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The CFDS Quarterly

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Published by authority of Brigadier-General L.G. Craigie, CD, QHDS, DDS, FICD, in April, July, October and January, the Quarterly serves as a means for the exchange of ideas, experiences and information within the Canadian Forces Dental Services. Views and opinions expressed are those of the authors and not necessarily those of the Director General of Dental Services or the Department of National Defence.

COVER

A historical flashback: UNEF I (1956–1967) Canadian Dental Detachment, Rafah.

The Corps flag floats loftily under Middle East skies, proudly accentuating our first involvement with U.N. peacekeeping. – At this particular time of the year, how many of us would willingly trade off our winter rigors for a soothing transfusion of that warm (albeit dry) sunshine!

IN THIS ISSUE

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The diagnosis and treatment of myofascial pain dysfunction

(The temporomandibular pain dysfunction syndrome)

CAPT R.S. SOROCHAN, B.Sc., D.M.D.

The Temporomandibular Joint (TMJ) Pain – Dysfunction Syndrome, or Myofascial Pain – Dysfunction (MPD) Syndrome, as it was named recently, has remained a controversial subject for some time. Since Costen first described TMJ problems in the 1930's, concepts of pathogenesis have progressed from the simple mechanistic ideas of hypermobility, jaw displacement and lost vertical dimension, to the more complex neurophysiologic and psychophysiologic hypotheses of today. As the pathogenesis has changed so have the concepts of treatment; thus much of the literature on the subject is confusing, as indicated in a recent survey by Green.[6] Of the researchers and clinicians surveyed, only 51 percent of the physicians and 65 percent of the dentists acknowledged there was such a syndrome, and the symptomatology and recommended treatment described by the respondants varied considerably.

There is no question that a MPD Syndrome does exist; it is only the outer limits of symptomatology which are still being debated.[6] Rosenbaum[13] has gone so far as to state:

> *"... next to dental caries, TMJ Dysfunction Syndrome is probably the most common cause of facial pain that a dentist treats."*

Definition of the MPD Syndrome:

The Syndrome is difficult to define but the cardinal symptoms are:[6,8,15]

(a) pain,

(b) muscle tenderness,

(c) joint sounds, and

(d) limitation of movement.

(a) Pain

[1,3,5,6,8,15,17,19] is usually unilateral in origin and consists of a dull ache in the ear or preauricular area that may radiate to the angle of the mandible, temporal area, or lateral cervical region. It is relatively constant but usually is more severe on arising, or else it is relatively mild in the morning and gradually gets worse as the day progresses. The pain is

frequently increased at mealtimes; it may simulate neuralgias and usually accompanies the other three cardinal symptoms.

(b) Muscle Tenderness

is the most common symptom and is usually reported by the patient, but is easily discovered by palpation. The most frequent areas of tenderness are over the neck of the mandible and the region distal and superior to the maxillary tuberosity. The angle of the mandible or the temporal crest may also be involved. The tenderness is presumed to represent areas of spasm of the masticatory muscles.

(c) Joint Sounds

are the second most common symptom and are usually heard as a clicking or popping. If such sounds are the only symptom, then the patient does not necessarily have the syndrome.

(d) Limitation of Jaw Movement

is defined as the inability to open the jaws as widely as normal i.e. 40-45 mms interincisally, or as a deviation of the mandible on opening. Patients seldom have joint noises if there is limitation but usually there has been a past history of such noises.

Laskin[8] extends this definition by suggesting that, in addition to having one or more of these cardinal symptoms, a patient with MPD Syndrome must also have the following negative characteristics:

(a)
Absence of clinical, radiographic, or biochemical evidence of organic disease changes in the TMJ; and

(b)
Lack of tenderness in the TMJ when it is palpated through the external auditory meatus.

He believes that the MPD Syndrome begins as a functional problem but can lead to organic changes so that the negative characteristics are no longer applicable. In such latter stages it may be difficult to determine clinically whether the patient has the MPD Syndrome or if the pathologic condition is primary. The significance of the negative characteristics is that they indicate the primary site of the problem is in the masticatory muscles rather than in the structures of the joint. Such a concept forms the essential basis for understanding the etiology of the MPD Syndrome.

Etiology of the MPD Syndrome:

Laskin points out that the successful management of any disease depends on an accurate diagnosis and an understanding of the etiology so that a rational treatment plan can be formulated. It is generally agreed that most TMJ Dysfunction problems are manifested primarily in the muscles of mastication rather than in the TMJ itself; i.e. most of the symptoms of the MPD Syndrome are caused by myospasms of the masticatory muscles.[6,8, 15,19] What causes the myospasms and, conversely, what the myospasms cause, are the two areas of greatest controversy.

There is also considerable agreement that certain pathological conditions which affect the TMJ can produce symptoms which are very similar to those observed in the MPD Syndrome, and that TMJ Dysfunction can lead only to degenerative changes. The diagram by Laskin[8] summarizes the etiology of the syndrome very well. (Figure 1)

He states in the same article that myospasms can be initiated in one of three ways:

(a) Overextension,
(b) Overcontraction, and
(c) Fatigue.

