The ROYAL CANADIAN DENTAL CORPS Quarterly

VOLUME 3 NUMBER 4 JANUARY 1963

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THE RCDC QUARTERLY

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VOLUME 3 NUMBER 4 JANUARY 1963

THE ROYAL CANADIAN DENTAL CORPS ASSOCIATION

Brigadier E.M. Wansbrough, OBE, MM, ED, CD,
FICD, FACD

When officers of the RCDC are requested to support the above organization they may very well ask "What is this Association?" "What does it do?" and "What is its purpose?".

In order to answer these questions a brief history is in order, which it is hoped will help to explain the objectives as stated in the Association constitution, i.e., "To promote the efficiency and esprit-de-corps of the Royal Canadian Dental Corps and to co-operate with fellow members of the Conference of Defence Associations in the promotion of general efficiency of Canada's Defence Forces."

Prior to and during the Second World War, dental officers were eligible for membership in the Defence Medical Association. However dental officers who attended the annual meetings found that the agendas were filled with specific medical problems which did not apply to the Dental Corps since it had, long since, been a separate Corps. The suggestion was made that a dental division be constituted but this idea did not find favour with the Medicals and it was decided to establish a separate organization to be known as the Defence Dental Association. Ex-militia officers of the Arms and Services of the Canadian Army who served in the CDC during the Second World War knew full well how much these associations had contributed in the lean days of the Non-Permanent Active Militia and were keen to have such an Association.

During the summer of 1947 an organizing committee composed of Col DS Coons, Col LV Janes and Major HC Thompson, all of Hamilton, Ontario, was given the responsibility to submit an application for membership in the Conference of Defence Associations. This membership was granted and a letter was dispatched to all ex-CDC officers in Canada which set forth the aims and objects of the Association. A channel of communication with the Minister of National Defence and the Chief of the General Staff was established to permit direct replies from these officials on matters dealing with the resolutions endorsed at the annual meetings.

Initially, the Association's membership was composed solely of ex-officers of the wartime Canadian Dental Corps and branches were formed in several cities across Canada. However, with the authorization and formation of the RCDC(M) the emphasis shifted to these units and their problems. It was thought that the facilities of these units would serve as rallying points where all officers of the RCDC, CADC, RCDC(R) and RCDC(M) could meet from time to time to consider matters of general interest.

The first meeting of the Defence Dental Association was held in the Mount Royal Hotel, Montreal on Oct 29-30, 1948. The Executive consisted of:

Honorary President	-	Brig FM Lott
President	-	Col LV Janes
1st Vice President	-	Col DS Coons
2nd Vice President	-	Lt Col CL Strachan
3rd Vice President	-	Lt Col LA Stirling
Secretary-Treasurer	-	Major HC Thompson
Assistant Secretary-Treasurer	-	Lt Col WH Smith

Since that time, meetings have been held annually, with Ottawa being chosen as the primary site. This arrangement permits many senior officers of the three Armed Services to attend the meetings with some regularity. Perusal of the minutes of these meetings indicates the variety and complexity of the subjects discussed. Many resolutions have been framed and forwarded to the Conference of Defence Associations. In 1952 one of these called for the change in the name of the organization to the Royal Canadian Dental Corps Association. One of the most worthwhile results of the meetings has been to provide an opportunity for the Commanding Officers of militia units to get together to discuss their common problems and to review their progress during the current year.

In common with so many other organizations there are ever present financial problems. Dependent to a great extent on the vagaries of an annual government grant and the energy and vigor of the Commanding Officers of units in collecting and forwarding the annual dues, the treasur~ has often been in a precarious state. However, due to the skilful manipulation and management of the treasurer, the late Col HR McLaren, the accounts were always paid.

Although the dispersal of the RCDC units from the Atlantic to the Pacific provides wide distribution and representation of the Corps in the Armed Services of Canada, this dispersal also produces many problems of a challenging nature. These problems can only be discussed and resolved through a face-to-face meeting and the annual meeting of the Association provides such a medium. Administration, training, recruitment, accommodation, standards and regulations for awards are subjects which appear regularly in the minutes and are the subject of careful thought and discussion.

It is, therefore, with the hope of welding together all these elements and diverse interests that the RCDC Association exists. The working executive this year, Lt Col WG Campbell - President, Col CB Climo - Secretary, and Col CE Woods - Treasurer, can only accomplish so much. They depend on the active interest and support of all officers (past and present) of the Royal Canadian Dental Corps for the continuing success of this most worthwhile organization.

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A ROOT CANAL FILLING TECHNIQUE USING NEWLY DESIGNED INSTRUMENTS AND SILVER POINTS

Major JJN Wright, DDS

Many different endodontic techniques[1,2,3], produce consistent results of excellent quality when carried out by specialists who have had years of experience. However, the "occasional endodontist" requires a technique which will give dependable results and which can be easily mastered by a dentist of average skill. As a result of work done by Ingle[4] and presented before The Second International Conference on Endodontics held in Philadelphia in 1958, a new and standardized system of designating instruments and points has been introduced. These instruments and points are now available to dental officers and their uniform size and taper make it possible for the "occasional endodontist" to produce root canal fillings of high quality.

