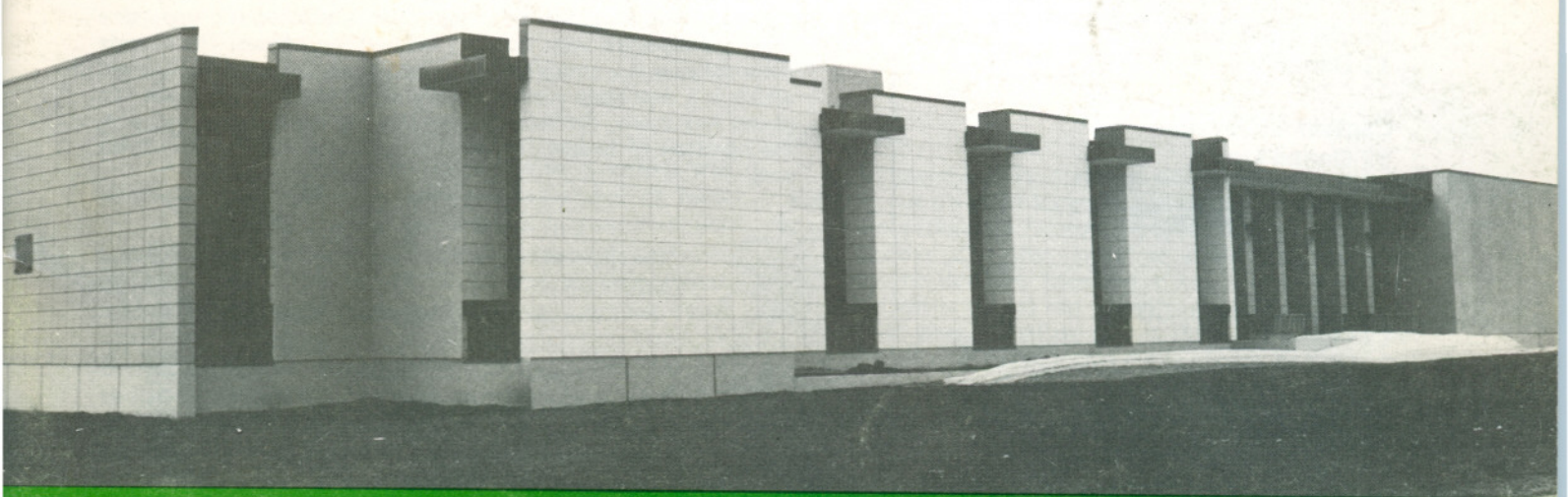
The Canadian Forces Dental Services Quarterly

Bulletin du Service Dentaire des Forces Canadiennes



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The CFDS Quarterly

Volume 16 Number 2, July 1975

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Bulletin du SDFC

Volume 16, Numéro 2, Juillet 1975

Publié avec l'autorisation du brigadier-général L.G. Craigie, CD, QHDS, DDS, FICD en avril, juillet, octobre et janvier, le Bulletin sert à l'échange d'idées, d'expériences et d'informations au sein du Service dentaire des Forces canadiennes. Les opinions exprimées dans ce Bulletin sont celles des auteurs Elles ne sont pas nécessairement partagées par le Directeur général du Service dentaire ou le ministère de la Défense nationale.

In this issue • Dans le présent numéro:

Cover • couverture

The new Dental Building at CFB Calgary has combined the two previous clinics into one homogenous operation covering both Barracks. The architectural design of this building is a departure from the standard type building seen on most Bases. The outside color scheme is a combination of coral red, beige and light green which is a departure from the norm as far as colors go. Since this photo was taken, the surrounding area has been landscaped with the addition of hedges and trees as well as a newly seeded lawn area.

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PREVENTIVE DENTISTRY SURVEY AT NDHQ CLINIC

CAPT G.R. BOWES

PROJET ENQUÊTE SUR LA PRÉVENTION DENTAIRE AU SERVICE DENTAIRE DU Q.G.D.N.

CAPITAINE G.R. BOWES

AIM

To study the effectiveness of the Canadian Forces Preventive Dentistry Program at NDHQ Dental Clinic Ottawa, Ont.

OBJECTIVES

To evaluate:

a. The effectiveness of patient education, as presented at this clinic and as required by the Preventive Program, insofar as it concerns basic factors of oral hygiene, particularly dental plaque;
b. The extent to which this education motivates patients to practice certain oral health procedures; and
c. The level of patient interest generated by the Preventive Program.

METHOD

A questionnaire composed of nine questions was developed to assess a respondant's knowledge of basic factors concerning dental plaque and oral hygiene methods, and of his personal activity in the recommended measures of home care (Figure 1). One hundred servicemen completed this questionnaire during their annual recall appointment, prior to any refresher instructions or demonstrations. A similar questionnaire, which did not contain questions 8 or 9, was answered by a randomly selected group of thirty-five civilians.

The results were tabulated by calculating the percentage of respondants in each population who answered questions one through five correctly and the percentage of responses to each possible answer to statements six through eight (Tables 1-3).

BUT

Étudier l'efficacité du programme de prévention dentaire des Forces canadiennes au service dentaire du Q.G.D.N., à Ottawa.

OBJECTIFS

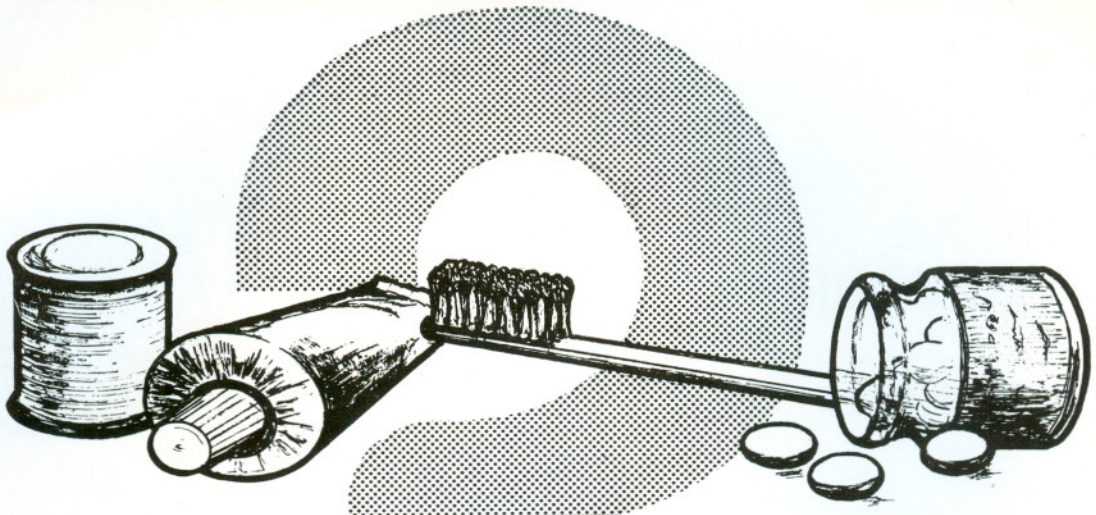
Évaluer:

a. l'efficacité de l'éducation des clients, telle qu'elle est dispensée à ce service et suivant les exigences du programme de prévention dentaire, en ce qui a trait aux facteurs principaux de l'hygiène orale, notamment de la plaque bactérienne sur les dents;
b. dans quelle mesure l'information dispensée motive les clients à adopter certaines habitudes d'hygiène orale;
c. l'intérêt suscité chez les clients par le programme de prévention dentaire.

MÉTHODE

Un questionnaire composé de neuf questions a été établi en vue d'évaluer les connaissances des sujets en ce qui a trait aux principaux facteurs touchant la plaque dentaire et les méthodes d'hygiène orale, et pour connaître leurs habitudes personnelles concernant les soins recommandés (fig. 1). Cent militaires ont rempli le questionnaire lors de leur rendez-vous annuel de rappel, avant toute instruction ou démonstration. Trente-cinq civils choisis au hasard ont répondu à un questionnaire semblable ne comportant pas les questions 8 ou 9.

Les résultats ont été compilés en calculant le pourcentage de sujets dans chaque groupe qui ont répondu correctement aux questions un à cinq, et le pourcentage de réponses donné pour chaque choix offert aux numéros six à huit (tableaux 1-3).



DENTAL PREVENTIVE QUESTIONNAIRE

LES SOINS DENTAIRES PRÉVENTIFS

Please answer the following questions by circling the most appropriate answer:

1. **Dental plaque causes:**
   a) sore throat and tonsillitis,
   b) gum disease and tooth decay,
   c) cancer of the tongue,
   d) cold sores on the lips and tongue.

2. **Dental plaque consists of:**
   a) salivary components,
   b) bacteria,
   c) bacterial products,
   d) all of the above.

3. **Dental plaque formation is a continuous process and it forms in:**
   a) 12 hours,
   b) 24 hours,
   c) 48 hours,
   d) very few people.

4. **Dental plaque forms:**
   a) on the enamel at the gum line,
   b) on the chewing surfaces of the back teeth,
   c) on the enamel surface between the teeth,
   d) all of the above.

Veuillez répondre aux questions suivantes en encerclant la réponse la plus appropriée:

1. **La plaque dentaire entraîne:**
   a) le mal de gorge et l'amygdalite;
   b) l'inflammation des gencives et la carie dentaire;
   c) le cancer de la langue;
   d) des ulcères aux lèvres et à la langue (feux sauvages).

2. **La plaque dentaire est composée:**
   a) d'éléments salivaires;
   b) de bactéries;
   c) de produits bactériens;
   d) de tout ce qui précède.

3. **La formation de la plaque dentaire est un processus continu qui**
   a) prend 12 heures;
   b) prend 24 heures;
   c) prend 48 heures;
   d) touche très peu de gens.

4. **La plaque dentaire se forme:**
   a) sur l'émail près des gencives;
   b) sur la surface à mastiquer des dents postérieures;
   c) sur l'émail entre les dents;
   d) toutes les réponses ci-dessus sont bonnes.

5. **Disclosing tablets are:**

   a) only used in the dental office,
   b) used to indicate the location of dental cavities,
   c) a harmless vegetable dye which will stain plaque,
   d) all of the above.

6. **I brush my teeth:**

   a) rarely,
   b) occasionnally,
   c) daily,
   d) twice a day,
   e) three times a day or more.

7. **I use dental floss:**

   a) rarely,
   b) occasionnally,
   c) daily,
   d) every two days,
   e) other (explain).

8. **The Preventive Dentistry Program of the Canadian Forces is:**

   a) of no benefit to me,
   b) of some benefit to me,
   c) of much benefit to me,
   d) a drag.

9. **Other comments and suggestions on the space below.**

COMMENTS

5. **Les comprimés révélateurs:**

   a) sont utilisés au cabinet du dentiste seulement;
   b) servent à déceler les caries dentaires;
   c) consistent en un colorant végétal inoffensif qui teint la plaque dentaire;
   d) toutes les réponses ci-dessus sont bonnes.

6. **Je brosse mes dents;**

   a) rarement;
   b) à l'occasion;
   c) tous les jours;
   d) deux fois par jour;
   e) trois fois par jour ou plus.

7. **Je me sers de soie dentaire:**

   a) rarement;
   b) à l'occasion;
   c) tous les jours;
   d) tous les deux jours;
   e) autre (préciser).

8. **Le programme de prévention dentaire des Forces armées canadiennes:**

   a) ne m'apporte aucun avantage;
   b) m'apporte quelque avantage;
   c) m'est très profitable;
   d) m'ennuie.