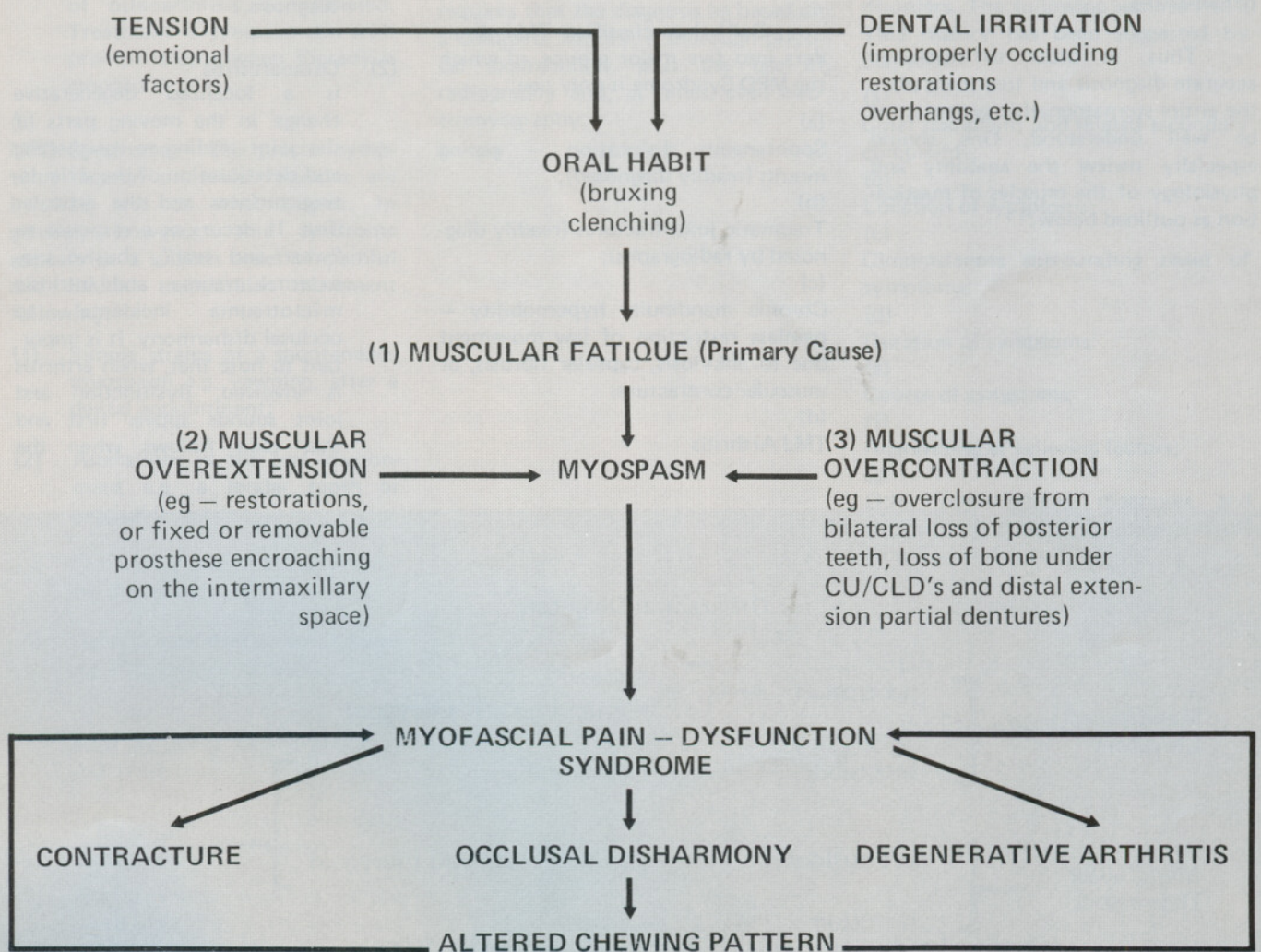
According to this "psychophysiologic" theory, the most common cause of myospasms is muscle fatigue produced by chronic oral habits that are often an involuntary tension-relieving mechanism.

Myospasms can not only cause pain and limitation but they may also lead to changes in jaw position so that the teeth do not occlude properly. Laskin[8] has observed that if this abnormal jaw position persists for several days the teeth may shift to

FIGURE 1

ETIOLOGY OF THE MYOFASCIAL PAIN DYSFUNCTION SYNDROME

– from Laskin



Differential Diagnosis:

accommodate the new position, which explains why some patients suddenly exhibit occlusal disharmonies when the spasms are relieved and the rebalanced muscle allows the jaws to return to their original relationship.

Organic changes such as occlusal disharmonies, degenerative arthritis and any contracture which may result, tend to make the condition self-perpetuating.

Thus, in order to reach an accurate diagnosis and treatment plan, the entire stomatognathic system must be well understood. One should especially review the anatomy and physiology of the muscles of mastication as outlined below:[15]

In the past all TMJ pains of undetermined origin have been classified as a single entity, which has resulted in a single philosophy of treatment. As recorded by Laskin: "It is the lack of diagnositc discrimination that probably accounts for many of the failures in management of TMJ disorders".[8] It is important to consider each patient individually and as an individual.

Bell[1] has classified TMJ disorders into five major groups, of which the MPD Syndrome is only one:

(a)
Spontaneous dislocation – gaping mouth (readily diagnosed);
(b)
Traumatic joint-fractures (readily diagnosed by radiographs);
(c)
Chronic mandibular hypomobility – painless restriction of jaw movement due to ankylosis, capsular fibrosis, or muscular contracture;
(d)
TMJ Arthritis

(1) Rheumatoid Arthritis
is a systemic disease characterized by proliferation of granulation tissue from the synovial membrane onto the articulating surfaces. The inflammatory symptoms occur with ordinary joint use and predispose to osseous resorption and eventual ankylosis. The systemic nature of the disease provides the diagnosis.

(2) Osteoarthritis
is a localized degenerative change in the moving parts of the joint leading to roughening and deterioration of the articulating surfaces and the articular disc. It occurs as a response to "wear and tear", abusive use, external trauma, and intrinsic microtrauma incidental to occlusal disharmony. It is important to note that, when arthritis is involved, dysfunction and joint sounds appear first and that pain follows when the

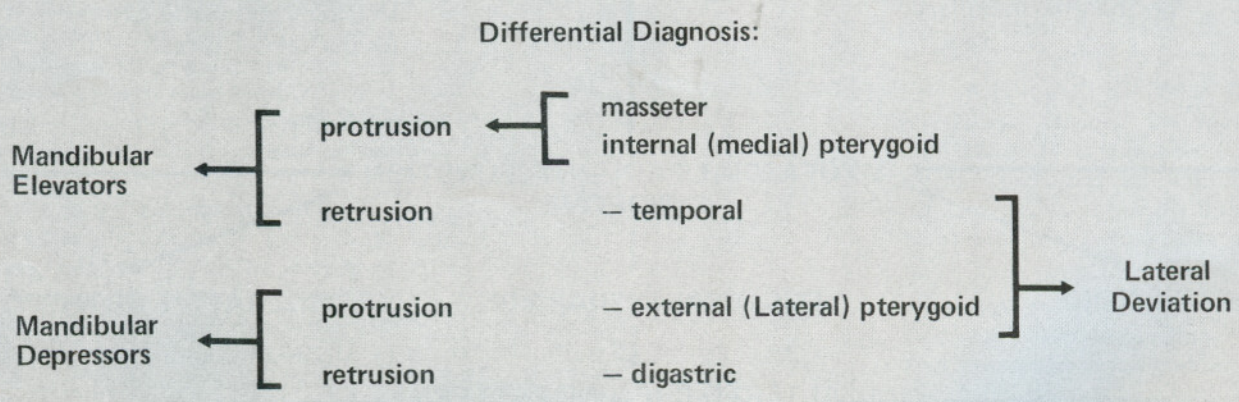


Figure – 2

articulating surfaces have been damaged. Muscle involvement appears secondarily and complicates the entire problem by increasing the dysfunction. Classically, if there is a history of stiffness on awakening accompanied by functional pain that gradually disappears with use and returns with fatigue at the end of the day, then a diagnosis of osteoarthritis is indiciated. Treatment is symptomatic with prompt relapse when therapy is stopped.