Numbering System

The new size numbers, unlike the old are not just arbitary figures but denote the diameter of the instrument at a point where the cutting blade begins (near the tip point D1 Fig. 1). The sizes range from 10 to 100 and express this diameter in tenths of millimeters.

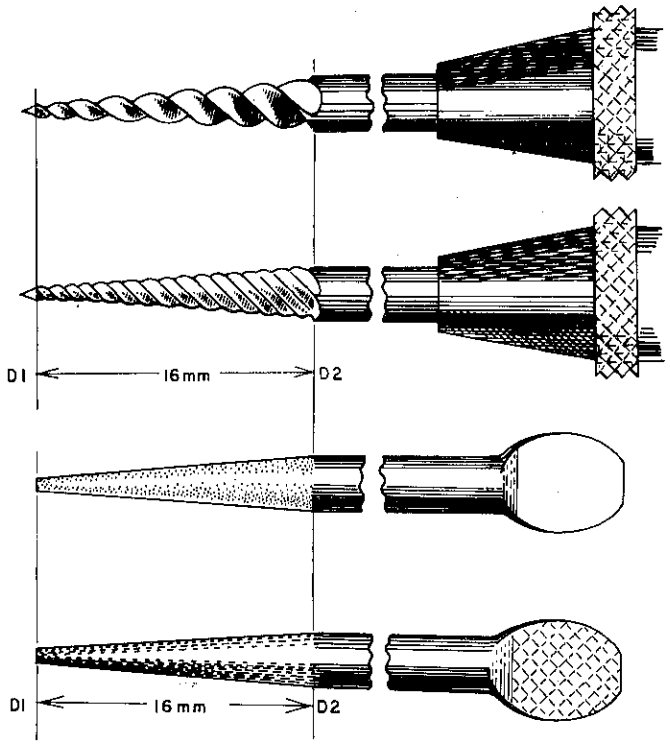

Fig. 1[1]

A number 10 instrument or point for example is 10/100 or 0.1 mm in diameter at D1 while a number 25 is 0.25 mm.

Sixteen millimeters up the shaft from the point D1 is a point designated D2 which is 0.3 mm larger in diameter than D1 and thus provides a uniform taper for all sizes. Silver points, which are identical to the cutting instruments in number, taper and increment can thus be selected in the correct size without resorting to the "trial and error" method.

The following is an approximate comparison of the old and new number systems according to size:

Old	New	Old	New	Old	New
0	10	-	35	7	60
1	15	5	40	8	70
2	20	-	45	9	80
3	25	6	50	10	90
4	30	-	55		

The use of these new instruments and points thus makes it possible to obtain consistently well-prepared canals and accurately adapted silver points, with a considerable saving in operating time during the fitting stage.

Objective of Endodontic Technique

When considering root canal filling techniques the objective is to obtain a hermetic seal from the dentinocemental junction at the root apex to the floor of the pulp chamber. This seal should also obturate all accessory and lateral ramifications of the root canal.

Requirements of Root Canal Filling Material

An ideal filling material should be:

1. Non-irritating to periapical tissues.
2. Impervious to tissue fluids.
3. Adaptable and adhesive.
4. Radiopaque.
5. Nonvolatile and nonshrinking.
6. Bacteriostatic.
7. Able to penetrate lateral and accessory canals.
8. Easy to sterilize.
9. Non-staining.
10. Easy to prepare, manipulate and place.
11. Easy to remove from pulp chamber and root canal if necessary.
12. Stable.

There is no material at present which satisfies all these requirements. However, a technique of lateral condensation of gutta percha in combination with a fitted master silver point and sealer comes very close to the ideal. The method of lateral condensation of gutta percha alone can produce excellent results. However, even in the hands of the most competent endodontists there is always the danger of over-filling due to elongation of the gutta percha cones under the pressure of condensation.

Silver cones with sealer are ideal for fine canals, but in the larger canals such as are found in the maxillary anteriors, silver cones alone do not satisfy many of the requirements stated previously. In particular, their slight taper is likely to fit snugly for only a few millimeters in the apex of the canal.

A technique in which the master point is a standardized silver point fitted in a canal prepared by standardized instruments and in which the remainder of the canal is filled by the lateral condensation of gutta percha cones is a method which can easily be mastered by any dentist. This technique combines the advantages of both materials. The silver point can be placed precisely where desired in relation to the apex, fitting snugly in the apical area where it "corks" the foramen and prevents over-filling with the condensed gutta percha.

Silver points have the following advantages when used as master points:

1. They are manufactured to correspond to the size and taper of the cutting instruments.

2. They are rigid enough to be inserted into the canal with considerable force.

3. They follow curved canals readily.

4. They are easily sterilized by flaming.

5. They do not elongate during lateral condensation procedures.

Technique for Filling Large Canals with Closed Apices (Maxillary Anteriors)

The canal must first be adequately prepared and biomechanically cleansed to the dentinocemental junction at the root apex before it is ready for filling. In this regard the apical portion of the canal must be enlarged by the file or reamer to ensure complete obliteration by the silver point.