9. **Autre commentaires ou suggestions:**

COMMENTAIRES

RESULTS

RÉSULTATS

Populations surveyed — Military 100 Civilian 35

Populations étudiées Militaires 100 Civils 35

TABLE 1

Percentage Distribution of Correct Responses to Questions Concerning General Knowledge

QUESTION#	MILITARY	CIVILIAN
1	98	54.3
2	68	34.3
3	37	17.1
4	71	60
5	86	45.7

TABLEAU 1

Distribution proportionnelle des réponses correctes aux questions faisant appel aux connaissances générales

QUESTION	MILITAIRES	CIVILS
1	98	54.3
2	68	34.3
3	37	17.1
4	71	60
5	86	45.7

TABLE 2

Percentage Distribution of all Responses to Statements Concerning Home Care

STATEMENT	MILITARY	CIVILIAN
6 a	0	0
6 b	0	5.7
6 c	31	24.3
6 d	65	57.1
6 e	4	11.4
7 a	38	22.8
7 b	39	28.5
7 c	16	11.4
7 d	3	11.4
7 e	4	25.7

TABLEAU 2

Distribution proportionnelle de toutes les réponses aux énoncés touchant les soins à domicile

ÉNONCÉ	MILITAIRES	CIVILS
6 a	0	0
6 b	0	5.7
6 c	31	24.3
6 d	65	57.1
6 e	4	11.4
7 a	38	22.8
7 b	39	28.5
7 c	16	11.4
7 d	3	11.4
7 e	4	25.7

TABLE 3

Percentage Distribution of all Responses to Statements Concerning Reaction to Preventive Dentistry Program (Military Only)

STATEMENT	MILITARY
8 a	2
8 b	44
8 c	53
8d	1

TABLEAU 3

Distribution proportionnelle de toutes les réponses aux enoncés touchant l'attitude face au programme de prevention dentiare (militaires seulement)

ÉNONCÉ	MILITAIRES
8 a	2
8 b	44
8 c	53
8 d	1

ANALYSIS

Table 1 indicates that this group of military personnel are twice as aware of dental plaque and what it causes than are their civilian counterparts. (98% vs. 54.3%). Similarly sixty-eight percent of the military personnel knew the components of dental plaque, whereas only thirty-four percent of the civilians responded correctly. Question 3, concerning the time frame for plaque development, was answered correctly by only 37% of military personnel. The remainder thought that it formed within 12 hours, which indicates that they were aware of the rapidity of plaque accumulation and erred in that direction. No similar trend was noted in the civilian responses as their answers to the question were scattered somewhat indiscriminately from "12 hours" to "very few people".

The question concerning areas of plaque formation elicited a relatively similar correct response from both military and civilian populations (71% vs. 60%). The high percentage of correct responses from the military personnel is not surprising, but that of the Civilians does not correlate with the percentage of correct responses they made to the other questions. The reason for this discrepancy may lie in the wording of the question which probably invites the respondent to make the correct choice.

Eighty-six percent of military personnel knew what disclosing tablets were whereas only 45.7% of the civilian population replied correctly, and of these, 11.4% were admitted guesses. The number of admitted guesses from the military population was not determined but even if it was in the same proportion as the civilian figure, the survey indicates that the military are more knowledgeable on this subject.

There was no statistically significant difference between the civilians and military populations in their responses to the questions concerning frequency of brushing and flossing (Questions 6 and 7). This finding, when combined with data from the previous questions, suggests that although the military population had better knowledge concerning oral hygiene, they were not applying their knowledge to any better effect than the civilians. On the other hand it may be that the civilian respondents were more motivated than the military to produce an "acceptable" answer to these questions and were, therefore, not entirely honest. Such an explanation is prompted by the relatively high and suspect percentage (11.4) who said they brushed their teeth three times a day.

DISCUSSION

These results prompt consideration of how best to motivate military personnel in the Ottawa area to improve their personal oral hygiene. Although this survey helps to confirm that the educational aspect of the preventive program has been effective, new motivational methods appear to be required to supplement patient education. Some possible methods are:

1. Shock tactics — as through slide presentations of the effects of poor oral hygiene. This measure is not recommended by various groups.

ANALYSE

Le tableau 1 indique que le groupe de militaires étudié est deux fois plus conscient de la plaque bactérienne sur les dents et de ses causes que le groupe de civils (98% contre 54.3%). De même, 68% des militaires savent de quoi se compose la plaque dentaire, tandis que seulement 34% des civils ont répondu correctement. Quant à la question 3 sur la période de formation de la plaque bactérienne, seulement 37% des militaires ont donné la bonne réponse. Les autres ont répondu 12 heures, ce qui indique qu'ils savaient que la plaque bactérienne se formait rapidement, d'où le sens de leur erreur. Aucune tendance semblable ne se manifeste chez les civils, leurs réponses se répartissant au hasard entre "12 heures" et "touche très peu de gens".

La question concernant les zones de formation de la plaque bactérienne a été répondue correctement par presque autant de civils que de militaires (60%, 71%). La proportion élevée de bonnes réponses de la part du personnel militaire n'a rien de surprenant, mais celle des civils n'est pas en corrélation avec le pourcentage de réponses correctes qu'ils ont données aux autres questions. Cet écart peut s'expliquer par la formulation de la question qui suggère en quelque sorte la bonne réponse.

Quatre-vingt six pour cent des militaires savent ce que sont des comprimés révélateurs, la proportion correspondante chez les civils n'étant que de 45.7%; 11.4% de ces derniers admettent avoir fait leur choix au hasard. On n'a pas déterminé combien de militaires avaient répondu au hasard, mais même si ce chiffre correspondait proportionnellement au nombre de civils ci-haut, l'enquête révèle que les militaires sont mieux renseignés que les civils sur cette question.

Aucune différence statistique significative n'apparaît entre les deux groupes étudiés quant aux réponses fournies aux questions sur le brossage et l'utilisation de la soie dentaire (questions 6 et 7). Si l'on tient compte des données concernant les questions précédentes, cela indiquerait qu'en dépit de leurs connaissances plus étendues en matière d'hygiène orale, les militaires ne pratiquent pas ce qu'ils savent mieux que les civils. En revanche, il se peut que les civils aient voulu plus que les militaires donner une réponse "acceptable" à ces questions; autrement dit, on peut mettre en doute l'honnêteté de leurs réponses. On peut pencher vers une telle explication en constatant la proportion élevée et suspecte (11.4) de civils qui disent se brosser les dents trois fois par jour.

DISCUSSION

Les résultats indiquent qu'il y a lieu de se demander comment motiver davantage les militaires de la région d'Ottawa à améliorer leur hygiène orale personnelle. L'enquête confirme jusqu'à un certain point que la dimension éducative du programme a porté fruit, mais il semble qu'on doive envisager de nouvelles façons de motiver les gens en vue de compléter l'information fournie. Voici quelques moyens qui s'offrent à nous:

1. Certains procédés chocs — par exemple, des diaporamas sur les conséquences néfastes d'une mauvaise hygiène orale. Divers groupes s'opposent à cette méthode.

2. A system of priority treatment whereby patients who practice good oral hygiene and have a low plaque index are given priority for time-consuming, expensive treatment such as root canal thereapy, removable and fixed prosthetics. All other patients would be entitled only to routine dental care on the understanding that, if their oral hygiene improved, they would become entitled to more comprehensive treatment.

SUMMARY AND CONCLUSIONS

The benefits of the Preventive Program were fully appreciated by 97% of the military personnel. This response indicates a wide acceptance of the preventive approach to dentistry, and is encouraging to all those dental personnel involved in the Preventive Program.

Conclusions

1. Military personnel have a more extensive knowledge of dental plaque than do civilians. This finding is probably due to the education provided servicemen through the Canadian Forces Preventive Dentistry Program.
2. Despite their better knowledge regarding dental plaque, military personnel are not better motivated to practice good oral hygiene than are civilians.
3. The Canadian Forces Preventive Dental Program should stress motivation rather than education at this clinic which has a patient commitment composed largely of mature servicemen who have been exposed to the program for many years. In areas with a younger patient strength the educational aspects of the program should continue to be reinforced.

Some of the "other comments" made in the space provided in the questionnaire proved to be most enlightening. One in particular summarizes the findings of this survey:

"I believe in the Preventive Program, but, it is one thing to believe and quite another to put everything to practice. Thanks for the effort."

2. Un mode de traitement prioritaire selon lequel les clients qui pratiquent de bonnes méthodes d'hygiène orale et qui ont un faible indice de plaque dentaire sont reçus les premiers pour les traitements longs et coûteux, comme la thérapie des racines et du canal, la confection de prothèses amovibles et inamovibles. Tous les autres clients n'auraient accès qu'aux soins dentaires courants, étant entendu que si leur hygiène orale s'améliorait, ils pourraient recevoir des soins plus complets.

RÉSUMÉ ET CONCLUSION

Quatre-vingt dix pour cent des militaires reconnaissent les avantages qu'ils retirent du programme de prévention dentaire, ce qui indique que la prévention dentaire est acceptée par un grand nombre, fait encourageant pour tout le personnel dentaire engagé dans ce programme.

Conclusions

1. Les militaires ont des connaissances plus étendues sur la plaque dentaire que les civils. On peut probablement attribuer cet état de choses à l'information que dispense aux militaires le Programme de prévention dentaire des Forces canadiennes.
2. Malgré leurs connaissances plus étendues au sujet de la plaque bactérienne sur les dents, le personnel militaire n'est pas mieux motivé que les civils en ce qui a trait aux méthodes d'hygiène orale.
3. Le Programme de prévention dentaire des Forces canadiennes devrait mettre plus d'accent sur la motivation que sur l'éducation à ce service, vu que la population desservie est composée en grande partie de militaires d'âge mûr déjà sensibilisés au programme depuis nombre d'années. Dans les secteurs où la clientèle est plus jeune, on devra continuer à renforcer les aspects éducatifs du programme.

Certains commentaires inscrits dans l'espace prévu à cette fin dans le questionnaire se sont révélés des plus éclairants. Une personne a résumé ainsi les résultats de l'enquête:

"Je crois au programme de prévention, mais croire et mettre en pratique sont deux choses bien différentes. Merci pour l'initiative."

EPIDEMIOLOGICAL STUDIES OF PERIODONTAL DISEASE

MWO S.L. MACLEAN

ÉTUDES ÉPIDÉMIOLOGIQUES SUR LA PÉRIODONTITE

ADJUDANT-MAÎTRE S.L. MACLEAN

Epidemiology is defined as the study of the occurrence and distribution of disease, usually restricted to epidemic or endemic, but sometimes broadened to include all types of disease. Serving as they do a variety of purposes, epidemiological studies are used by the public health worker to evaluate the need for treatment of a population and to assess the manpower and equipment required to meet this need. The researcher, on the other hand, may use them to correlate the prevalence and incidence of a disease with various etiological factors and thus enable clinical and public health workers to develop and conduct programs to combat those factors which are of public health significance.

Although it has already furnished our profession with valuable information, epidemiology of dental disease is still an under-used, rapidly expanding science. All types of therapy should be tested and evaluated in clinical trails before being introduced for general use and the efficacy of even accepted, widely used and time-honored therapeutic measures should be questioned and re-evaluated through clinical trials. This is particularly important with regard to periodontal disease which is most amenable to investigation by means of the epidemiological approach.

Periodontal disease continues to be a major global health problem and failure to apply readily available and practicable preventive measures has been cited as a major cause.[1] By intelligent use of epidemiology and clinical trials it should be possible to fully exploit man's perennial search for knowledge and, in the near future, to base periodontal therapy mainly on facts and to only a very limited degree on opinion. Considerable progress has already been made in this direction through various researchers and the studies they have conducted.