(e)
MPD Syndrome – The precise symptoms depend on which muscles are involved and to what degree. In general, however, this syndrome appears as a sudden onset of painful and limited mandibular movement following:[1]

(1) Simple strains or a spontaneous myospasm e.g. yawning, after a dental appointment;

(2) Alterations in the oral environment e.g. a tender tooth or gingival irritation;

(3) Occlusal disharmony aggravated by clenching;

(4) Other masticatory interference e.g. degenerative changes;

(5) Changes in oral consciousness such as being overly aware of oral structures;

(6) Referred pain from some deep somatic or visceral source;

(7) Acute illness such as upper respiratory infections, mononucleosis, hepatitis and neuromuscular ailments; and

(8) Medications e.g. phenothiazines.

One must also rule out neuromuscular disorders, infection, bone diseases, bone tumors and hysteria as possible causitive factors before arriving at a final diagnosis.

To summarize, the symptoms of the MPD Syndrome are easy to recognize but the exact diagnosis and management of the facial pain are difficult. Effective management requires that the diagnosis be based on a complete history, a thorough physical examination, plus the use of radiography and, at times, even electromyography.

History

Obtaining a complete history is probably the most important single process in the diagnosis of the MPD Syndrome. The clinician must check such things as previous medical disorders relating to the syndrome, emotional status, timing of symptoms, history of a blow to the face, and prior attempts at treatment. By use of such a history the clinician can frequently rule out most organic and traumatic disorders. The following summary of a TMJ history has been suggested by Schwartz:[15]

(a)
Chief complaint and related secondary complaints;
(b)
Location of symptoms;
(c)
Circumstances surrounding onset of symptoms;
(d)
Duration of symptoms;
(e)
Course of symptoms;
(f)
Aggravating or relieving factors;
(g)
Other consultations, diagnoses, and treatments received, including effects of these treatments;
(h)
Past medical history;
(j)
Past dental history;
(k)
Emotional considerations; and
(m)
Miscellaneous.

Clinical Examination

The complexity will depend on each individual patient. It is recommended that the following procedures be carried out:

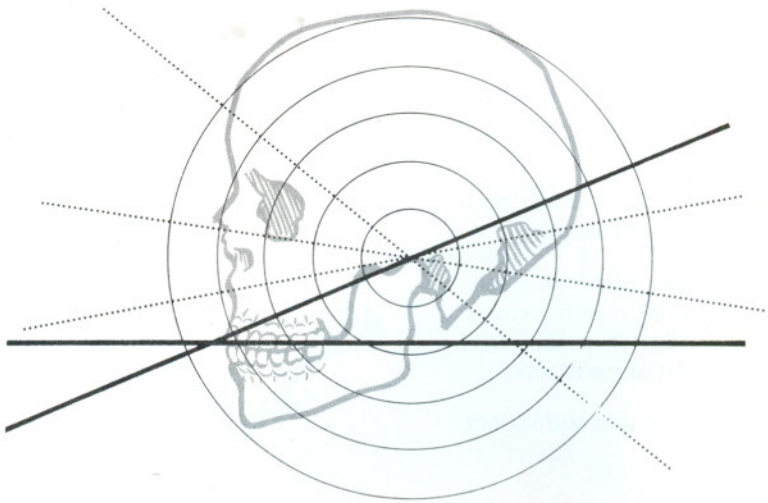
(a)
Note general appearance and symmetry.
(b)
Eliminate the possibility of organic disease through tests.
(c)
Test mandibular movements for deviations, pain, etc.
(d)
Palpate TMJ for pain and location of pain laterally and through auditory meatus, check the range of movement plus the condylar movement, and check joint noises. A stethoscope is helpful.
(e)
Palpate muscles of mastication for pain and check size. The frequency of spasm occurs, in descending order, in the masseter, insertion of the internal pterygoid, insertion of temporalis, occasionally the insertion of the external pterygoid, and finally the neck muscles.
(f)
Rule out any local oral cause for the TMJ symptoms by examining the dental structures, including cervical sensitivity, parotid duct, position of teeth, relation of the arches, and occlusal interferences.

Radiography

A complete and undistorted radiographic examination is a prime requisite for evaluation of the TMJ[18] but is a supplement only and may not be conclusive in its findings. Useful radiographic techniques for the TMJ are:

(a)
Lateral transcranial oblique: to demonstrate condylar fossa relationships at various mandibular positions.
(b)
Anterior – posterior transorbital: to show the necks of the condyles.
(c)
Submento-Vertex: used when there is limited opening, to show the necks of the condyles.
(d)
Panoramics: to show the ascending rami with their condyloid and coronoid processes. They are excellent for identifying traumatic injuries and neoplasms.

To assess many organic TMJ disorders is so difficult and requires so much experience that expert assistance should be sought for assessment of the films.[15]



Management of the MPD Syndrome:

A correct etiological diagnosis is the key to successful clinical management and management is directed towards restoring normal functions. Hence, management consists primarily of physiotherapy plus a consideration of the individual's emotional state and occlusion. The physiotherapy consists primarily of habit retraining, myotherapeutic exercises, pain relief, and restoration of normal muscle length. Properly motivated, informed and cooperative patients can frequently accomplish occlusal disengagement without the use of a bite plate or occlusal splint.[2,19]

Nonsurgical Management

The MPD Syndrome can be considered in three phases and the specific and appropriate treatment for each phase identified as follows:

(a)
Early Functional Incoordination Phase (clicking, hypermobility, and chronic subluxation) is managed by habit retraining and myotherapeutics.
(b)
Spasms of the muscles of mastication leading to limitation of movement and dull aching pain in the TMJ area is treated through methods of pain relief and spasm breaking techniques.
(c)
The final stage of muscular contracture which leads to hypomobility without pain is managed by exercises which restore normal muscle length.

The methods of nonsurgical management are

(a) Occlusal Disengagement
(in the presence of myalgia, myospasms or arthralgia).

