinic to Close

The many Corps personnel who have served in the clinic at Zweibrucken will probably be saddened to learn that the clinic will close its doors on 1 Aug. Of the personnel remaining in Europe MAJ Cyrenne will become Base Dental Officer, 1 Wing and CPL Norma Boles will move to 4 Wing. CAPT Weeks is returning to Canada on posting to Namao and PTE Tucker was recently married and following her release on 1 Aug will return to Canada with her husband who has been posted to the Vancouver area.

Promotion

During promotion ceremonies at Supreme Headquarters Allied Powers (SHAPE) Belgium, COL B Christmas, Canadian Forces National Military Representative pins stripes on newly promoted SGT(A) WD Buxton, with assistance of WO(S) G Keeling. An illustration of unification of the Canadian Forces.

Civilian Dentists

Four civilian dentists are now employed in the Air Division by NPF for treatment of dependants. Drs Ivor Hamilton and Chad McIntosh are located in Lahr and Drs Peter Brymer and Peter Crack are at Baden Soellingen. Two operatories and an officers lounge have been added to the clinic in 4 Wing and a separate dependants' clinic will be opened in Lahr sometime this summer.

1 Dent Eqpt Dep

by CPL MD Longford

Sports

The Depot was represented at the No 13 Unit on June 20 by MWO Ernie Everett, SGT Matt Hall and CPL Don McKay. It would seem that their ground appreciation was carried out in a very detailed manner as Matt went around in 81 which won him the Molson Trophy for low gross and gave him first choice at the awards table.

Don McKay won The Canadian Breweries Trophy for low net, B flight and a chance at the groaning table as well.

Leave

The members of the Depot, can now and then be caught with a far away look in their eyes. This look may represent either the worlds largest fish, or the best dressed girl (single men only) or, a lost copy of some accounting document but more probably leave plans for getting away to some special Utopia.

Professional Training

University of Toronto
MAJ JF Begin - Public Health - Sep 69 - Jun 70

University of Montreal
MAJ JH Marion - Two year Post-Graduate course in Orthodontics

Walter Reed Institute of Dental Research
MAJ JFA Marcil - Advance Science of Dental Practice - Aug 69 - Aug 70
MAJ MH Andrews - Post-Graduate training in Periodontics - Jul 69 - Jun 70

Dr Hospital Toronto, Ont
LCOL AG Andrews - Oral Surgery - Jul 69 - Jul 70

Training

Canadian Forces Staff College, Toronto - Sep 69-Jun 70
MAJ MN Deyette

Canadian Forces School of Instructional Technique - CFB Clinton

Instructors Course - 26 May-11 Jun 69
MWO McDonald MO; CPLs JA Clint, RK James

Junior NCO Course
PTE JA Muir, PTE LA Lambert

Welcome to the Corps

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

CWO JW Taylor; CPLs D Frerichs, GG Carscadden, GE Sykes; PTE RAG Gayler, PTE VJ Arsenault, PTE D Purich, PTE KR Lamont, PTE KL Davis, PTE(S)(W) RJ Thomas, PTE(S)(W) MR Williams, PTE(S)(W) LE Supple, PTE(A)(W) NL Rivers, PTE(A)(W) SE Greene, PTE(A)(W) IL Kuepper

Promotions

To LCOL - JMA Donely
To CAPT - RJ Burns, RD Carver, MJ Cherun, JRJ Cote, JSHL Duchesne, MA Fortier, RY Gish, GM Hodges, P Kozak, KR Morley, CN Murray, DK MacKenzie, MFA Pilon, PP Psaila, RW Rix, GE Rocque, JBGM Simoneau, DB Smith, RI Stammers, JC Steel, DE Watson
To MWO - E McFadden, LR Barret, HEW Reid
To WO - DC Hughes
To SGT - WE Tweed, TRJ Kukurudziak, WD Buxton
To CPL - J Van Hemert, TJ Cooper

Retirements and Releases

MAJs JR Robertson, GOV Dippel, JD Bourque; CAPTs G Jalbert, JPJ Laporte, JAGD Pigeon, WH Dunnigan, MG McRae, JWC Walls, RWC Adams, DD Robertson, JO Strom; CWOs JE Shiner, TA Jones; MWO(A)(W) P Savage; WOs CR White, AD Bourgeois, TH Southin, GH Storms; SGTs WE Hill, AE Werkmann; CPL GR Burt; PTE(S) JW Nesrallah, PTE(S) RL Hebert, PTE(A)(W) BR Tucker, PTE(A)(W) MF Roseberry; Mrs R Dyrland, Mrs MA Osler

Postings

Since space does not permit listing all postings this Quarter you are referred to the postings section of CFSOs and the new RCDC Location List.

Vital Statistics

Marriages

CAPT JF Stengl to Tamar Tkachenko; CPL PR Coss to Miss Sharleen Pineault, CPL RG Brighty to Hugette Miscouche; PTE(A)(W) RR Tucker to CPL(A) Caddey

Births

Daughter - CAPT & Mrs IMC Wambera (13 DU), CAPT & Mrs WEJ Nind (14 DU), CAPT & Mrs PE Arnold (1 DU); SGT & Mrs N Cable (14 DU), SGT & Mrs TR O'Mara (13 DU); CPL & Mrs AH Peck (Adopted) (11 DU), CPL & Mrs DW Griffiths (14 DU); PTE & Mrs CH Forsythe (12 DU), PTE & Mrs LA Lambert (15 DU)

Son - MAJ & Mrs RB Andrews; CPL & Mrs A Busse (11 DU); Correction: CAPT & Mrs MacInnis twin daughters reported in the April issue of the Quarterly are in fact sons. "Viva la difference".

Condolence

Sincere sympathy is extended to SGT J Laverty who lost his wife in May and to COL LG Craigie, CPL TA Larouche, SGT Frank Martell and CPL "Joe" Martell whose mothers recently passed away.