Investigations in recent years have led to the conjecture that the prevalence and severity of periodontal disease may be influenced by social and economic factors. Arno[2] examined approximately 1300 adults in Oslo and found that the prevalence of gingivitis is significantly higher in workers than in staff members. He suggested that this finding might be attributed to the relatively poor oral

On définit l'épidémiologie comme l'étude de l'apparition et de la distribution des maladies, habituellement à caractère épidémique ou endémique, mais parfois on inclut tous les genres de maladies. Les études épidémiologiques servent à plusieurs fins. L'hygiéniste, notamment, s'en sert pour déterminer si une population a besoin de traitement et pour évaluer la main-d'oeuvre et l'équipement nécessaires pour répondre au besoin. Le chercheur, par contre, peut recourir aux données épidémiologiques pour établir une corrélation entre la fréquence et l'incidence d'une maladie, d'une part, et divers facteurs étiologiques, d'autre part, fournissant ainsi au clinicien et à l'hygiéniste de précieux renseignements qui permettront de créer des programmes en vue d'attaquer les causes ayant trait à l'hygiène publique.

Bien qu'elle ait déjà fourni de précieux renseignements à notre profession, l'épidémiologie des maladies dentaires est encore une science que l'on n'utilise pas assez, malgré qu'elle soit en pleine expansion. Tous les genres de traitement devraient faire l'objet de tests et d'évaluations au moyen d'épreuves cliniques avant d'en répandre l'utilisation. De même, on doit remettre en question et ré-évaluer l'efficacité de procédés thérapeutiques répandus et consacrés par le temps. Ces exigences sont particulièrement importantes en ce qui touche la périodontite, qui se prête très bien à une étude épidémiologique.

La périodontite continue d'être un problème de santé publique important. Une des principales causes que l'on cite dans la documentation est le fait qu'on n'utilise pas les mesures préventives existantes et praticables[1]. En recourant de façon intelligente à l'épidémiologie et à des épreuves cliniques, on pourrait exploiter à fond cette soif éternelle de connaître propre à l'homme et, à l'avenir, fonder le traitement de la périodontite surtout sur des faits et dans une faible mesure seulement, sur des opinions. Grâce à divers chercheurs et aux études qu'ils ont dirigées, des progrès considérables ont déjà été réalisés dans cette voie.

Les enquêtes menées ces dernières années font ressortir que la fréquence et la gravité de la périodontite peuvent être attribuables, jusqu'à un certain point, à des

hygiene of the workers rather than environmental factors per se. Russel[3], as a result of studies made of North American rural and urban children, concluded that there seems to be an undefined factor in the life pattern of persons with a greater education which tends to hold periodontal disease in check. Other researchers have found a significant correlation between consumption of tobacco and severity of gingivitis, which led them to the conclusion that the use of tobacco may be a contributing etiological factor in gingivitis. Russel and Ayers[4] observed more severe periodontal disease in people with untreated carious lesions than in people without such lesions. Perhaps the reason is that many of these people also have poor oral hygiene, which conclusion would lend support to Arno's study. Stammyer[5] found frequency of toothbrushing to be correlated with the amount of observed clinical gingival irritation.

A classical study by Brantdzaeg and Jamieson[6] is of particular significance. Using various modified quantitative methods, 206 recruits in the Sanitary Training Centre of the Norwegian Army were examined and charted. Existing amounts of debris and calculus were assessed to yield scores on the Debris and Calculus Indices respectively. The subjects' personal, medical and dental histories were recorded and interviews elicited information concerning the amount and kind of tobacco used, frequency and method of toothbrushing and other related data. The clinical examiner was unaware of the answers to these questions when the participants were examined.

Statistical analysis of the data revealed significant relationships between periodontal health and the place of residence during childhood, education, use of tobacco, the number of unfilled cavities and toothbrushing. Overall, the differences in periodontal health were found to be directly related to differences in oral hygiene.

Epidemiological evidence provide by Waerhaug[7] and Stahl[8] tends to support the conclusion of Brantdzoeg and Jamieson. However to conclude that such relationships exist is probably not yet warranted because there has been personal bias in selection of material quoted. Although a sincere attempt has been made to describe broad trends of thought which appear to be significant and germane to the subject, a final judgement of their significance and consequence can be made only in the light of future studies and experience.

In order to precisely identify the many types and degrees of periodontal disease, various recording systems (periodontal disease indices) have been developed to quantify entities such as morbidity rates, gingivitis, gingival recession, and bone loss as revealed by x-rays. Periodontal disease indices developed by Ramfjord and numerous others have been reviewed by Waerhaug[7]. The entities cited are not all applicable or acceptable in every study. For example it has been found that the x-ray indices are not reliable because of distortion and the difficulty in assessing bone and tissue loss. Furthermore, it is usually impracticable to keep an experimental group together long enough

facteurs socio-économiques. Arno[2] a examiné environ 1300 adultes à Oslo et a découvert que la fréquence de la gingivite est beaucoup plus élevée chez les travailleurs que chez les employés de bureau. Il suggère que cela peut dépendre plus de la mauvaise hygiène orale des travailleurs que de facteurs environnementaux proprement dits. Russel[3], en se basant sur des études menées sur des enfants nord-américains de milieux rural et urbain, conclut qu'il semble exister un facteur inconnu dans le mode de vie des gens plus instruits qui fait que la périodontite n'a pas prise. D'autres chercheurs ont trouvé une corrélation significative entre la consommation de tabac et la gravité de la gingivite, ce qui les amena à conclure que le tabac pourrait être une des causes de la gingivite. Russel et Ayers[4] ont observé que la périodontite était plus grave chez les gens qui avaient des caries non traitées que chez ceux qui n'en avaient pas. Cela peut tenir au fait que nombre de ces personnes ont aussi une mauvaise hygiène orale, ce qui confirmerait l'étude de Arno. Stammyer[5] a trouvé que la fréquence du brossage des dent était en corrélation avec l'ampleur de l'irritation des gencives observée cliniquement.

Une étude classique effectuée par Brantdzaeg et Jamieson[6] est d'un intérêt particulier. En utilisant diverses méthodes quantitatives modifiées, ils examinèrent 206 recrues au Centre de formation sanitaire de l'Armée norvégienne, puis notèrent les résultats sur un graphique. Ils évaluèrent les quantités de débris et de calcul présentes pour obtenir des scores en fonction des indices de débris et de calcul respectivement. Les antécédents personnels, médicaux et dentaires des sujets ont été consignés et, au moyen d'entrevues, les chercheurs ont recueilli des informations sur la quantité et le genre de tabac utilisé, la fréquence du brossage des dents et la méthode employée, et autres sujets connexes. Le clinicien chargé de l'examen ne savait rien de ces réponses lorsqu'il examina les sujets.

Une analyse statistique des résultats a révélé un rapport significatif entre la santé périodontique et le lieu du domicile pendant l'enfance, le niveau d'instruction, l'utilisation du tabac, le nombre de cavités non obturées et le brossage des dents. Grosso modo, on a trouvé que les différences observées sur le plan santé périodontique étaient directement reliées aux différences d'hygiène orale.

Les constatations épidémiologiques de Waerhaug[7] et Stahl[8] vont dans le même sens que la conclusion de Brantzoeg et Jamieson. Toutefois, il serait probablement prématuré d'affirmer que de tels rapports existent étant donné le penchant personnel exercé dans le choix de la documentation citée. Bien qu'un effort sincère ait été fait pour décrire les tendances générales de pensée qui semblent avoir un rapport avec le sujet, on ne saurait formuler un jugement final sur leur portée et leur effet qu'à la lumière d'autres études et expériences.

Afin d'identifier avec précision les nombreux types et degrés de périodontite, divers systèmes de notation (indices de la périodontite) ont été mis au point pour quantifier les taux de morbidité, la gingivite, la récession gingivale et la détérioration de l'os telle qu'elle est révélée par les rayons X. Waerhaug[7] a revu les indices de la périodontite mis au point

to assemble an accurate longitudinal study and sequential record from x-rays.

The PMA[9] index was probably the first practical, and scientifically supportable numerical system developed for recording periodontal conditions. The three letters stand for papillary (P) marginal (M) and attached gingiva (A). The PMA scores can be added and the sum taken as representing the status of the individual's periodontal health. The PMA index is not perfect and, like all gingivitis indices, its greatest defect is that there is no provision for identification of the destructive phases. Since it is well recognized that periodontitis is a destructive process which can and does progress steadily throughout life, this deficiency is of considerable importance. The highest values of a gingivitis index are often recorded during puberty because hormonal imbalance makes inflammation more overt during this period. The value of an epidemiological survey of the adult population, however, is dependant on determining the destructive consequence of gingival inflammation. Russell's Periodontal Index[10] (PI) is a serious attempt to quantify this destruction and Ramfjord's Periodontal Index[11] (PDI) is developed from Russell's. One weak point of this latter index is that it contains no provision for distinguishing between slight and extreme pocket deepening. However, for a total inventory of a patient population, the Ramjford index is probably the most accurate tool available as it is based on measurements rather than estimates. It has been used in many surveys and clinical trials in several countries.

There are numerous other factors that must be considered in a comprehensive epidemiological study of periodontal disease including evaluation of oral hygiene, gingival bone count, malocclusion and various other conditions. Fortunately there seems to be an index to evaluate almost all conditions in the oral cavity, as well as certain extrinsic factors. Each of these has been used and modified by various researchers in the field, most of whom admit to a personal bias in their selection of certain indices.

Tooth mortality and its causes have been studied extensively, and, as noted previously, so have the correlation of periodontal disease with age, oral hygiene, socio-economic status, effect of tobacco as well as general disease, nutritional factors, the influence of sex, and, in the tropics, the effect of the betel nut. In essence, research of periodontal disease can involve not only the complete dental history but also the medical and personal history of each person investigated.

Surveys from all over the world have demonstrated that periodontal disease is present in some form or another in practically all races, and that the severity varies widely. It is far from being a new disease. As long ago as 400 BC Greek soldiers were plagued by a painful, acute gingival disorder which researchers have since concluded was probably acute necrotizing ulcerative gingivitis.

Periodontal disease per se does not necessarily produce significant discomfort. It is its final consequence,

par Ramfjord et nombre d'autres chercheurs. Les indices cités ne sont pas tous applicables et acceptables dans chaque étude. Par exemple, on a découvert que les indices de rayons X ne sont pas sûrs à cause de la distortion et de la difficulté à évaluer la détérioration de l'os et des tissus. De plus, il est souvent impossible de rassembler un groupe expérimental pendant assez longtemps en vue de diriger une étude longitudinale précise et d'obtenir des radiographies nécessaires.

L'indice PMA[9] est probablement le premier système numérique pratique et vérifiable scientifiquement qui ait été établi pour enregistrer les conditions périodontiques. Les trois lettres du sigle signifient la gingivite papillaire (P), marginale (M), adhérente (A). Les scores PMA s'additionnent et la somme peut être considérée comme représentant l'état de santé du sujet au point de vue périodontique. L'indice PMA n'est pas parfait: comme tous les indices de la gingivite, son plus grand défaut est de ne pouvoir identifier les phases destructives. Comme il est bien établi que la périodontite est un processus destructeur qui progresse régulièrement tout au long de la vie, cette déficience est loin d'être sans importance. Les valeurs les plus élevées d'un indice de la gingivite s'observent le plus souvent pendant la puberté parce que le déséquilibre hormonal rend l'inflammation plus évidente pendant cette période. La valeur d'une enquête épidémiologique au sein d'une population adulte, cependant, tient au succès avec lequel on détermine les effets destructifs de l'inflammation gingivale. L'indice périodontique de Russel (PI)[10] représente une tentative sérieuse pour quantifier cette détérioration et l'indice périodontique Ramfjord A(PDI)[11] est dérivé de celui de Russell. Un point faible à noter au sujet de ce dernier indice: il ne permet pas de distinguer entre un agrandissement léger et extrême de la cavité alvéolaire. Par contre, pour effectuer un inventaire global d'une population donnée, l'indice Ramfjord est probablement l'instrument le plus précis que l'on possède actuellement, puisqu'il est fondé sur des mesures et non sur des estimations. On l'a employé pour nombre d'enquêtes et d'épreuves cliniques dans plusieurs pays.