Properly motivated, informed, and cooperative patients can be taught to voluntarily avoid habits such as clenching. A recent study by Yavelow and Wininger[19] suggests the patients can control and relieve the myospasm through conscious efforts to avoid the spasm-producing stimuli. However, when voluntary methods fail, a modified Hawley bite plane can be used for from 3 to 6 weeks to decrease the pain by allowing free mandibular movement. Longer useage may result in the extrusion of teeth. If splinting is required for more than six weeks it is recommended that the clinician employ an occlusal splint which is adjusted so that as many teeth as possible strike the splint simultaneously in normal biting and clenching positions. Once the pain is controlled the patient should only wear the splint during times when he is most likely to clench or brux. After a week or two he should remove it for a trial period. Often the problem is episodic and symptoms will not occur. If they do, the appliance should be reinserted until the situation is again controlled. The patient should be re-evaluated to determine if any psychic factors exist. Possibly some occlusal adjustment may be required but no irreversible changes should be made to it until the exact cause can be correlated with the symptoms.

(b) Physiotherapy

Application of heat is most useful because it can produce some sedation, analgia, and relief of muscle tension.

(1) Superficial heat. For masseter, temporal, and cervical muscles, repeated 20 to 30 minute exposures are recommended, using hydrocollator packs.
(2) Ultrasound Diathermy is recommended as therapy for the medial or lateral pterygoids. Such therapy is contraindicated in the orbital region and the condylar area during their growth periods and should be discontinued if therapeutic effects have not been attained after ten days.

All heat applications must be followed by exercise.

(c) Myotherapy

To obtain good motivation, the patient must understand why he does the exercises. They should be carried out:

(1) under the supervision of a therapist;
(2) voluntarily,
(3) against physical resistance;
(4) within painless limits; and
(5) after heat therapy.

A typical exercise is the "Retrusive Reflex Relaxation Exercise" wherein the patient's mandible is guided into closing in the most retruded position that causes no pain. The patient then guides the mandible with postero-superior pressure and opens his mouth in the retrusive position until clicking or subluxation occurs. The opening is repeated to the point just before the above symptoms occur. An increased symptom-free opening is usually possible after this exercise has been carried out over a period of time.

(d) Myospasm Control

Proper management of myospasms depends on accurate localization of the affected muscles. An effective method of treatment is to spray ethyl chloride from a point 12-18 inches above the skin on the area overlying the painful muscle and then instruct the patient to exercise the muscle carefully. As other painful areas appear, spray them also and have the patient exercise them when the pain is relieved (10-30 minutes). This method is effective for masseter, temporal, and most cervical muscles. It is important to bear in mind the general anaesthetic and flammable properties of ethyl chloride. This is the therapy of first choice but, if it does not work, it may prove effective to inject the trigger area with 1-2 mls lidocaine without vasoconstrictor, followed by exercise. Be careful not to inject inflamed muscles because the injection will increase the inflammation, pain, and spasms. Between treatments instruct the patient to exercise the muscles within painless limits. Voluntary restriction, within limits, is the cardinal principle of physiotherapy in order to stop the pain-cycling effect of continuous mus-

cle use. Complete immobilization, however, defeats the purpose and is contraindicated.

These methods may only provide transient relief but even so are of diagnostic value to show where the spasms are. Furthermore, if the spasms are extreme, injection with lidocaine may allow enough opening to obtain impressions for occlusal splints.

Hypomobility secondary to myospasm can be overcome through retrusive reflex relaxation exercises followed by active stretch exercises.

(e) Drug Therapy

Muscle relaxants such as phenobarbital and diazepam plus an oral analgesic are recommended. The muscle relaxant has essentially a central action with only questionable specific peripheral activity, but it will help relieve the tension-producing part of the syndrome.

Direct injection of any drugs to the TMJ is usually contraindicated and should only be made by an oral surgeon or qualified physician.

(f) Psychological

Most authorities agree that psychological stress plays a significant role in TMJ reactions. Several have found the neurotic or the obsessive compulsive person to be most susceptible,[10,14,15] and a recent study has implicated frustration as playing a more important role in the syndrome than even anxiety does.[17]

Anxiety has been linked with pain and it is felt that the relationship occurs in three ways:[15]

(1) Emotional tension may lead to spasms of striated muscle.

(2) Anxiety may lead to widespread dysfunction of the Autonomic Nervous System, which can result in pain from spasm or dilatation of blood vessels, producing vascular headaches or migraines.

(3) Anxiety may lead to "hysteria" in which the pain has no objective signs at all and is usually described in bazarre and dramatic terms. It should be remembered when treating people afflicted in this manner that the pain is real to them and must be taken into account. The doctor must establish an atmosphere conducive to rational cooperation, trust and mutual respect. Obviously, the patient must be treated as an individual and eliciting a comprehensive history is very important. However, do not try to be a psychiatrist. Merely attempt to relate physical problems to life situations to determine whether or not the patient may have a psychiatric problem. The neurotic is resentful of any suggestions that his symptoms are imaginary but is very responsive to scientific investigations of what these symptoms mean and how they occur. Therefore it is best to try to establish in the patient a mature, honest, and rational understanding, and to carry out only that dental work which is absolutely necessary until there is less anxiety and less muscle spasm.

In general, the best therapeutic results have come when patients were handled conservatively from the beginning and were provided with honest useful information regarding the physiology and the psychology of their condition.

Surgical Management

Only those patients with demonstrable articular pathology and who experience pain which definitely arises from the TMJ should be considered for surgery. A correct diagnosis is essential since the performance of contraindicated surgery may accentuate rather than alleviate the symptoms.[7,15]

Contraindications for Surgery

(a)
Myofascial Pain (i.e. MPD Syndrome).
(b)
Psychoneurosis.
(c)
Temporal Arteritis – The pain is constant, extends along the distribution of the temporal artery and occurs primarily in elderly patients.
(d)
Pain of Neurovascular Origin.
(e)
Malingering – This is manifest by a history of trauma with no evidence of pathology and requires a psychological examination.
(f)
Trigeminal Neuralgia.

Indications for Surgery

Patients who definitely have intra-articular disease, as verified by a radiographic study, and who have failed to respond to conservative treatment and who have none of the previously described contraindications are eligible for surgery. Henny has described a procedure of a high condylectomy which he claims offers complete relief of symptoms and a return to normal jaw function in almost all instances.[7] He classifies candidates for surgery into four categories:

(a) Osteoarthritis.
(b) Rheumatoid Arthritis.
(c) Deformity and dysfunction of the TMJ after fracture of the condyloid process.
(d) Neoplasms – rarely.