1. The tooth is isolated with a rubber dam and all surfaces around the crown disinfected with untinted tincture of metaphen or a similar disinfectant.

2. The previously prepared tooth is opened using an aseptic procedure, the medicated paper point is removed and the canal is irrigated with sodium hypochlorite.

3. The largest file used in the preparation of the canal is fitted with a rubber stop at a predetermined length (corrected working distance) and the walls of the canal are cleansed of any exudate which may have seeped into the canal.

4. A silver point of the same size as the instrument used in 3 above is selected (usually a #50 for maxillary anteriors). The point is grasped by a pair of hemostats at the predetermined length and sterilized by flaming.

5. The silver point is inserted into the canal until the hemostat touches the incisal edge. (The incisal edge is used as the visual landmark in determining the canal length). The silver point must fit snugly in the apical part of the canal. If the fit is not tight enough a small portion can be cut from the apical end of the point until a snug fit is obtained.

   Note: If the preparation terminates at the root apex the point needs no shaping at the apical end. However, if the preparation terminates short of the root apex (the dentinocemental junction) the point must be sharpened with a sandpaper disk to correspond to the point on the reamer or file used in the preparation of the canal.

6. After fitting, the point is cut even with the incisal edge and a radiograph taken to verify its position. (Fig. 2 #1).

   Note: While the radiograph is being processed, fine gutta percha points are transferred from a bath of untinted tincture of metaphen and placed between the folds of a sterile towel on the bracket table ready for lateral condensation. A sterile Kerr #3 spreader is also placed between the folds of the sterile towel.

7. The canal is dried with sterile paper points.

8. If the radiograph confirms an accurate fit, the silver point is notched half way through at the level of the gingival attachment.

9. The sealer is mixed as directed by the manufacturer and the apical half of the silver point is coated with the sealer and inserted into the canal until the tip is even with the incisal edge (Fig. 2 #1).

10. A sterile Kerr #3 spreader is inserted beside the master point and forced up by rotating the spreader back and forth while constant apical pressure is maintained (Fig. 2 #2).

11. A fine gutta percha point is picked up with a pair of cotton pliers in the right hand and held ready. The spreader is removed with the left hand and the fine gutta percha cone is inserted immediately into the pathway created by the spreader (Fig. 2 #3). This operation is repeated until no further points can be inserted into the mass (Fig. 2 #4). It should be noted that the spreader is always inserted on the same side of the master point.

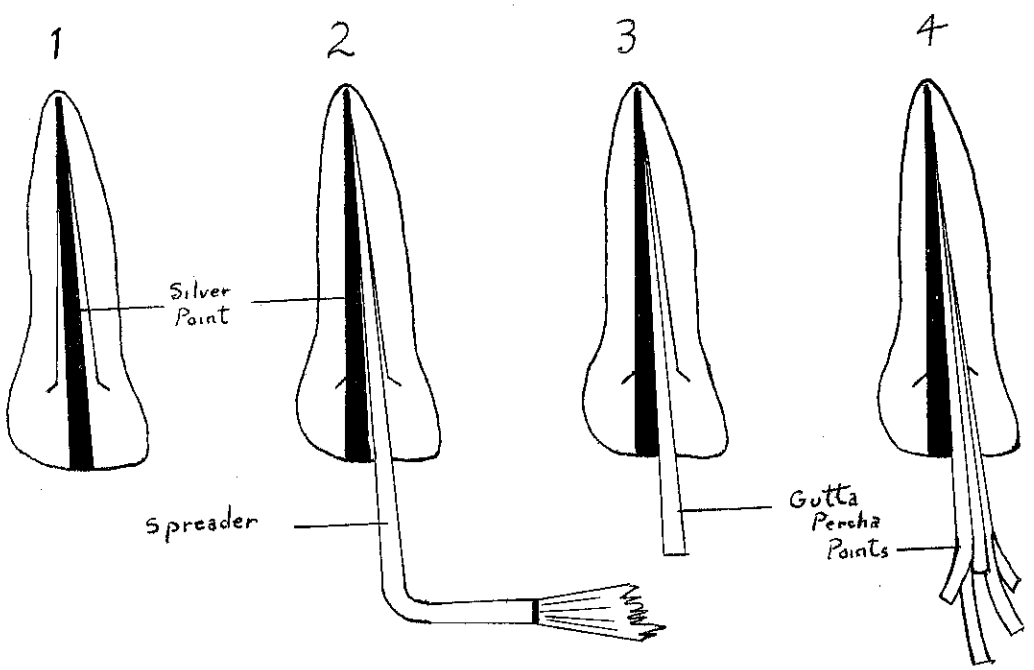

Fig. 2

12. A radiograph is taken to check the density of the filling.

13. If the filling is satisfactory, the gutta percha is removed from the coronal portion of the pulp chamber with a heated instrument. The portion of the silver point above the previously prepared notch is now removed by wiggling it back and forth until it breaks. All traces of sealer and gutta percha must be removed from the coronal portion of the pulp chamber to prevent future discoloration. The chamber is swabbed with chloroform and dried.