De nombreux autres facteurs entrent en ligne de compte dans une étude épidémiologique complète de la périodontite, notamment l'évaluation de l'hygiène orale, la malocclusion et diverses autres conditions. Heureusement il semble y avoir un indice pour évaluer presque n'importe quelle condition dans la cavité orale, en plus de certains facteurs extrinsèques. La plupart de ces indices ont été employés et modifiés par divers chercheurs dans le domaine; la plupart admettent avoir un penchant personnel dans le choix de certains indices.

La mort des dents et ses causes ont fait l'objet d'études extensives, de même que la corrélation entre la périodontite et l'âge, l'hygiène orale, le niveau socio-économique, l'influence du sexe et, dans les tropiques, l'effet de la noix d'arec. Essentiellement, la recherche en matière de pédiodontite peut englober non seulement les antécédents dentaires, mais aussi les antécédents médicaux et personnels du sujet examiné.

the loss of teeth, that causes the greatest problems both for the individual patient and for the health services. In underdeveloped countries periodontal disease is the most destructive dental disease and should be considered accordingly by both educationalists and public health administrators. Unfortunately, at present it appears that such is not always the case.

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Editor's Note

The author acknowledge Reference No 7 as his main reference for this paper, which was presented in its original form as a partial fulfilment of the requirements of his attendance on the Dental Therapist Course at CFDSS in 1974.

Des enquêtes menées dans toutes les régions du monde ont montré que la périodontite se manifeste sous une forme ou l'autre dans presque toutes les races et que sa gravité varie beaucoup. Nous sommes loin d'avoir affaire à une maladie nouvelle. En l'an 400 A.J. déjà, des soldats grecs avaient été affligés d'un trouble gingival aigu et douloureux, que les chercheurs ont identifié depuis comme étant probablement l'état aigu de la gingivite ulcérative nécrosante.

En soi, la périodontite ne produit pas nécessairement un malaise notable. C'est la conséquence finale, la perte des dents, qui entraîne les difficultés les plus graves, tant pour le sujet touché que pour le service de santé qui doit le traiter. Dans les pays en voie de développement, la périodontite est la maladie dentaire qui fait le plus de ravages, et c'est à ce titre qu'éducateurs et administrateurs de l'hygiène publique doivent s'y intéresser. Malheureusement, on ne peut pas dire que c'est toujours le cas actuellement.

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Note du Rédacteur en chef

L'auteur reconnait s'être surtout inspiré de la référence n° 7 pour rédiger son article, lequel fut d'abord présenté pour répondre partiellement aux exigences du cours de thérapeute dentaire offert par les Forces canadiennes en 1974.

ACID ETCHING FOR A BETTER TREATMENT BRIDGE

BY CAPT. P. LAROSE

Introduction

The most effective method of replacing missing teeth, is by means of a fixed bridge[1,2] but, because of several factors, including clinic treatment priorities, patient seniority, available chair and lab time, it is not always feasible to construct such a permanent bridge immediately. (Fig. 1)

The most frequently used temporary restoration in these cases is the acrylic partial denture ('flipper'), which rests solely on soft tissue and, therefore, mechanically irritates palatal or lingual tissues.

Recently, Cutwright and Woody[3] suggested using a prosthetic tooth, acid etching and an Ultra-Violet light-polymerized composite for temporarily replacing a single missing anterior tooth.

Described here is a similar technique using the Concise Enamel Bond System (Fig. 2), which is readily available in the CFDS.

Figure 1. Officer cadet reports to dental clinic with broken acrylic partial denture used to replace upper right central incisor.

Figure 2. Concise Brand Enamel Bond System.

Figure 3. Prosthetic tooth is trimmed to fit edentulous space.

Figure 4. Devetailed retention groove on lingual aspect of prosthetic tooth.

Figure 5. Proximal surfaces of adjacent teeth are etched. Soft tissues are protected by rubber dam.

Figure 6. Finished restoration offers advantages of fixed bridge with conservation of hard and soft tissues.

UN MEILLEUR BRIDGE GRÂCE À L'ATTAQUE À L'ACIDE

PAR LE CAPITAINE P. LAROSE

Introduction

La méthode la plus efficace pour remplacer les dents, lorsque la chose est possible, consiste à installer un bridge inamovible[1,2]. À cause de plusieurs facteurs (dont les priorités de traitement clinique, la priorité des clients, le temps disponible tant au cabinet qu'au laboratoire), il n'est pas toujours possible de confectionner un bridge immédiatement (fig. 1).

Dans ces cas, la méthode de restoration la plus fréquemment utilisée est le dentier partiel en acrylique *("flipper")*. Celui-ci repose entièrement sur des tissus mous et irrite donc mécaniquement les tissus du palais et de la langue.

Récemment, Cutwright et Woody[3] ont suggéré d'utiliser une dent prothétique, l'attaque à l'acide *("acid etching")* et un composé polymérisé à la lumière ultraviolette pour remplacer temporairement une seule dent avant qui manque.

Le présent article décrit une technique semblable reposant sur le *Concise Enamel Bond System* (fig. 2), facilement disponible au service dentaire des Forces canadiennes.

Figure 1. Un officier cadet se présente au service dentaire avec un dentier partiel en acrylique brisé, lequel remplaçait l'incisive centrale droite du haut.

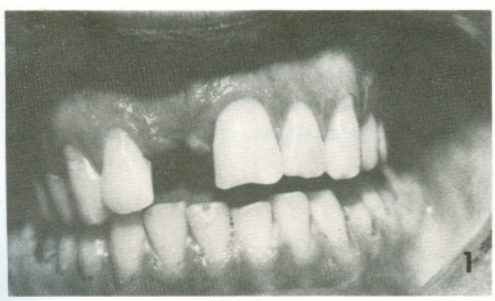
Figure 2. Le Concise Brand Enamel Bond System.

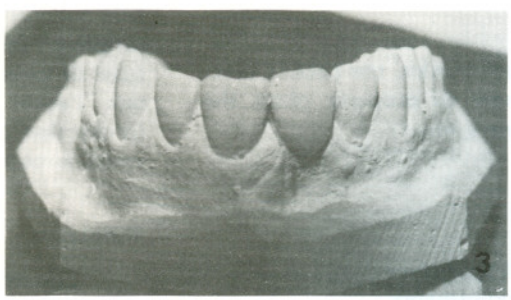
Figure 3. La dent prothétique est ajustée à l'espace édenté.

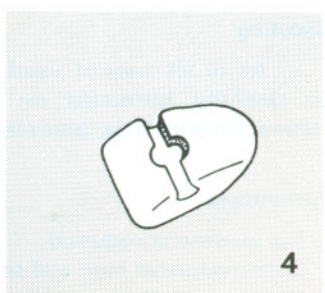
Figure 4. La rainure de rétention à queue-d'aronde pratiquée sur la surface linguale de la dent prothétique.

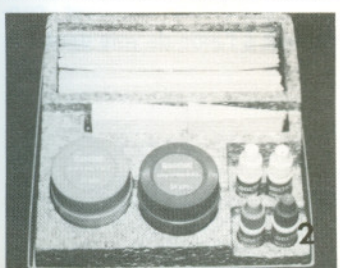
Figure 5. Les surfaces à proximité des dents adjacentes sont attaquées à l'acide. Une digue en caoutchouc protège les tissus mous.

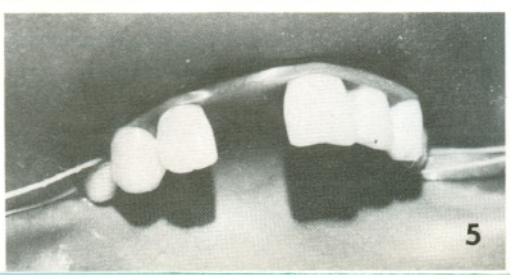
Figure 6. La dent restaurée offre les avantages d'un bridge fixe tout en conservant les tissus durs et les tissus mous.

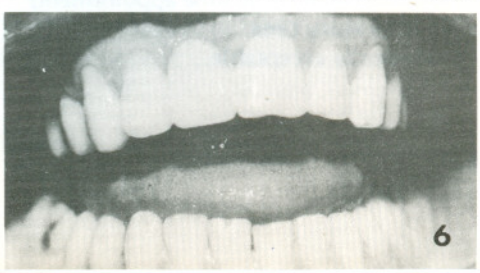












Technique

1. Select a plastic prosthetic tooth of proper size, shape and shade.

2. Adapt the tooth on a pre-obtained cast or directly in the mouth – ensuring gingival aspect rests gently on the gingiva (Fig. 3).

3. With a large inverted cone bur, cut a mesiodistal retention groove (dovetail) along the lingual aspect of the prosthetic tooth (Fig. 4).
4. Isolate teeth with rubber dam.

5. Etch enamel of proximal surfaces of adjacent teeth for one minute using supplied Etching Liquid (37% phosphoric acid) (Fig. 5). Rinse thoroughly with water and dry with air.

6. Cut a small hole in rubber dam where prosthetic tooth is to contact gingiva (ensure saliva does not infiltrate and contact etched surfaces).

7. Mix equal amounts of *liquid* resin and apply to etched proximal surfaces.

8. Mix equal amounts of *paste* composite – fill plastic tooth retention groove and apply to proximal surfaces on top of liquid resin.

9. Place plastic tooth in correct position and immobilize till composite sets.

10. Remove excess composite, adjust occlusion and polish – using twelve bladed burs, sandpaper disks and strips.

Acid Etching

Manufacturer's instructions[4] regarding acid etching must be carefully adhered to. A dabbing rather than a rubbing motion must be used. Should saliva contact the etched surface, the area must be re-etched. Precautions must also be taken to prevent acid from flowing onto adjacent soft tissue (rubber dam or copal varnish protection).

Cleaning

As in all cases of fixed prosthetics, the patient must be carefully instructed on how to properly clean the restoration with floss, pipe cleaners, etc.

Advantages

- No anesthetic required
- Conservation of hard and soft tissues
- Minimum chair time (one appointment)
- No laboratory time
- Esthetically acceptable.

Technique

1. Choisir une dent prothétique en plastique de dimension, forme et teinte appropriées.

2. Adapter la dent sur une empreinte obtenue au préalable ou directement dans la bouche, faisant en sorte que la partie gingivale repose doucement sur la gencive (fig. 3).

3. À l'aide d'une meule en forme de cône renversé, pratiquer une rainure de rétention à queue-d'aronde le long du côté lingual de la dent prothétique (fig. 4).

4. Isoler la dent avec une digue en caoutchouc.

5. Toucher l'émail des surfaces à proximité des dents adjacentes pendant une minute avec le liquide fourni à cette fin (37% acide phosphorique) (fig. 5). Rinser à fond avec de l'eau et sécher à l'air.

6. Percer un petit trou dans la digue de caoutchouc où la dent prothétique doit toucher la gencive (faire en sorte que la salive ne s'infiltre pas pour toucher les surfaces attaquées à l'acide).