Summary

The Temporomandibular Joint Pain – Dysfunction Syndrome, now known as the "Myofascial Pain – Dysfunction" Syndrome, is thought to be primarily caused by myospasm of the muscles of mastication. The cardinal symptoms are pain, muscle tenderness, joint sounds, and limitation of movement.

Effective management of the Syndrome requires a definitive etiological diagnosis based on a complete history, a thorough physical examination, plus radiography and in some instances, electromyography. Nonsurgical management is directed towards restoring normal function and hence consists primarily of physiotherapy which considers both the person's emotional state and occlusion. Surgical management is indicated only for those patients who have intra-articular organic disease, who have failed to respond to conservative treatment, and who have no contraindication for surgery.

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13th. annual-CFDS GOLF TOURNAMENT

CFB Trenton

September 11—12

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The 1975 edition of this annual event took place at CFB Trenton on Thursday and Friday, 11-12 September. Ninety-nine golfers participated on both days and one hundred and sixteen current and former members attended the presentation banquet.

Unlike last year, the weatherman cooperated extremely well and he, or the golf committee (it depends on who one was listening to at the time), only allowed the rain to fall at night.

Sincere congratulations are extended to the CFDS School team (MWO Todd, WO Hall and Sgt Garnett) on their one-stroke win over the 14 Dental Unit team (Maj Headley, Capt Wright and Cpl Lamontagne). Their triumph was most appreciated by the Golf Committee, since the Westerners were threatening to take the "RCDC(R) Officers Trophy" home permanently if they had won for the third consecutive year!

The prize list was long and it wen

RCDC (R) Officers Trophy Low Team Gross

1. Team Member -- MWO R. Todd
2. Team Member — WO M.J. Hall
3. Team Member — Sgt L. Garnett
4. KM Baird Trophy — Gross 36 — Maj A. Marcil
5. GR Covey Trophy — Gross 18 — Maj G. Bisaillon
6. Tournament Net Prize — Low Net 36 holes — Maj R. Headley

Prizes 1 — 6 presented. Other prizes selected from table in following order:

7. 1st Low Gross 1st flight — Cpl G.R. Lamontagne
8. 1st Low Gross 2nd flight — MCpl R.J. Tallack

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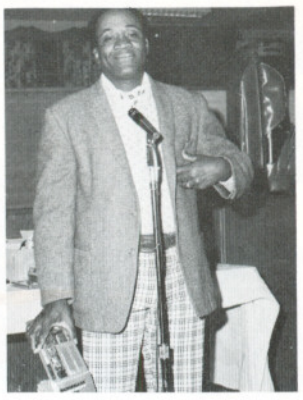

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photo guide

1. Maj Bissaillon receiving the "GR Covey Trophy" from Col Pierce for the low gross score over 18 holes.
2. BGen Craigie tees off – opening the 13th Annual CFDS Golf Tournament.
3. BGen Craigie presenting the "RCDC(R) Officers Trophy" and individual prizes to the CFDSS team: MWO Todd, Sgt Garnett and WO Hall for the low gross team score over the 36 holes.
4. Our Colonel Commandant presenting the "KM Baird Trophy" to Maj Marcil for low gross score over 36 holes.
5. Maj Headley displays the prize he accepted for the Tournament low net score.

like this...

9. 1st Low Gross 3rd flight –2LT B. Harper
10. 1st Low Net 1st flight – Capt J.R. Harrison
11. 1st Low Net 2nd flight – Capt W.J. Jury
12. 1st Low Net 3rd flight – WO D. Cormie
13. 2nd Low Gross 1st flight – MWO R. Todd
14. 2nd Low Gross 2nd flight – MCpl D. Cote
15. 2nd Low Gross 3rd flight – Sgt W. Tweed
16. 2nd Low Net 1st flight – Col L.R. Pierce
17. 2nd Low Net 2nd flight – MWO G. Bradley
18. 2nd Low Net 3rd flight – Maj R.A. Fortier
19. 3rd Low Gross 1st flight – Capt G. Boulanger
20. 3rd Low Gross 2nd flight – Cpl D. Purich
21. 3rd Low Gross 3rd flight – Maj W. Budzinski
22. 3rd Low Net 1st flight – Col G. MacDougall
23. 3rd Low Net 2nd flight – Capt D.R. Vandahl
24. 3rd Low Net 3rd flight – WO R.J. Lowery
25. Best Woman Golfer – Sgt(W) H. Bigras
26. Closest to Hole – Friday No. 3 – LCol M. Deyette
27. Longest Drive – Friday No. 18 – Sgt L. Garnett
28. Most Honest Golfer – Sgt D. Langford

Ticket for Golf Bag drawn by Col W.R. Thompson – Winner Col D.H. Protheroe

To those who missed the winner's circle, there is always next year; be sure to join us for the 14th Annual.

13th annual
CFDS
GOLF
TOURNAMENT
CFB Trenton

CFDSS NEWS

by: Sgt L.H. Pion, CD

A large turnover of staff personnel has been experienced at the school over the past few months. Many of those leaving have spent considerable time and effort in bringing the training standards of the CFDSS to the enviable level they now occupy. Those personnel who are posted in to replace the "old timers" appreciate this fact and are rapidly taking up the "lamp" with enthusiasm.

An unusual event has occurred in that MWO George Bradley, who retired from the Armed Forces in May of this year is back in harness once more. He was granted authority by NDHQ to continue his fine services as Dental Therapist for another year.

Col L.A. Richardson, Commandant CFDSS and LCol N.H. Andrews, Chief Instructor, accompanied by CWO E. Everett and CWO M.O. McDonald visited the Phase II and III DOTP officers at Camp Ipperwash, Ontario, 09 – 11 Jul 75. BGen L.G. Craigie, DGDS, was also a visitor to Camp Ipperwash on 10 Jul when the DOTP Officers played host to their guests at a steak Bar-B-Q.

LCol P.R. McQueen attended a Continuing Education Course (Fluorides) at Dalhousie University 11 – 14 May 75.

MWO Roy Todd and MWO Doug Davies presented a table clinic to the Ontario Dental Association Convention held in Toronto 20-21 May 75.

LCol N.H. Andrews was Parade Commander 5 Jun 75 during the farewell visit to CFB Borden of Rear Admiral Stevens, Commander, Training Command.