14. A temporary seal or a permanent filling is placed in the pulp chamber. A translucent material such as silicate or acrylic should be used as a permanent filling material. A substance such as crown and bridge cement should not be used as it will reduce the translucency of the crown and produce a dull appearance.

Summary

The new numbering system used for the endodontic cutting instruments and silver points recently added to the RCDC Stores List has been explained and the advantages of standardizing their size, increment and taper have been noted. A technique for filling large root canals which have closed apices has also been described.

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CONTROLLED TOOTH DIVISION

Lt Col WR Thompson, CD, DDS

The majority of teeth can be and are removed uneventfully by conventional exodontic procedures. Discussion is warranted, however, regarding that minority of extractions which result in excessive bone loss and/or prolonged sessions involving almost the entire range of the surgical armamentarium and the patience of the dental officer.

Pre-operatively the extraction should never be referred to as "simple". Every tooth with its supporting structures differs and many fractures of the root, crown and alveolar bone are impossible to predict or prevent. Other fractures, however, could be avoided by a more thorough pre-operative clinical examination, radiographic study and surgical plan. These factors are necessarily considered to some extent prior to every extraction but consideration must determine not merely that a tooth must be extracted but how it should be extracted.

The majority of surgical complications arise during the extraction of multi-rooted teeth and in these cases, "controlled tooth division" should be considered. This term refers to the division of the tooth by bur or chisel as a planned procedure to ensure an unimpeded path of removal with minimal bone loss. This procedure overcomes the tendency to apply excessive force, maintains better control and thus reduces the incidence of surgical complications.

INDICATIONS

Clinical examination should include both intra and extra-oral considerations. Much may be ascertained from the extra-oral facial form of the patient. If the face is square and compact, the zygomatic process will probably be low, the lips thick

and inelastic and the masseter muscle well developed. Intra-orally the dental ridge will usually be short, the buccal vestibule limited, the bony margins thick and the tongue and sublingual tissues high in the floor of the mouth. These factors not only make an extraction more difficult by limiting access to the operative site but they suggest dense bone and a low, large sinus cavity. The longer facial forms present less formidable problems but surgical procedures may be complicated by thin alveolar bony support and long roots of the molar teeth.

In addition to these general clinical observations the specific tooth to be extracted must be studied clinically and radiographically. The variances which indicate closer scrutiny and consideration of tooth division in the surgical plan are as follows:

1. Molar teeth with widely divergent roots

   If the overall mesio-distal measurement of the roots is noticeably greater than the width of the crown, extraction will probably be impossible without causing fracture to the root or bone. Sectioning of the tooth will retain this bone or keep its loss to a minimum.

2. Molar teeth with locked bone between the roots

   The roots curve out to a wider area than the crown then turn sharply in, locking sufficient bone to prevent tooth removal without fracture. These teeth must be individually judged from experience as many with a small amount of locked bone can be removed without complication.

3. Molar teeth with extensive decay

   Extensive decay often results in insufficient tooth structure for adequate application of the forceps. The resultant slipping from the tooth could be extremely disconcerting to a patient and exasperating to a dental officer. The problem should be explained to the patient and the tooth sectioned initially.

4. Isolated teeth in the posterior region of the maxillary arch

   Tuberosity fracture may result during posterior extractions, especially in older patients. Heavy occlusal stress over long periods causes the bone around such teeth to become extremely dense and the periodontal membrane to become very thin. Tooth division in these cases may be indicated.

5. Multi-rooted teeth with root canal fillings and/or post crowns

   Pulpless teeth are well known to fracture more readily with the application of force. Sectioning will eliminate this complication in most cases.

6. Teeth with a heavy buccal ridge of bone near the cemento-enamel junction

   Unless these teeth are sectioned initially, a considerable portion of the buccal alveolar wall may fracture.

7. Maxillary cases in which the sinus floor extends deeply between the molar roots

A portion of the floor of the sinus will often be removed with the tooth unless sectioning is carried out.

8. Maxillary cases in which the sinus cavity extends into the tuberosity area

This extension hollows out and weakens the tuberosity. Sectioning will eliminate excessive pressure and thus avoid possible tuberosity fracture during the extraction of maxillary second and third molars.

9. Impacted Teeth

The majority of these teeth require sectioning to facilitate removal, to conserve alveolar bone and to prevent pressure on the mandibular canal.

10. Teeth with an abnormal number of roots

Normal force cannot be applied to most of these teeth without resulting in fracture.

11. Teeth requiring extraction where the mandible is small and thin

Sectioning may be required to prevent fracture of the mandible if the teeth are large, abnormal in shape and firmly embedded.