7. Mélanger des quantités égales de résine *liquide* et appliquer aux surfaces proximales rongées par l'acide.

8. Mélanger des quantités égales de composé *en pâte,* remplir la rainure de rétention de la dent en plastique et en appliquer aux surfaces proximales par-dessus la résine liquide.

9. Placer la dent en plastique dans la bonne position et l'immobiliser jusqu'à ce que le composé ait durci.

10. Enlever le composé excédent, ajuster l'occlusion et polir à l'aide de meules à douze lames, de disques et bandes de papier sablé.

L'attaque à l'acide

Il faut suivre à la lettre les instructions du manufacturier concernant l'attaque à l'acide[4]. C'est par un mouvement de tamponnement et non de frottement qu'il faut toucher la dent. Si la salive vient à toucher la surface rongée à l'acide, il faut recommencer le procédé. Il importe aussi de prendre des précautions nécessaires pour empêcher que l'acide ne coule sur les tissus mous adjacents (protection au moyen d'une digue en caoutchouc ou de vernis au copal).

Nettoyage

Comme pour toute prothèse inamovible, il faut indiquer clairement au client comment nettoyer convenablement la prothèse fixée, soit à l'aide de soie dentaire, de cure-pipes, etc.

Disadvantages

– Single missing tooth situation only
– More delicate cleaning procedures required
– Strictly temporary.

Summary

A simple technique for constructing an anterior temporary bridge using the Concise Enamel Bond System and a prosthetic tooth is described. Technique advantages include conservation of hard and soft tissues, reduced chair and lab time and no anesthetic is required. It is recommended for single missing tooth situations only.

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Avantages

– Aucune anesthésie requise
– Conservation des tissus durs et des tissus mous
– Temps au cabinet réduit au minimum (un rendez-vous)
– Aucun travail de laboratoire
– Prothèse acceptable du point de vue esthétique

Inconvénients

– Le procédé ne s'applique que s'il s'agit d'une seule dent.
– Des procédés de nettoyage plus délicats s'imposent.
– Une mesure strictement temporaire.

Résumé

Une technique simple pour construire un bridge avant temporaire utilisant le *Concise Enamel Bond System* et une dent prothétique est décrite. Les avantages de ce procédé comprennent la conservation des tissus durs et des tissus mous, la réduction du temps requis au cabinet et dans le laboratoire, et la possibilité de pratiquer le tout sans anesthésie. Cette technique est recommandée uniquement pour les clients ayant perdu une seule dent.

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THE YELLOW CODED PATIENT AND THE DENTAL ASSISTANT

BY SGT T.A. JAMES

LES DENTS JAUNES ET L'AUXILIAIRE DENTAIRE

PAR LE SERGENT T.A. JAMES

THE PROBLEM

It has been said that a conservative is a man who throws a 25 ft rope to a person drowning 50 ft from shore and shouts encouragement for him to swim the other half of the way, for the good of his character; while a liberal throws a 50 ft rope to a person only 25 ft from shore and then lets go of the other end and walks away to do another good deed.

There is a tendancy on the part of many of us to be either too conservative or too liberal in handling patients who have seriously neglected their oral health and hygiene – those patients we refer to as "Yellow-Coded".

We can be too conservative on the one hand by throwing him the short rope of pointing out the problems he has created for himself through neglect and poor oral hygiene without offering any corrective treatment. We can be equally remiss by liberally treating his immediate problem and making him feel relatively comfortable but failing to counsel him in the procedures needed for him to keep himself that way and obtain a truly healthy mouth.

That yellow coded patients present problems in the clinic is clear to us all. Indeed, they present so many problems that it is often difficult to discover what they all are or to sort them out. But there is one underlying problem which is common to them all and it is largely responsible for their being in such poor oral health that they *are* yellow coded. This problem is one of attitude and, whereas most other problems can be dealt with primarily only by the dental officer, much of the responsibility for changing a patient's attitude rests with the dental assistant.

WHY THE PROBLEM EXISTS

Characteristically the yellow coded patient is *dentally alienated* and our task is to get him or her *dentally orientated.* Some of the possible factors causing such alienation are:

1. Fear of needles, the drill and/or pain;
2. A previous unhappy experience in the dental office;
3. Overcrowded conditions which create long waiting periods and make it difficult to get appointments;
4. The "hassle" he has to go through to get away from the unit;
5. The feeling that dental care is too time consuming – ie: patient is too busy with his job;
6. The misconception that military dentists are "poorly qualified".

LE PROBLÈME

On a déjà dit qu'une personne conservatrice était celle qui lançait une corde de 25 pieds à quelqu'un en train de se noyer à 50 pieds de la grève et qui l'encourageait par ses cris à nager l'autre moitié, pour l'édification de sa personne; une personne libérale, en revanche, lance une corde de 50 pieds à quelqu'un qui ne se trouve qu'à 25 pieds de la grève, puis laisse tomber l'autre bout et s'en va accomplir une autre bonne action.

Un bon nombre d'entre nous avons tendance à être soit trop conservateur, soit trop libéral, face aux clients qui ont négligé sérieusement leur hygiène orale.

D'une part nous pouvons être trop conservateurs en lui indiquant les problèmes qu'il s'est créés lui-même en négligeant son hygiène orale, sans lui offrir aucun traitement correctif. Nous pouvons tout aussi bien errer dans le sens contraire en traitant son problème immédiat et en le mettant relativement à l'aise, sans pour autant le conseiller sur la façon de rester ainsi et d'avoir une bouche vraiment en santé.

Nous sommes tous bien au courant du fait que les clients négligents présentent toutes sortes d'ennuis au service dentaire. En fait, les problèmes qu'ils apportent sont si nombreux qu'il est souvent difficile de les découvrir tous et de les isoler les uns des autres. Toutefois, il existe un facteur sous-jacent commun à toute cette catégorie de clients, lequel explique en grande partie pourquoi leur bouche est en si mauvaise santé. Nous voulons parler de l'attitude de ces clients. La plupart des autres problèmes sont surtout du ressort du dentiste, mais la responsabilité de changer l'attitude d'un client incombe à l'auxiliaire dentaire.

POURQUOI LE PROBLÈME EXISTE

Le client négligent est typiquement réfractaire aux soins dentaires et notre tâche est de le motiver à accepter d'être soigné. Certains des facteurs qui peuvent expliquer cette réticence sont:

1. La peur des aiguilles, de la drille, de la douleur;
2. Une expérience antérieure malheureuse au cabinet du dentiste;
3. Les longues listes d'attente qui font qu'il est difficile d'obtenir un rendez-vous;
4. La difficulté à se libérer de son travail;
5. L'impression que les soins dentaires prennent trop de temps; le client est trop pris par son emploi;
6. La fausse impression que les dentistes militaires ne sont pas compétents.

THE SOLUTION

A conscientious, understanding dental assistant can contribute to a patient's positive dental attitude. A willingness to discuss his problem creates an interest that is essential to his motivation and the following three measures for managing the yellow coded patient are suggested:

a. VENTILATION

The DA should try to get the patient to relate or ventilate his fears and talk about his past experiences. From such a history one should be able to determine what has contributed to his negative attitude toward dentistry.

b. EASING ANXIETY

After the patient has let you in on all or some of his fears, the challenge is then to put him at ease. For example, he may suffer from a fear of the unknown or of the clinic itself. The assistant should demonstrate and explain to him exactly what the different pieces of equipment are and how they work. Since he knows he is in poor dental health, assure him that it is the dental officer's job to help him and to treat him. It is *most* important not to condemn the patient for being in such poor dental health. Be honest; patients know when you are trying to "snow" them. It is important to tell him something positive even if it's only: "Well, at least you came in".

c. PLAQUE CONTROL AFTER TREATMENT

Plaque control is one of the main keys in establishing and maintaining good oral health once the patient's treatment is completed. Here too the dental assistant has an important role to play since a good plaque control program involves re-motivation as well as staining, instruction in brushing and flossing and the follow-up checks of his home-care. We can be of considerable value in improving his motivation by explaining the importance of the program to him in language he understands. One approach is to tell the patient that plaque control is his "insurance policy" that all the treatment he has received will continue to be to his benefit as long as he keeps up the payments by practicing good home care. A further analogy which helps get the point across is to liken the plaque count or index to verifying that the payments on the policy are being kept up.

It is most important that we follow-up and maintain contact with the treated yellow-coded patient to promote and strengthen a positive attitude in him towards his oral health.

The DA as a member of the dental team has a responsibility to assist and encourage the patient to carry out practices beneficial to his own personal health.

LA SOLUTION

Un auxiliaire dentaire consciencieux et compréhensif peut aider le client à adopter une attitude positive face aux soins dentaires. Le fait d'être prêt à discuter son problème suscite un intérêt qui est essentiel à sa motivation. Plus précisément, on suggère les trois façons suivantes d'aborder ce genre de clients:

a. OUVRIR LA QUESTION

L'auxiliaire dentaire devrait essayer d'amener le client à parler de ses craintes et expériences passées. En retraçant ces antécédents, il devient alors plus facile de déterminer ce qui a contribué à l'attitude négative du sujet face aux soins dentaires.

b. APAISER SES CRAINTES

Une fois que le client a bien voulu vous faire part de certaines de ses craintes, le défi à relever est alors de le mettre à l'aise. Il se peut, par exemple, qu'il ait peur de l'inconnu ou de service dentaire comme tel. L'auxiliaire dentaire devrait lui montrer l'équipement dont se sert le dentiste et lui expliquer le fonctionnement de chaque instrument. Puisqu'il sait que ses dents sont en mauvais état, il faut l'assurer que le dentiste est là pour l'aider et le traiter. Il ne faut surtout pas condamner le client parce qu'il est en si mauvaise santé sur le plan dentaire. Soyez honnête; le client décèlera vite toute tentative de le tromper. Il est important de lui dire quelque chose de positif même si ce n'est que souligner le fait qu'il a fait l'effort de se rendre chez le dentiste.

c. LE CONTRÔLE DE LA PLAQUE BACTÉRIENNE APRÈS LE TRAITEMENT

Le contrôle de la plaque bactérienne sur les dents est un des principaux moyens d'établir et de maintenir une bonne hygiène orale une fois que le traitement proprement dit est terminé.

Une fois de plus, l'auxiliaire dentaire peut jouer un rôle important, puisque tout bon programme de contrôle de la plaque dentaire comporte la motivation du client tout aussi bien que l'utilisation de la teinture, les instructions concernant le brossage et l'emploi de la soie dentaire, ainsi que les vérifications des soins personnels effectués à la maison. Notre apport peut être précieux si nous réussissons à le motiver davantage en lui expliquant l'importance du programme dans un langage qu'il comprend. Une façon d'envisager la situation consiste à dire au client que le contrôle de la plaque est sa "police d'assurance" et que tout le traitement reçu continuera de porter fruit aussi longtemps qu'il versera ses primes, c'est-à-dire qu'il pratiquera de bonnes méthodes d'hygiène orale. Une autre analogie qui fait bien passer le message est de rapprocher l'indice de la plaque dentaire à la vérification du paiement des primes par le client.

Il est très important de maintenir un contact avec le client que nous avons décrit dans le présent article afin de susciter et de renforcer chez lui une attitude positive face à sa santé orale. À titre de membre de l'équipe dentaire, l'auxiliaire dentaire a la responsabilité d'aider et d'encourager le client à mettre en pratique les recommandations visant à améliorer son propre état de santé.