Capt N.L. Mezar, a Reserve Dental Officer with 64 Fd Bty RCA Yorkton, Saskatchewan, visited CFDSS 15 – 17 Jul 75. LCol P.R. McQueen, Base Dental Officer, CFB Borden, briefed him on the role, organization and training conducted at CFDSS.

LCol N.H. Andrews spoke to the Newfoundland Dental Nurses' and Assistants' Association Convention 17 – 20 Aug 75.

Our Colonel Commandant, BGen (Ret'd) K.M. Baird visited the School on the first of August and held a brief "Re-badging" ceremony in which he presented our other ranks with their new CFDS cap badge.

It's "Old-Hat" To Him,
but the Chief Gets a New Badge

Shown getting his from General Baird is CWO McDonald and, just to interject a really historical note, this is the fourth dental cap badge that the Chief has worn since joining the Canadian Forces in 19?? – well, whatever year it was, the amalgam gun was still on the "secret weapon" list.

DOTP graduation parade held

BGen L.G. Craigie, accompanied by 2Lt M.L. Irwin (U of A), DOTP Parade Commander and Capt F.J. Reid, inspecting DOTP Phase II and III graduates during the 1975 Graduation Parade at CFB Borden

BGen L.G. Craigie, DGDS, visited the CFDSS 30 Jul – 01 Aug 75 to inspect and review the Phase II and III Graduation Parade held 01 Aug 75 at CFB Borden. This group of pictures bears testimony that it was a great show again this year.

BGen Craigie presents 1Lt Irwin (U of A) with the "Honor Cadet Trophy – Phase III"

BGen Craigie presents 2Lt B.P. Harper (U of T) with the "Honor Cadet Trophy – Phase II"

BGen Craigie presents the "Chief Instructor's Trophy" to 2Lt E.A. Toporowski (U of S)

BGen Craigie presents 2Lt J.J. Severs (UBC) with the "Field Exercise Trophy – Phase III"

BGen Craigie presents 2Lt D.S. Stoski (U of A) with the "Field Exercise Trophy – Phase II"

Just to prove that they didn't spend all summer perfecting their skill on the parade square, here are a couple of other pictures which show these "persons" at Camp Ipperwash in July.

Unit personnel in attendance at the All-Ranks Conference. Editor's Note: From the second row back, its rather difficult to recognize anyone, but at least everyone has his/her hat on!

Social functions included a barbecue the first evening and a golf tournament on the final day of the Conference, at the Valcartier Golf Course. Major André Marcil won the golf tournament with a score of 77. (Trust an outsider to come in and carry off the honours!)

The hospitality extended by the Valcartier Clinic staff and their efforts in making local arrangements so pleasant were greatly appreciated.

FAREWELL TO STAFF MEMBERS

Good wishes and good cheer were extended to Sgt Ray Joly at a small, convivial luncheon held 20 Aug 75. Sgt Joly has now begun a one-year extension of service at FMC HQ after serving 15 Dental Unit well for almost five years.

SPORTS

Dental personnel must be getting in lots of golf at CFB Valcartier. Major G. Bisaillon recently qualified for the Regional Golf Tournament. It is also reported that all prizes in the Annual Medical/Dental Golf Tournament were won by the Valcartier dental staff.

2Lt Reid, 3rd year DOTP student at McGill University may soon make a name for himself on the links. Participating in the Canadian Amateur Golf Tournament held in New Brunswick 13-16 Aug 75, he placed among the top 30 competitors. He says that he was not at his best this summer and is aspiring to even better achievements next year.

Capt Loiselle and Cpl Brisebois recently spent several weeks on TD at CFS Chibougamau. In spite of a heavy workload, they managed to do a little fishing on the weekends. Capt Loiselle was ecstatic over the good fishing in that area but delegated the cleaning of the fish to Cpl Brisebois. They report a catch totalling 54 for two fishing trips.

A SMELLY AFFAIR

This summer the St Jean Clinic was once again chosen by an enterprising couple as an ideal place to raise a family. However, as the couple involved was a pair of skunks, this proved to be a very smelly affair indeed! It has kept the clinic staff as well as the CFB St Jean engineers busy all summer employing various methods, from traps to fumigation, in an attempt to persuade the skunks to vacate their quarters under the floor of the clinic. At last report, they raised quite a stink about it but finally left!

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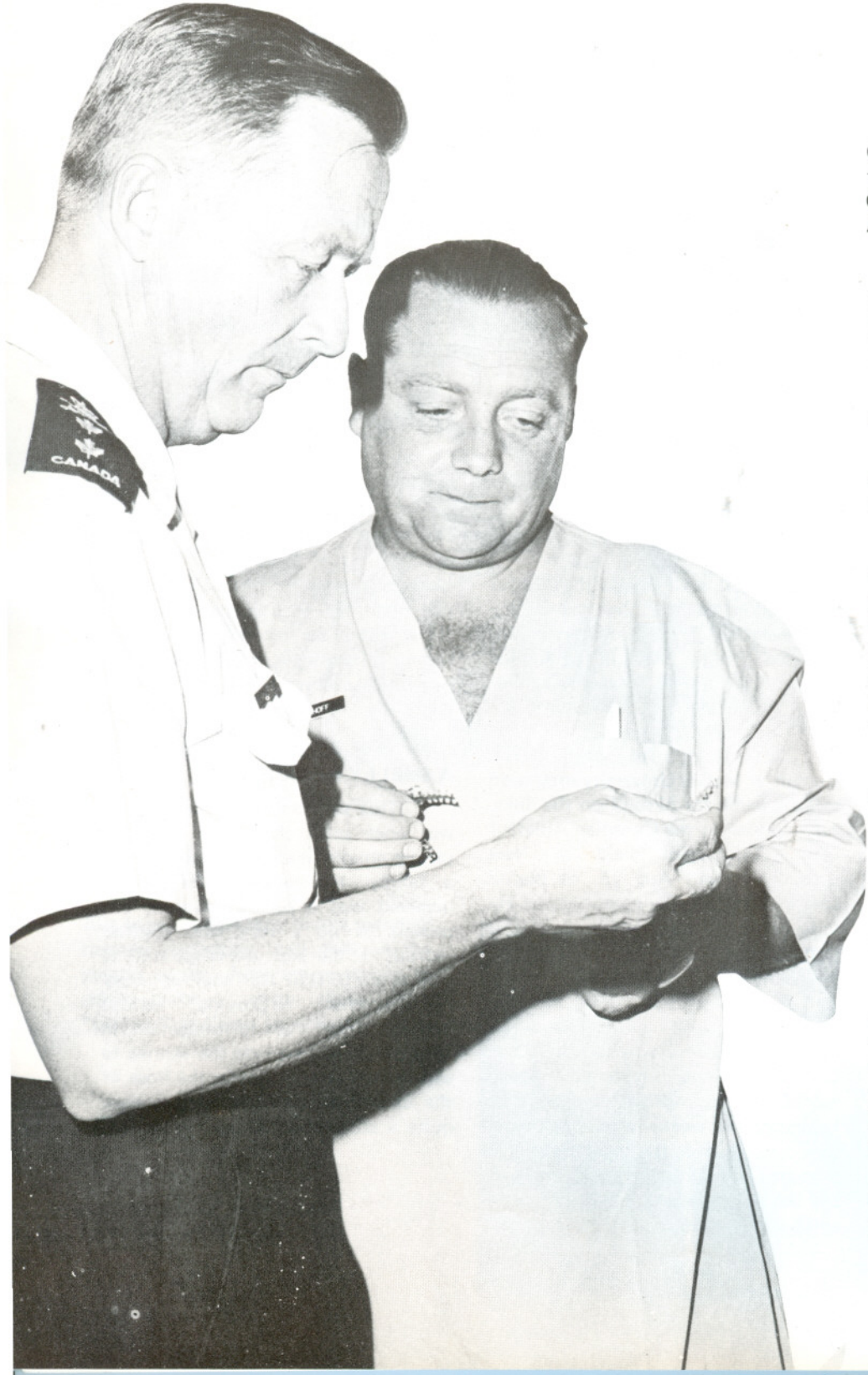
Field Dental Unit News