12. When the initial force applied to mandibular molars suggests possible dislocation or partial dislodgment of the condyle head

This may occur in spite of mandibular support during removal. Sectioning should be considered to prevent stretching of the ligaments or damage to the temporo-mandibular joint.

13. When the application of normal force fails to produce the expected movement

In these cases sectioning should be resorted to since excessive or uncontrolled force causes many fractures of the root, crown and alveolar bone.

It is not suggested in all instances listed above, that a flap be raised, bone removed and the tooth sectioned before removal. It is emphasized, however, that the tooth must be carefully assessed clinically, radiographically and often by the limited application of force to determine if controlled tooth division is indicated.

TECHNIQUE

It is not within the scope of this paper to outline a sectioning procedure for each type of impaction or abnormal situation. A procedure will be outlined, however, for a maxillary and mandibular molar tooth with widely divergent roots. With the exception of impacted teeth, the technique as described can generally be applied to other cases.

The following procedure is recommended when tooth division is undertaken for the removal of an upper molar:

1. A buccal flap is raised. When tissue and bone resorption has occurred a horizontal flap will suffice. This incorporates only the gingival tissues about the tooth to be extracted and those teeth immediately adjacent. If resorption has not occurred, a vertical incision may also be required to allow sufficient soft tissue retraction.

2. A small amount of buccal bone is removed to expose the area just below the cemento-enamel junction. This bone may be removed with bur or chisel.

3. The buccal roots are now separated from the crown and lingual root with a cross-cut fissure airotor bur. This mesio-distal horizontal cut is made across the buccal roots slightly apically from the cemento-enamel junction. The cut is angled slightly toward the root trifurcation to aid in division. The bur depth should be slightly less than the estimated thickness of the buccal roots. A straight, flat-bladed elevator will complete the fracture of the buccal roots from the crown and lingual root.

4. The crown and lingual root are now removed in one section by the use of forceps.

5. The remaining buccal roots are divided by making a vertical cut with the same airotor bur. The flat-bladed elevator may be required to complete this division.

6. The less divergent buccal root is now removed with narrow-beak anterior forceps or, dependent on the root curvature, by elevator pressure. The remaining root is similarly removed.

7. The bony margin is smoothed with a bone file before suturing.

If the maxillary crown is grossly involved with caries it may be necessary to cut off the entire crown. The three roots are then separated by vertical cuts with the bur and the sections removed as single rooted teeth.

When a lower molar tooth requires controlled division the following procedure is instituted:

1. The gingival tissue margin is separated from the offending tooth. A flap is seldom required.

2. The crown of the tooth is sectioned bucco-lingually with the airotor bur. The cut is initiated on the buccal surface of the crown and extended through the lingual. The bur is then applied in the centre of the crown and extended apically to the depth of the root bifurcation. The bur cut is then extended laterally from the bifurcation almost to the buccal and lingual bony walls.

3. A flat-bladed straight elevator will ensure that the tooth is separated to the bifurcation.

4. The separated sections are removed with lower anterior forceps as individual single-rooted teeth. The less divergent root is removed first.

5. The socket area is smoothed and closed in the conventional manner. Sutures are seldom required.

If the roots are extremely divergent or enclose a considerable amount of locked bone a flap will be required. A small amount of buccal alveolar bone is then removed and to facilitiate root removal, the entire crown is separated from the roots. This division is made near the cemento-enamel junction to ensure sufficient root projection for forceps application. The individual roots are separated vertically and the bur cut extended to well below the bifurcation. This extension reduces the bony support and thus the resistance to root movement. The roots are now removed individually with forceps or elevators.

The airotor bur is preferred for controlling division because it cuts more quickly than conventional burs and the method is more familiar to dental officers than the chisel sectioning technique. Furthermore, the bur removal of a definite amount of tooth structure ensures space for movement.

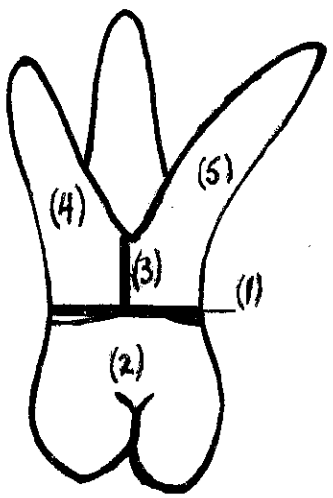

Fig. 1

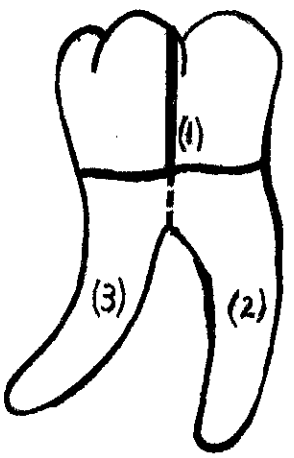

Fig. 2

CONTROLLED DIVISION AND EXTRACTION TECHNIQUES

Figure 1 - Maxillary Molar

(1) Mesio-distal horizontal cut.

(2) Crown and lingual root extracted.