"DENTAL WHITES TO COMBAT CLOTHING"

Reflections on Junior Leadership Course 7503 by the Graduation Parade Commander

CPL N. CREELMAN

"DU BLANC À LA TENUE DE COMBAT"

Réflexions sur le cours élémentaire de formation au commandement (Nº 7503) par le Commandant de la revue lors de la remise des diplômes, le

CAPORAL N. CREELMAN

What's a nice girl like me doing in a place like this? Sort of reminds me of a book I read a hundred years or so ago called "A Maid and Million Men". The girl in the story took her brother's place in the Regiment for a few hours so he could visit his wife and, without notice, the troops were drafted overseas, sister and all.

But times are changing: here I am *under orders* to report to the Bos'n School to begin Junior Leadership training. The odds aren't quite a million to one: but they *are* three to twenty-eight and odds like that I don't need.

"What's that Sergeant?" "My hair's too long?" "Since when is two inches of hair too long?"

"Base Defence training? I just *know* I'm going to need that!"

"What's an FN C1? Now look here, "Annie" proved long ago you can't get a man with a gun."

"For heavens sake! Twelve years previous service as an airwoman and physical training instructor, and *now all this ! !*

I can sum up Day-One in a single word. Phooey!

Qu'est-ce qu'une fille sympathique comme moi vient faire dans un endroit comme celui-ci? Ça me rappelle un livre que j'ai lu il y a une centaine d'années, intitulé: *A Maid and Million Men.* La jeune fille dont on fait mention dans l'histoire remplaça son frère au Régiment pendant quelques heures pour qu'il puisse aller visiter sa femme et, pendant son absence, on fit passer les troupes outremer sans préavis, la jeune soeur étant du groupe aussi.

Mais les temps ont changé: on m'a *donné l'ordre* de me rapporter à l'École de commandement pour y suivre un cours de formation élémentaire. Je ne me retrouve pas seule parmi un million d'hommes, mais je pourrais bien me passer de cette situation qui fait que nous sommes seulement trois femmes pour vingt-huit hommes.

"Vous dites, sergent?" "Mes cheveux sont trop longs?" "Depuis quand considère-t-on que deux pouces de cheveux, c'est trop long?"

"Entraînement à la défense? Exactement ce dont j'ai besoin ...je le préssens déjà!"

"Qu'est-ce qu'une FN C1? Eh bien! "Annie" a prouvé il y a longtemps déjà qu'on n'accroche pas un homme avec un fusil."

Junior Leadership Course 7503
Cpl(W) E.W. Creelman – top honour student and parade commander.

Day-Two over and done with — then Day-Three: Not a bad bunch. Some of our foibles are cause for great mirth and the instructors are quick to criticize. But they're just as quick to laugh and help.

Second week: Quite a bit of it seems old-hat. Sort of like a TV rerun. Hate to admit I'm enjoying the break away from the clinic. Who would have thought a female voice would carry so well on the parade square!

The course content's not too bad, even though it's designed for the young, newly-promoted Corporal.

Third week: Exercise Second-Step. Oh well, sleeping with 28 fellows isn't so bad! If they'd only stop snoring!

Fourth week: Exercise Wrap-up. My Lord! If only I *could*. It's *freezing* out here!

Another week gone so soon — the comradeship between staff and students is good.

Graduation week. The FN rifle turned out to be pretty simple after all. Yes sir, a good course; the platoon is a real team now. Who came first? Good God! I did? ?

Ah! those instructors, quick to criticize, quick to laugh, quick to help . . . . . .

"Franchement! Douze ans de service comme aviateur et instructeur d'entraînement physique, et *maintenant tout cela!*

Je peux résumer la première journée par un seul mot: inutile!

La deuxième journée passe... puis la troisième: le groupe n'est pas mal. Certains de nos points faibles suscitent le rire général et les instructeurs ne manquent pas une chance de nous critiquer. Mais ils n'hésitent pas plus à nous venir en aide.

Deuxième semaine: du déjà-vu, c'est le moins qu'on puisse dire. Un peu comme une reprise à la télévision. J'hésite à admettre que je me sens bien loin de la clinique. Qui aurait pensé qu'une voix féminine porterait si loin sur le terrain de manoeuvres!

Le contenu du cours n'est pas trop mal, même s'il s'adresse au jeune caporal nouvellement promu.

Troisième semaine: exercices de la deuxième étape. Enfin, dormir avec 28 hommes, ce n'est pas si mal! Si seulement ils cessaient de ronfler!

Quatrième semaine: couvrez-vous bien! Juste ciel! Si seulement je le pouvais. On gèle ici!

Une autre semaine écoulée déjà. La camaraderie entre le personnel et les étudiants est bonne.

La semaine de la remise des diplômes. La FN n'a pas été trop difficile à manipuler après tout. Oui, ce fut un bon cours; la section s'est constituée en une véritable équipe. Qui est arrivé premier? Pas possible! Moi ? ?

Ah! ces instructeurs, ils ne perdent pas de temps pour critiquer, rire, nous aider...

The top honour student and parade commander is Cpl Creelman EN DENT CL A 722 from the Chilliwack Detachment of 11 Dental Unit. The reviewing officer is Maritime Forces Pacific COS LOG ADM Officer Col GA Berry, DFC, CD.

NO 1 DENTAL UNIT NEWS

On the 23rd of May, the personnel of No 1 Unit held a social evening in honour of three of its members who are leaving the Service. As a memento of their association with us, they were presented with CFDS Plaques, as shown in the photos.

For Captains Dave Rowat and Gaetan Boulanger, their Ottawa postings must have been reasonably happy since they both are going into private practice in the area now that they have completed their five years of compulsory service. We wish them the very best of success in the future.

The third member, Sgt Bev Gilkes had only been with us for a year following her return from Europe, but during that time she added a lot to the Unit, particularly to the detachment at Ottawa North. She was particularly competent in demonstrating some of the finer points of curling to both her team mates and her opponents. Bev has decided to seek the greener pastures around Oshawa and our best wishes went with her.

Another member of the unit was entertained by the unit WO's and Sgt's at the Sgt's Mess upon his release from the CFDS. The guest of honour, Capt Al Charlebois, being well trained at Cold Lake in the fine art of pacing his consumption of liquid refreshments, was able to hold his own and arrived home in a reasonable state of repair. Not many officers who have been entertained in the Sgt's Mess can make such a claim. Al has set up practice in Kingston.

No. 1 Unit – Major Carver presenting plaque to Capt Rowat.

No. 1 Unit – Major Carver presenting plaque to Capt Boulanger.

No. 1 Unit – Capt Boulanger presenting plaque to Sgt. Gilkes.

12 DENTAL UNIT NEWS

CAPT D.H. BROWN

Personnel from the Halifax/Shearwater area held a party at the Chief Petty Officers Mess in Shearwater on the evening of 6 Jun 75 to say farewell to those officers and NCOs posted out of the Unit. A steak dinner was followed by a dance with music provided by a group from the Stadacona Band.

HMS Hermes, a Royal Navy amphibious assault ship, visited Halifax for approximately two weeks in May. The British dental team, Lt Surg Brian Griffiths and PO Alan Curtis, made several professional and social calls in the Halifax area.

MWO MacLean SL has been appointed supervising officer of the CFB Cornwallis Junior Ranks Club.

Although two members of the Gagetown clinic, Cpl McLeod and Capt Sasse played on the championship Base Hockey Team, only Cpl McLeod was named to the HQ, CFB Gagetown All Star Team.

SAFETY CITATION AWARDED

The safety record of this unit has been recognized at three of our detachments recently. In Photo #1, Major Kelland, Base Dental Officer at CFB Greenwood is shown receiving a citation from Mr Ross Mackintosh, Field Representative for the Workmans Compensation Board, while in Photo #2 Sgt BL Mackie receives one on behalf of the Shearwater dental staff from Mr John Paddon while Mr JD Tomney, SSO GSAFE (Marcom) (second from left) and Col BA Oxholm, Base Commander CFB Shearwater look on.

The CFB Summerside detachment was presented with a similar award in recognition of 365 consecutive days without a lost-time injury by the dental staff.

CD AWARDED

On 25 Apr 75, Cpl RF Buchanan was presented with his CD by Major WA Gray as shown in the accompanying photograph (#3).

LCol Brogan has accepted an appointment to the Advisory Committee of the NB Provincial Council, Boy Scouts of Canada.

MCpl Brian Rector and Cpl Hanna Dijkstra sponsored a promotion party at the Fleet Club on 21 May for all dental personnel in the area. Many stories were retold and much ale consumed by those present.

A number of unit personnel are making plans to attend the CDA Convention in St John's NFLD in Aug 75. The CO is making three alternate travel plans after his last bout with Newfie weather!

Cpl R.F. Buchanan was presented with his CD by Major W.A. Gray on 25 April, 1975.

13 DENTAL UNIT NEWS

FLASH – OFFICERS THOROUGHLY TROUNCE OTHER RANKS – FLASH

The sporting event of the season took place at the CFB Trenton Golf Club on 4 Jun 75. This event was the "Officers vs Other Ranks" semi-annual golf tournament comprising personnel from HQ and 13 Dental Unit Det Trenton. The officers trounced the other ranks, *once again*, winning by an enormous lead of ten strokes.

Sincere thanks are extended to MWO Mickey Kidd for completing the first nine holes. The appearance on the greens of Joyce Pero and Kim Gasbolt did much to foster a high degree of competitiveness among the male participants. Rumour had it that Maj Dave Jones cut short his stay in the Middle East just to lead the officers to this outstanding victory. That rumour was laid to rest when his score was made public – but – welcome home anyway, Dave!

Base Dental Detachment at CFB Greenwood was presented with a citation for 365 days of accident free operation. The presentation was made to Major Kelland, B Dent O, by Mr. Ross MacIntosh, Field Representative for the Workman's Compensation Board on Friady 11 April 1975.

Sgt B.L. Mackie accepted a safety citation on behalf of the Shearwater Dental Staff from Mr. John Paddon, Field Representative of Accident Prevention Division, Workmen's Compensation Board of Nova Scotia. The award was presented in recognition of 365 consecutive days without a lost-time injury by the dental staff.
Observing the presentation are Mr. J.D. Tomney, SSO GSAFE(MARCOM) and Col B.A. Oxholm, Base Commander, CFB Shearwater.

FAREWELL – AUREVOIR

Maj HA Chestnut, RMC Dental Det, proceeded on terminal leave 5 May 75 upon completion of his period of obligatory service. Arnie is remaining in Kingston, Ontario and will be practising in partnership with Al Charlebois, a recent member of 1 Dental Unit.

14 DENTAL UNIT NEWS

Most of the activity in 14 Dental Unit lately concerns the formation of Air Command and all the paper work that these changes entail. HQ 14 Dental Unit has now been moved and we are enjoying our new offices in the main Command HQ building.

With the addition of Capt Bill Dawson, three of our members based in Winnipeg are now members of the Charleswood Golf Club. Bill decided to join because he heard that membership guaranteed he would be as good a golfer as MCpl Roy Tallack and Sgt Al Gray who were already members.

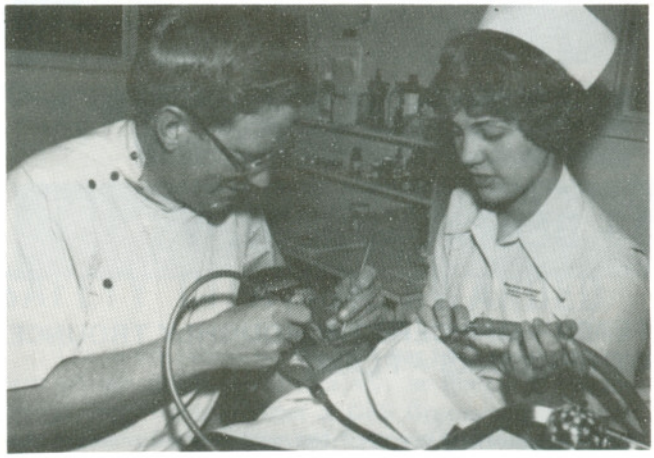
During the month of March student dental nurses from Red River Community College arrived at the Winnipeg Detachment for a period of assessment and on-job-training. This experience serves two very important purposes: It shows the staff how well the students are assimilating their training and the students get a better idea of what being a dental assistant is all about.