Sergeant B.F. Hannay, C.D.



MGen D. McAlpine the new Commander of CFE inspected dental facilities at the Dependants Clinic, Caserne and at No 1 Clinic Lahr in Aug 75.

BGen Craigie and Mrs Craigie, accompanied by LCol and Mrs Reynolds, attended the USAREUR 7th Army Dental Training Conference 17-19 Sep 75 in Garmisch, Germany.

SOCIAL EVENTS

Maj and Mrs Higgins hosted a get-to-gether at their home on the occasion of his promotion.

Members of No 1 Clinic with support from HQ's (Mrs C MacLean) participated in a Volkslauf. The walk was 10 kilometers, with participants ranging in age from 1 to 40. (Ye Olde Editor's Note – I knew we were getting them pretty young now-a-days – but One Year Olds in the CF? ?)

A "First Aid Station" was manned by WO & Mrs Sprathoff for necessary cures and thirsts. After the "Walk" a Bar-BQ was held at the home of Maj and Mrs Bouris. The latter event was rated a complete success!

SPORTS

Sgt Hannay managed to make it to the annual golf tournament at CFB Trenton and, although no prizes came back, he had a good time. Compliments are extended to CFB Trenton Dental Unit for organizing a very successful tournament.

WO Sprathoff explaining laboratory procedures to MGen McAlpine

Sgt Bob James, is shown demonstrating his ability on the ice.

Bob has refereed for the past four years in the Belgian, Dutch, and Northern France hockey leagues. He has refereed games in Reims, Dunkerque, Amiens, Den Hague and Brussels, as well as S.H.A.P.E.

The annual contest was held this summer between Lahr and Baden Dental Detachments for the coveted "Horses Head". Baseball was the game and Baden were the WINNERS, AGAIN! Unfortunately Maj Bouris retains the undesirable anatomical section for the present.

1 Dental Equipment Depot News

Sgt R.L. MacLellan, C.D.

VISITS

LCol J.W. Fletcher, DDPR-2, accompanied by LCol J.E. Crofton, DDPR-2 designate, and Captain E. Kellett, career manager Sup Tech 911 Trade, visited 1 DED on 28 – 29 July.

Cpl H.G. Habberjam and Cpl R.G. Duffield proceeded on TD to CFS Moosonee 7 – 11 July to remove all supplies and equipment from the Dental Clinic.

CWO L. Lawson visited CFB London 14-15 July to carry out the annual clinic inventory check.

PERSONNEL

Mrs. Shirley Gorr, a civilian employee at this unit, gave birth to a 9 lb 1 oz baby girl, Christina Marie, on 10 Jun 75.

A small gathering and presentation was held in the Centennial Centre on 19 June to say goodby to WO "Joe" MacPhee on posting to 15 Dent Sup Section on 2 July.

welcome

Mrs MM Anderson, Pte JAD Beland, Pte (W) MA Burrowes, Capt GK Campbell, Pte (W) LM Crockett, Cpl (W) JA Gariepy, Pte MC Gilbert, Capt CA Grabowski, Pte (W) GS Main, Cpl DG Mellott, Miss G Morrison, Mrs G Parks, Pte C Plante, Pte (W) JL Purdy, Capt CG Sproule, Miss Kathy Spurr, Pte MG Tessier, Mrs Carol Whelan.

farewell

Cpl AM Alkenbrack, Mrs Ann Andrew, Mrs Linda Audet, Mrs JS Benton, Capt DH Brown, Mrs JL Buchanan, WO JE Clarke, LCol JE Crofton, Capt WO Donald, Mrs L Green, Sgt JR Joly, Maj AL Kelland, Mrs J MacKlin, Mrs M Menn, Sgt JM McLean, Lt PD Peterson, MWO JE Raymond, Capt JW Shore, Maj IW Susser, MWO JC Therrien, Miss Van Amburg, Mrs J Vaness, Cpl RD Wade.

promotions

Major RWF Woodworth

CWO CH Adams, RF Matheson

MWO JA Atherton, JA Christiansen, D Davies, EA Duve, JM Patterson, LG Peverill

WO A Busse, JG Cliche, JD Cormie, NL Highfield, A Jack, H. Kalmet, MD Longford, DW Mason, TH Taylor

SGT RF Abfalter, GC Beaulieu, FN Boosamra, LJ Kallman, LA Lambert, LA Overbye, TJ Parent, CJ Rheault, AM Wilson

MCPL DB Allen, OT Baird, MT Brosha, JJ Boulay, RF Buchanan, RM Clarke, JR Cornett, MP Dallaire, ML Haley, JP Larivee, P Maelde, DJ Morphett, AH Peck, RA Portuondo, JM White

CPL JJ Pero

training

Post-Graduate Specialty Courses

The following officers have commenced two-year programs leading to specialist qualification in the disciplines indicated:

Maj WA Gray – Prosthodontics, at the William Beaumont Army Medical Centre, El Paso Texas.