(3) Vertical cut between the buccal roots.

(4) Less divergent buccal root extracted.

(5) Remaining root removed.

Figure 2 - Mandibular Molar

(1) Bucco-lingual cut through the crown and root trunk to the bifurcation.

(2) Less divergent section extracted.

(3) Remaining section extracted.

CONCLUSIONS

A planned procedure for controlled tooth division on indicated teeth will result in:

1. Preservation of important areas of osseous structure.

2. Avoidance of displacement of portions of teeth into adjacent structures such as the maxillary sinus.

3. Prevention of mandibular nerve injury.

4. Prevention of injury to adjacent teeth and their supporting structures.

5. Considerable saving in time.

6. Increased patient co-operation and confidence.

SUMMARY

Increased pre-operative emphasis, clinically and radiographically, on facial, oral and specific tooth variances will demand that tooth division be employed on a greater number of teeth.

The variances have been discussed and a technique for controlled tooth division outlined. The latter overcomes the tendency to apply excessive force, maintain better control and thus reduce the incidence of surgical complications.

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DIAGNOSIS OF THE "WHITE" ORAL LESIONS

Captain WB Hudgins, DDS

Since the establishment of dentistry as a profession in the mid-nineteenth century, it has evolved to a position of great responsibility in the health service professions. Yet, some practitioners have not recognized their obligation to accept responsibility for diagnosis of soft tissue lesions.

The dentist's working time and interests are concerned with the oral cavity. The patient in the dental chair is a captive subject. It is unreasonable and neglectful to miss an opportunity to recognize potentially dangerous lesions because they may be unrelated to immediate dental problems.

The following is an attempt to group together the white lesions of the oral cavity into the innocuous and those having possible serious implications.

1. INNOCUOUS WHITE LESIONS

   a. White Sponge Nevus

      This entity is most commonly found on the buccal mucosa where it presents a shiny white opalescent surface which may be filamentous in character. It is not a keratinized lesion, but the result of heaping of edematous epithelial cells which give it its spongy character. It is congenital, familial, and asymptomatic which facilitates its differential diagnosis.

   b. Nicotinic Stomatitis

      Found on the posterior palatal region where the mucosa presents elevated white keratinized areas surrounding blocked mucous glands. The causative factor is pipe smoking, which produces both heat and chemical irritation. It regresses with removal of cause.

c. Lichen Planus

The etiology of lichen planus is obscure but is associated with nervous tension. Clinically the oral lesions are white or yellowish-white lines in a lace-like pattern, although they may take the form of annular rings or plaques.

The sites affected in order of frequency are: the buccal mucous membranes, tongue, lips, hard palate and gingiva. The lesions are normally asymptomatic.

If diagnosis presents a problem, skin lesions are frequently found on flexor surfaces of the arms and legs. Normal tissue and lichen planus will stain with Lugal's solution (glycogen content) where keratotic lesions will not take up stain.

It occurs most frequently in the 30 - 40 age group and may be further differentiated from the leukoplakias, in that the margins are ill-defined and there is no change in tissue tone or flexibility.

d. White Hairy Tongue

A condition of unknown etiology in which elongation of the filiform papillae on the dorsal surface of the tongue is the dominant feature. Clinically this is rarely observed because of discolouration caused by secondary infection or exogenous pigments of smoking, food or medicaments.

e. Moniliasis (Thrush)

This fungus infection of Monilia albicans or Candida albicans may appear anywhere in the oral cavity as multiple grayish-white patches which can be peeled off leaving painful bleeding surfaces.

The infection occurs in either the very young or the old and debilitated, and therefore should be no problem in the intermediate age groups except where antibiotic therapy has upset the normal oral flora.

f. Fordyce Spots

Clinically this condition is exhibited in about 80% of the population beyond puberty. Yellowish-white, hypertrophied, sebaceous glands appear in clusters on the buccal mucosa at the level of the occlusal plane and may extend to the lips and retro-molar area. The granules are asymptomatic and of no known clinical significance.

g. Geographic Tongue

These lesions of unknown etiology are characterized by depressed red areas of desquamation surrounded by normal or hypertrophied filiform papillae, which appear white by comparison. The condition is found predominantly in the adult female and exhibits periods of remission and pattern changing which may require continual reassurance to the patient that it is harmless.

h. Burns - Chemical and Thermal

The typical picture of white coagulated protein presents no diagnostic problem. Questionning will normally elicit the causative agent such as aspirin, phenol, perborate, zinc chloride or the thermal agent.

2. WHITE LESIONS WITH SERIOUS IMPLICATIONS

The white lesions of the oral cavity represent a diverse group of diseases and reactions to injury. Oral cancer is more serious and more important to the patient than any other condition with which it might be confused. Therefore, the possibility of cancer should be eliminated first before treating on the basis of a benign lesion or waiting for further developments.