By the time this article is in print we will be due to see you all in Trenton for the Annual Golf Tournament. 14 Dental Unit will again be defending champions and we hope to see you all there.

WO Henry Wagstaff has joined those elite people who fly. He describes his reaction to getting his licence in the following short article:

WO Henry Wagstaff prepares to take off after having heard that flying over those who walk on water brings better PER results.

Miss Kathy Neilsen of Red River Community College assists Capt Bill Dawson with Mrs. Lydia Less providing supervision in the background.



Miss Anne Nykolyszyn of Red River Community College receives on-the-job-training by assisting Capt Dick Hunt of the Winnipeg Detachment.

FLIGHT TEST – WO HENRY WAGSTAFF

This is my big day. After many months of anticipation, study, practice and butterflies, I am ready for the big test.

"Will I make it? "

"Will I be able to stall that plane and still bring it out level in time? "

"Will I be able to make those spins and satisfy the inspector? "

These are the questions running through my mind as I taxi out in the Cessna 150 which I have been flying for almost a year.

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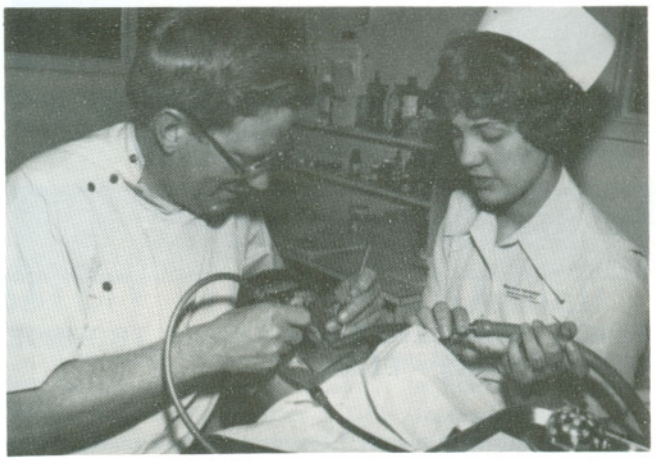

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FLIGHT TEST (cont'd)

How well I remember that first day I sat behind the controls and started learning the basic elements of flying!

"The instructors must be some sort of special fellows with extra strong nerves", I recall thinking to myself, as I pulled back on the stick that finally took us clear of the ground.

"Are we really airborne? "

"Am I really flying this thing? "

Well, that was "way back when". Today there is more serious business before me. This is my Final Exam!

"What am I going to be able to show for those 45 hours of ground school training and 60 hours in the air? Thirty-five hours is the minimum requirement, which means I'm just a little bit more qualified than *some* are. So, what am I worrying about? "

Seated beside me is Cpl Russ Cass, a former instructor of the Edmonton Flying Club and a Dept. of Transport inspector. I have spent several hours learning the rudiments with Russ and Capt J.P. Germain, and L.C. Kip Davis, the other capable instructors we have and now I am about to make history as the 16th person to obtain a pilot's licence with the Namao Flying Club since its inception in October 1972.

"Well, the take-off seemed OK. He seemed satisfied with the climb and level flight. Now for those stalls and spins."

"Yes, all emergency situations seemed all right."

"Oh, oh, that turn wasn't as good as yesterday. Maybe we had better try another of those."

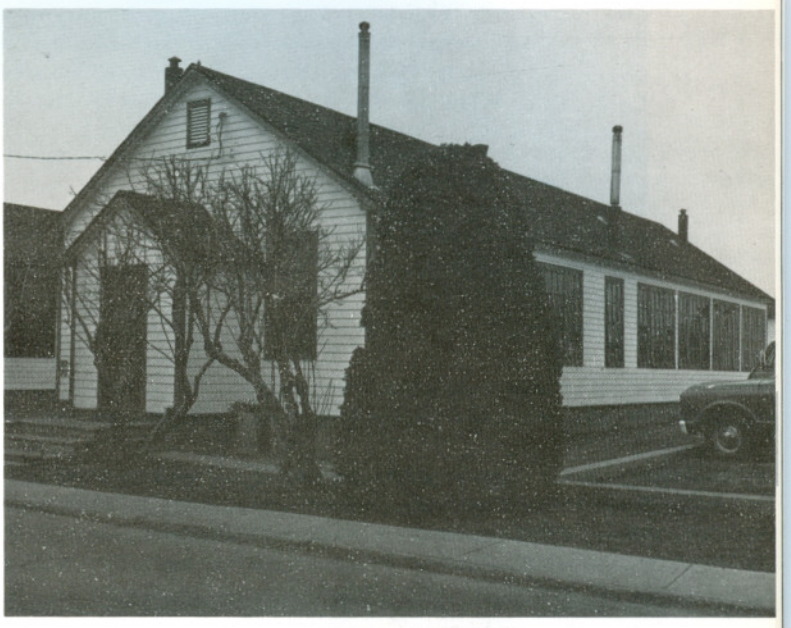
"Now for a nice smooth landing. Whew! "

Anticipation? – Yes, anticipation, – until I hear those sweet words:

"You passed, I'm off to do the paper work. You fuel up." Now beside that first solo certificate, (with all its huffs and puffs), I am able to hang the real thing which allows me to fly wherever and whenever I choose.

"Anyone want to go up for a flight? "

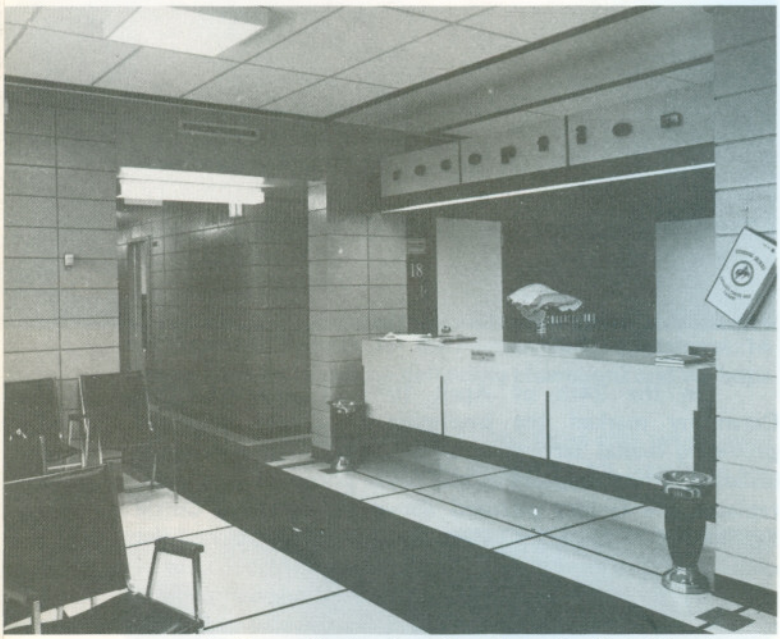
NEW DENTAL CLINIC FOR CFB CALGARY



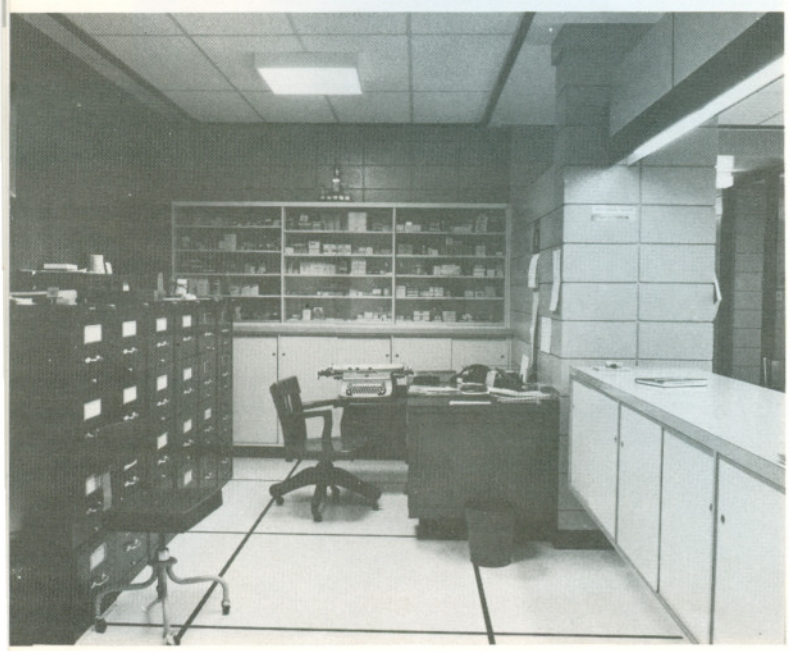
On the 24th of April 1975, a Ribbon-Cutting Ceremony marked the beginning of a new phase in providing dental services at CFB Calgary. The new clinic building, which appears as the cover photo of this issue, replaces the facility pictured above which served Currie Barracks from the early 1950s. Until the day it closed the dental staff were regaled by "old soldiers" with tall tales of how this "old clinic" and the Base Hospital had usurped the space occupied during World War 2 by the stables for the Cavalry horses. When the Sarcee clinic was opened during the 1960s, the dental detachment at Calgary became a split operation and so it remained until the new clinic was opened.

The photograph of the opening ceremony shows Brigadier-General (Retired) GC Evans about to snip the ribbon which is being held by BGen LG Craigie DGDS on the right and Col JC Brick Commanding Officer 14 Dental Unit on the left. That side of the ribbon was so heavy that Col Brick was assisted in the task by Major RH Headley B Dent O of CFB Calgary. Col CW Hewson, Deputy Commander 1 Cbt Gp HQ represented Brig Gen PA Neatly at the ceremony.

Some of the features of the new building are shown in these pictures.



As the patient enters the clinic the first thing he sees is this attractive Reception Area.



The Orderly Room, where the charts and files are kept in the cabinets and some of the dental supplies on the shelving and in the cupboards which appear in the background.

Preventive Dentistry Room.

After the ribbon cutting ceremony, Brig Gen Craigie accompanied by Major Headley made a complete tour of the new facility and this last photo shows the DGDS with the Base Dental Officer discussing the Lab equipment with WO Don Hill the senior Lab Technician.

Following the inspection of the new building Brig Gen Craigie lunched with the Senior Base Officials at the PPCLI Home Station Officers Mess before continuing on with his Alberta tour of Canadian Forces Dental Facilities.

RETIREMENT PRESENTATION TO MWO ABERNETHY

Major IW Susser, BDENTO CFB Winnipeg, presents an engraved silver tray to MWO EK "Gene" Abernethy on the occasion of his retirement from the CFDS while the remainder of the staff of the dental clinic prepare themselves for the speechmaking that is sure to follow.

COMMANDERS' COMMENDATION PRESENTED TO SGT HILL

A commendation from the Commander Training Command was presented to Sgt JF Hill of CFB Edmonton Dental Detachment on 17 June 1975. The citation reads:

> "For outstanding service beyond normal expectations, in support of the Preventive Dentistry Programme at the Namao Dental Clinic, CFB Edmonton.
>
> In spite of the complete disruption of clinic routine caused by the relocation of base dental facilities, Sgt Hill's initiative and effort over an extended period of time was instrumental in the clinic attaining a high degree of success in their Preventive Dentistry Programme objectives."

and is signed by R Adm R St O Stephens, Commander, Training Command.