Maj PR Darlington – Periodontics, at Walter Reed Army Medical Center, Washington DC.

Professional Training

Armed Forces Institute of Pathology – Washington DC

12th Forensic Dentistry Course 9 Oct 75:
Maj JD McCallum, Capt DE Rawson, Capt RE Fletcher

Canadian Forces Training CFDSS – CFB Borden

D Lab Tech PL 4 Course 9 Sep 75 – 16 Jul 76:
Cpl JB Bolduc, Cpl JJ Boulay, MCpl RF Buchanan, Cpl LE Deveaux, Cpl DC Hogan, Cpl AW Leach, Cpl JR Levesque, Cpl JAR Neveu

Dent Therapist PL 6B Course 9 Sep 76 – 16 Mar 76:
Sgt EF Barnes, Sgt(W) M Fletcher, Sgt D Frerichs, Sgt TV Girdlestone, Sgt JB Labrosse, Sgt MG Williams

D Lab Tech Adjustment Training 29 Sep – 30 Oct 75:
CWO M Beauvais, CWO H Bilbey, MWO JC Bleakney, MWO J Hossdorf, MWO JA Christiansen, MWO DC Hughes, MWO EE McFadden, MWO R Todd

Dent Therapists Adjustment Training 8-26 Sep 75:
Miss AM Chretien, Miss LJ Colter, Capt DS Fraser, MWO RK Jones (Militia), Capt RJ Rutledge, Miss ME Ward

Dental Assistant PL 3 8 Oct – 12 Dec 75:
Cpl B Bungay, Pte(W) DS Dane, Cpl JF Lemieux, Pte(W) SM MacDonald, Cpl BF McCabe, Pte(W) HM McCurdy, Cpl DG Melott, Pte(W) P O'Reilly, Cpl PD Paige, Pte JAM Paquin, Pte HA Ratajczak, Pte(W) MK Rees, Cpl WM Skanes, Miss K.E. Spurr

Officers Clinical Oral Surgery Course 15-26 Sep 75:
Capts JAG Chaume, MW Garriott, WJ Jury, P Kozak, JB Maurice, DE McPhee

Dental Officer Training Plan

Phase III – 26 May – 01 Aug 75:
2Lts DG Cahoon, ML Irwin, GW Iverson, CB Leek, PA Gillies, KV MacDonald, RD Mazurat, RA McWade, GJ Meisner, C Mensinga, MJT Michaud, JJG Rouillard, WC Schadt, JJ Severs, BR Taylor, EA Toporowski

Phase II – 18 Jun – 01 Aug 75:
2Lts JM Boisclair, DJ Brodie, BD Harper, J Gosselin, JK Pyne, EL Reid, DS Stosky.

CMR St Jean

Advanced Management Course 7 - 24 Jul 75:
Maj GD Petrie

CF Warrant Officers Acadamy

Senior Leaders Course 29 Sep – 05 Nov 75:
WO TH Taylor

CFWO Course #7507 18 Aug – 24 Sep 75:
Sgt P Mehler

SIT – CFB Borden

SIT – 1 Course 20 May – 05 Jun 75:
WO RJ Tremblay

CFB Borden

Junior Leadership Course 25 Aug – 26 Sep 75:
MCpl(W) IJ MacNeil

CF School of Administration and Logistics

Management and Organizational Analysis Course – 6 – 22 Aug 75:
Capt FJ Reid, CWO MO McDonald

Training with Industry

SS White Coy – New Jersey Dental Equipment Course – 16-20 Jun 75:
Sgt JG Cliche, CWO E Everett

married

Best wishes are extended to the following newlyweds:

MCpl RF Buchanan and
Miss Jane MacLean
Capt DR Vandahl and
Miss Sarah Helgeson
Pte(W) ML Roy and
Pte Boullaine

births

Congratulations to:
Cpl and Mrs JOJP Laperle
Capt and Mrs S Allington
Capt and Mrs LPJ Bilodeau
Capt and Mrs JLRP LaRose
Capt and Mrs RG Button
on the birth of their sons; and to

Maj and Mrs HM Amos
Capt and Mrs DH Wright
Mr and Mrs (Shirley) Gorr
on the birth of their daughters.

honours and awards

FICD INDUCTION

Col L.R. Pierce, Commanding Officer of 13 Dental Unit, was recently inducted as a Fellow of the International College of Dentists. Induction ceremonies were held during the CDA convention in St John's, NFLD. Official fellowship presentations took place on 18 August at the annual dinner and convocation of the Canadian Section of the International College of Dentists.

bereavements

CD
Maj HM Amos
Capt DH Brown
MCpl NG Jones
Cpl EA Morin
Sgt JR Ritchie

Our most sincere sympathy is extended to Capt RJ Leblanc on the death of his father.

Saving Yesterday's *Today* *For Tomorrow*

The Dental Museum of Canada
Le Musée Dentaire du Canada
495 Palmtree Avenue
London Ontario

B.A. McLeod CD.
Curator

Phone
(519) 471-7557

August 25, 1975

Commanding Officer,
No. 1 Dental Equipment Deport,
Canadian Forces Base,
Petawawa, Ontario.

Dear Sir:

In reference to our conversation of August 12, 1975, this is to inform you that registration of the Dental Museum of Canada with the Ministry of Consumers and Commercial Relations has been finalized. The museum has been established for the purpose of displaying items used by or associated with the dental profession. Enclosed is a donor form which will be included in a brochure to be distributed to all prospective donors.

Now that an interest has been taken in preserving all aspects of the dental profession, I hope that once an item has become obsolete it will be dontated to the museum.

A section of the museum has been allotted to the military dental corp and I would like to request your assistance in securing items that would add to this collection. I would also appreciate being contacted prior to the disposal of any dental items, to ensure the preservation of at least one.

Thank you for your help.

Sincerely,

B.A. McLeod, CD,
Curator.

Saving Yesterday's — Today — For Tomorrow

Such is the motto of The Dental Museum of Canada and we offer our congratulations and appreciation to those responsible for creating this means to preserve, centralize and put on public display memorablia of the profession in Canada. It is particularly gratifying that a section of the museum has been allotted to the military dental services and our readers are invited to respond to the invitation contained in the above letter. Any personal items you feel may be of interest to the Curator should be forwarded to him at the Museum.

Missing pages 17,18,19,20