A great problem lies in the discrepancies between clinical and microscopic diagnoses compounded by confusion in the definition of leukoplakia.[1] An abbreviated list of terminology in use today includes:

a. Pachyderma oris
b. Leukoplakia (several grades)
c. Carcinoma-in-situ
d. Focal keratosis
e. Asymptomatic cancer

Pachyderma oris and Focal keratosis are innocuous lesions but cannot be clinically diferentiated from the others.

Clinically these lesions all may appear white, may be raised or flat, fissured or smooth, large or small, with well-defined borders. They predominate in males over forty years of age and present anywhere on the oral mucosa; the lips, tongue, cheeks and floor of mouth being most frequently involved.

Szerlip[2] says that one cannot differentiate on a purely clinical basis which white patch is a benign lesion, which is truly precancerous or which is frank malignancy. On this basis Robinson[1] has growing support[3, 4] for using leukoplakia as a non-specific clinical term meaning only "white plaque" and carrying no implications of a precancerous condition.

A biopsy of all non-specific "white patch" or "leukoplakic areas" is essential if the dentist is to fulfil his responsibility in providing a complete and accurate diagnosis for his patients.

3. INDICATIONS FOR BIOPSY:

a. When careful examination fails to lead to a diagnosis.

b. Recognized precancerous lesion.

c. Lesions which present clinical signs of malignancy:

(1) Persistency
(2) Progressiveness
(3) Induration
(4) Ulceration
(5) Fixation of the base.

d. Lesions that fail to respond to recognized therapy.

SUMMARY

The clinical features of the white lesions of the oral cavity have been described.

The contention is held that clinical surface characteristics cannot be used to accurately predict the microscopic appearance of lesions; and that leukoplakia should be used as a non-specific clinical term.

A plea is made for increased use of biopsy service and its indications have been presented.

REFFERENCES

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A TRIP TO THE CONGO

Lt Col LG Craigie, CD, DDS

Most RCDC personnel look forward periodically to the time when they can get away from the office and do something different or go somewhere, if for no other reason than for a break in their daily routine. Because we are a comparatively small Corps and our role with the Canadian Forces necessitates that we concentrate with the larger military activity and formations which are not prone to move too far afield in peacetime, these interludes away from the office happen much too infrequently. Can you imagine the surprise you would feel if suddenly you received instructions to go to a far off place such as the Congo? This happened to me not too long ago when I received orders to visit the 57 Canadian Signal Unit in Leopoldville.

My schedule from my home station in Metz, France to Leopoldville in the Republic of the Congo looked something like this:

Lv Metz	-	1730 hrs	28 Oct 62
Ar Marville	-	1900 hrs	28 Oct 62
Lv Marville	-	0700 hrs	29 Oct 62
Ar Pisa	-	1500 hrs	29 Oct 62
Lv Pisa	-	0059 hrs	30 Oct 62
Ar Leopoldville	-	1100 hrs	30 Oct 62

You can see at a glance that the distance to be travelled is great - just add up the flying hours.

All Canadian soldiers posted to either Egypt or the Congo arrive direct from Canada at Pisa, Italy where they are divided into their separate groups. Those who are going on to Egypt take the North Star which arrives from Marville, France. The remainder, with the addition of other UN personnel, take the Yukon which came from Canada and proceed to the Congo. What a mixture of nationalities boarded the Yukon! To mention a few, there were military personnel from Austria, India, Denmark and Sweden and, believe it or not, a female secretary from Switzerland. We had a passenger list of some 78 people which included 18 soldiers who had just arrived from Canada.

On arrival, there was no doubt that most of us on board the Yukon had a misguided conception of the city of Leopoldville. Instead of the jungle that we had been viewing for better than two hours during the last leg of our journey, here was a modern airport with the second longest runway in the world. The air terminal building was modern in every respect, complete with a high terrace filled with people who were watching the activities below. Most of us had misjudged the climate too. We knew it would be hot but we were not prepared for such breathtaking heat, high humidity or the odour of wet vegetation. Little did we suspect then that within a few days we would be going about our tasks feeling and looking as cool as those who greeted us on our arrival.

Leopoldville itself is a beautiful city. Although the boulevards are overgrown with grass and some of the beautiful trees need trimming in certain sections of the town, the streets are wide and paved throughout. In fact a modern, lighted, four lane cross-town throughway divides the city. Ultra-modern apartment blocks can be seen everywhere and in a scenic section of the city running along the banks of the Congo river a surprisingly large number of embassies from all over the world are in operation. The local government and federal buildings are all of modern design. The most notable of these is an ultra-modern new Court of Justice building. Overlooking the city on one side is the Stanley Memorial while below is the mighty Congo River whose turbulent, muddy-gray waters seem to challenge one to proceed further. On the outskirts and in the hills is a modern university which boasts a newly-formed Faculty of Medicine.

Like many of our Canadian cities, Leopoldville too has problems. Since independence, the native population has more than trebled. No one really seems to know exactly, but the authorities estimate that over a million native Congolese have moved into the city, most of whom have come from the jungles, bringing with them their tribal customs and ways of life. Since housing and accommodation has not been able to keep up with this growth, most of the natives live in shacks or in very humble dwellings and these areas are indeed in sharp contrast to the luxurious surroundings of the better districts of the city. Employment is scarce and food is expensive but it is amazing how these people exist from day to day. The children seem happy and well cared for and the parents tidy and clean.