The photo shows the presentation of the award to Sgt Hill by LCol Kettyls, who acted on behalf of the Base Commander. Major PR Wooding, Preventive Dentistry Officer, was present at the ceremony.

15 DENTAL UNIT NEWS

FAREWELL TO STAFF MEMBERS

A farewell gathering was held at the St Hubert WO's and Sgts' Mess on 22 May 75 to bid farewell and extend good wishes to personnel leaving the St Hubert area. Those sent on their way in fine style were *Capt Laberge,* to enter private practice in Ste Thérèse PQ; *Capt Gélinas,* to conquer CFS Alert; *MWO Bennett,* to CFB Petawawa; *WO Hall,* to CFB Borden; *Sgt Beauchamp* all the way to Lahr, and *Sgt Garnhum* to CFS Holberg. There was a good turnout and everyone enjoyed themselves immensely.

A similar gathering was held at the Club Rendez-Vous in St Jean to send Capt Roy on his way to release, terminating his Short Service Commission. BBQ steaks and refreshments were enjoyed by all.

Maj Lemieux of Det Valcartier is off to enjoy a posting to 35 FDU Baden.

Capt Anne Higgins is welcomed as the new Admin Offr at Unit HQ.

SPORTS

All Det St Jean personnel turned out to support our Expos at the Baseball Season opener, only to have their enthusiasm dampened by wet cold weather, and to top it off the Expos lost! Some days are like that.

Cpl Brisebois has joined the CFB St Jean softball team in the Labbatt 50 League. Their record is now similar to the Expos: more defeats than wins.

At the last report Capt Loiselle and Cpl Brisebois were getting their fishing gear ready to try their luck in Chibougamau waters. Although a fish story was promised, they have remained peculiarly quiet about their catch.

TD TRIP TO MOSCOW

Maj HJ Nadeau and Sgt JL Fréchette, Det St Jean, were fortunate enough to be assigned the TD visit to Moscow 2-17 Jun to work under the Interdepartmental Dental Treatment Program. There has been no report regarding their tour of duty but it is hoped that the trip was enjoyed to the full.

CONVENTIONS

The following officers attended Les Journées Dentaires held at Queen Elizabeth Hotel, Montreal 26-28 May:

Maj FC Arpin, Maj JJ Lemieux, Capt JP Beauchemin, Capt JR Laberge, Capt JPR Lévesque, Capt JN Roy.

CANADIAN ARMY DENTAL CORPS PERSONNEL STILL REMEMBERED

The following letter is self-explanatory and if any of our readers were stationed at Farnborough during that period and remember Mrs Nicholl, her son would certainly enjoy hearing from you. Unfortunately, the picture mentioned in the letter was too indistinct to reproduce.

W. Nicholl
237 Lynchford Road
Farnborough
Hants
GU 14.GHH
GU 14.GHH

30th June 1975

Dear Sir,

I have just recently returned to England from a months holiday in Canada, while I was there due to injuries I was asking about the Canadian Army Dental Corps. I was given your address with the suggestion that you may be able to help.

The story is, that during the last war my Mother owned a Cafe in Camp Road, Farnborough, to which 90 per cent of the Dental Corp stationed in Three houses namely "Eric's own" "Stafford House" and "Clinette" all in Alexandra Road, Farnborough, all came for their Evening Meal.

Nearly all these chaps were so regular that they became more like friends.

I can only give you names of about four, they were Sgt Major McClaren, Sgt Eric Parkes, Tony Harrison, Delrimple. If a contact could be made it would be greatly appreciated.

I enclose a photograph of my Mother and myself in Uniform, sitting on the wall outside my Mother's Cafe.

If you can help and want any further information I will do my best to answer then.

Hoping you can help.

Yours faithfully,

WELCOME

Congratulations are in order for the following officers who graduated from their respective universities this Spring and, having been promoted to the rank of Captain, are now full-fledged Dental Officers:

Captains: P.G. Abott, S. Arlington, J.L. Bilodeau, J.G. Brass, R.G. Button, J.R.G. Cormier, H.M. Corrigan, W.H. Fallon, R.K. Hockney, J.R.M.P. Langlois, A.K. Larter, R.J. LeBlanc, J.R.R. Lévesque, P.M. Lobb, T.R. Melbourne, R.B. Orawiec, J.G. Poirier, L.C. St Pierre, G.E. Tucker, D.R. Vandahl, K.W. Whitemore.

We also extend a most hearty welcome to these new members of the CFDS:

Pte F.A. Alliston, Lt F.M. Bjerke, Pte(W) M.A.J. Boudreau, Pte A.P. Colbourne, Mrs. C. Constant, LCol J.E. Crofton, Mrs. G. Guertin, Pte J.D. Hickman, Capt(W) A. Higgins, Capt P. Kozak, Sgt J.A. Larouche, Mrs C. Owen, Pte(W) M.J.G.S. Picard, Pte(W) M.J.F. Rocheleau, Pte(W) M.R.N. Vallee.

FAREWELL

Our best wishes go with those who have recently terminated their direct association with CFDS, some with a full career of service behind them and others after a much shorter time with us:

MWO E.K. Abernethy, Capt T.A. Bradley, MWO G.E.C. Bradley, Capt J.A. Boulanger, Capt A.P. Charlebois, Maj H.A. Chestnut, Capt J.G. Duford, Maj R.E. Dyer, Capt R.J. Fennell, Capt H.V. Ferber, Capt J.M. Gelinas, Sgt B.A. Gilkes, Capt G.P.F. Greenacre, LCol W.H. Harrington, Maj L.R. Holland, Miss C. Houde, Capt F.V.R. Jackson, Cpl R. Jones, Capt J.R. Laberge, Mrs. P.G. Macklin, Maj F.R. Margetts, Capt C.G. Milne, Capt J.E.F. Paquin, Maj M.F. Pilon, Capt J.D. Rowat, Capt J.J. Roy, Capt J.R. Salois, Capt R. St. Louis, Cpl G.E. Sykes.

MARRIAGES

Cpl(W) S. Greene to Lt I. Fenton, Pte(W) J.L. Miller to Pte R. Purdy.

BIRTHS

Son to:	Daughter to:
Capt & Mrs. T.P. Levy	Cpl & Mrs R.A. Portuondo
Sgt & Mrs. R.A. Gayler	Capt & Mrs. B.D. Hamilton
WO & Mrs. J.A.N. Audet	Sgt & Mrs J.L. Violette
	Capt & Mrs. R.E. Riley
	Sgt & Mrs. R. Ritchie

BEREAVEMENTS

Our sympathy is extended to:

Capt J.E.R.J. Gauthier on the loss of his father.

Capt T.B. Cadden on the loss of his father.

Col W.R. Thompson on the loss of his father.

PROMOTIONS

To:

LCol – V.J. Lanctis

Maj – J.G. Chagnon, P.R. Darlington, E.W. Graham, P.D. Higgins.

WO – E.B. Borden

Sgt – G.G. Bowser, L.J.P. Nadeau, W.H. Renwick, J.E. Thomson, J.A. Wesley.

MCpl – G.W. Bowman, L.J.D. Côté, W.G. Cudmore, T.W. Mountain, B.C. Rector.

Cpl (W) – H.A.J. Dijkstra.

AWARDS

First Clasp to CD:

Sgt T.R. O'Mara, MCpl J.G. Riel.

CD:

WO J.A. Antherton, Cpl R.F. Buchanan, Sgt J.L. Pouliot, Cpl L.C. Street.

PROFESSIONAL TRAINING

USNDS Bethesda, Md
Periodontics 21-25 Apr 75
Major C.J.M. Boston

CDN FORCES TRAINING

CFB Bagotville – High Altitude Indoctrination – 11-12 Jun Maj G. Jacques

Middle Management Course

Capt C.B. Bullock	20 May–6 Jun
Capt E.F. Sasse	3 – 21 Mar

Junior Leaders Course

Cpl W.E. Blackley	2 – 23 Jan
Cpl W.M. Skanes	24 Feb-21 Mar

CFDSS

Dental Clinical Assistant TL3

23 Apr 75 – 25 Jun 75

Pte J.G.R. Anctil
Pte J.A.D. Beland
Pte M.F.J. Boudreau
Pte J.L. Chauss
Pte F.M.F. Deschamps
Pte M.R.A.M. Dufresne
Pte N.C. Gilbert
Pte M.L. Plante
Pte M.G.T. Picard
Pte M.H.H. Roy
Pte M.J. Rocheleau
Pte M.G. Tessier
Pte M.N.R. Vallee

Dental Therapist Adjustment Course

09 Apr 75 – 30 Apr 75

WO J.A.J. Fret
WO J. Dion
WO N. Cable
WO H.D. Wagstaff
WO R.D. Veinot
WO H.C. King
WO J.G. MacDonald
WO R.J. Lowery

Dental Laboratory Technician TL6A 07 Apr – 13 Jun 75

Cpl D.G. Allen
Cpl W.G. Cudmore
Cpl P. Maelde

Dental Clinical – Oral Surgery Course

30 Apr 75 – 14 May 75

Capt R.P. Alberti
Capt J. Beauchemin
Capt R.E. Fletcher
Capt R.S. Sorochan
Capt R.L. Thompson
Capt J.W. Valois

Dental Officer Training Plan Phase III
26 May 75 – 01 Aug 75

2LT D.G. Cahoon
2LT P.A. Gillies
2LT M.L. Irwin
2LT G.W. Iverson
2LT(W) C.E. Leek
2LT K.V. MacDonald
2LT R.D. Mazurat
2LT R.A. McWade
2LT G.J. Meisner
2LT C. Mensigna
2LT(W) M.J.T. Michaud
2LT J.J. G. Rouillard
2LT W.C. Schadt
2LT J.J. Severs
2LT B.R. Taylor
2LT(W) E.A. Toporowski

TRAINING WITH INDUSTRY

SS White, New Jersey –
Dental Equipment Course 16-20 Jun
Sgt JB Cliche

Back Row: Harms, Kettyls, K.M. Thompson, MacIntosh, Donelly, Hughson, W.R. Thompson, MacDonald.
Middle Row: Mulligan, Protheroe, Porterfield, Smith, Deadrick, Sills, Spracklin, Graff.
Front Row: Galvin, Cooke, Harris, Peterkin, Muller, Patterson, Crowley, Banks.

THOSE WERE VERY GOOD YEARS 1949-1950

This photograph shows the members of these two graduation years who undertook training at the old RCDC School in Ottawa during the summer of 1949.

Dental graduates of 1949 and 1950 have made and continue to make significant contributions to the Canadian Forces Dental Services. They are particularly unique in that so many of them became career officers and that they hold so many senior positions in the CFDS today. From their ranks emerged at least four officers now on pension and eight others who are still serving – viz.

Colonel WR Thompson, Director Dental Treatment Services – Ottawa

Colonel DH Protheroe, Commanding Officer 12 Dental Unit – Halifax

Colonel LR Pierce, Commanding Officer 13 Dental Unit – Trenton

Colonel JC Brick, Commanding Officer 14 Dental Unit – Winnipeg

Colonel LA Richardson, Commandant CFDSS – CFB Borden

LCol JM Donelly, Commanding Officer 1 Dental Unit – Ottawa

LCol HR Kettyls, Base Dental Officer CFB Edmonton and

LCol IA MacDonald, Base Dental Officer CFB Cornwallis.