One custom which may appeal to some Canadian soldiers, and which may be food for thought to others, is that the Congolese women seem to do all the heavy and laborious work. It is quite common to see a housewife walking down the road with an overfilled basket balanced perfectly on her head and carrying a small child "piggy-back" fashion in a fold of her sarong-like dress. By switching her child from her back to her side while still in the fold of her dress, a good Congolese mother can feed her youngster without any interruption enroute to her destination or to the task at hand. The men, on the other hand, seem to prefer work that calls for the least amount of physical exertion and prefer to be employed

as cooks, laundry boys, houseboys or any other occupation that will keep them out of the hot sun. As in Europe, the outdoor cafe is popular and here the men gather in groups to discuss world or local issues or maybe just to watch the people pass by.

Directly across the Congo river from Leopoldville which is in the Republic of the Congo, lies a town called Brazzaville which is in the Congo. Both are independent countries. The former, before independence, was Belgian territory and the latter French territory. Some of you may recall that it was from Brazzaville that General Charles de Gaulle, now the President of France, directed the French Resistance Movement for a time. As a matter of fact, the house in which he lived and made his headquarters is now a well-marked tourist attraction. Here, life is much the same as in Leopoldville but one gets the impression that the way of life in general is more orderly and purposeful. The stores and shops are well stocked with imported goods and foods from France and the native population dress for the most part in European and American fashions.

Shopping in the Congolese ivory markets is entertainment at its very best. No prices are ever displayed and a purchase is made only after so much haggling that both parties are near exhaustion. Along with pieces of carved ivory, amber necklaces, paintings and wood carvings, a variety of animal and reptile skins can be bought. For amusement there are quite a few nightclubs in Leopoldville and the Congolese Nationals would like you to believe, and with some merit too, that "the twist" originated here. The Canadian soldiers also enjoy the luxury of a private swimming pool along with the comforts of their own messes and lounges.

Everyone wonders whether or not cannibalism is still practised in the Congo. Apparently it is in some regions and rumour has it that human meat is occasionally available at the markets in Leopoldville. Imagine asking in pidgin English for a tender leg of Alfonse "deboned" or "defemured"! or a pound of tender "trapezius"! Incidentally, one of our mess stewards, a wondrous fellow named Gabrielle, always kept insisting that even if the worst came to the worst in the Congo he wouldn't eat a Canadian officer. The reason for this is perhaps that Gabrielle prefers lean meat.

Even though my visit was short, it was an interesting and informative experience. In spite of the uncertain and tense political situation that exists at present in the Republic of the Congo, I couldn't help but feel envious of those Canadian servicemen who have such a golden opportunity to discover more about this wonderful country.

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Dental Treatment - Canadian Service Personnel in the Congo

Of the 301 Canadian personnel stationed in the Congo some 235 are located at Leopoldville. Lt Col Craigie's report on dental examination of 171 available personnel revealed that 90% were dentally fit. He further noted that some Canadian personnel acquired a rapid accumulation of calculus, primarily in the lower anterior region, along with a "brown stain" which was very difficult to remove. The etiology of the stain is unknown but it would appear the calculus formation and staining is of a local environmental nature rather than systemic.

(From a brief on the dental requirements and conditions of Canadian Service personnel serving in the Congo presented to DGDS by Lt Col LG Craigie.)

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WELCOME TO THE CORPS

A hearty welcome to the Corps is extended to the following personnel:

Capt	JML	Rochefort	-	to CJATC Rivers Manitoba
Pte	CS	Brown	-	to RCDC School
Pte	DE	Fraser	-	to RCDC School
Pte	DC	Hughes	-	to Vedder Crossing BC
Pte	JJ	Gallivan	-	to RCDC School
Pte	MD	Longford	-	to Camp Valcartier Que
Pte	JE	Silverson	-	to RCDC School
LAW	MN	Boles	-	to RCAF Stn St Jean
AW2	MOB	Cyr	-	to RCAF Stn St Jean
AW2	MM	Delory	-	to RCAF Stn St Hubert

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PROMOTIONS

Congratulations are offered to the following RCDC personnel on their recent promotions:

WO2	RG	Peebles	-	to Lt
Ssgt	EE	Mazerall	-	to WO2
Ssgt	RD	McHugh	-	to WO2
Sgt	SM	Toole	-	to Ssgt
Sgt	CA	Young	-	to Ssgt
Cpl	HK	Drawe	-	to Sgt
Cpl	CC	Millard	-	to Sgt
Cpl	DT	Moran	-	to Sgt
Pte	RA	Neill	-	to Cpl
Pte	A	Pink	-	to Cpl
Pte	CstC	Sabine-Paisley	-	to Cpl
Pte	RH	Stenabaugh	-	to Cpl

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RETIREMENTS

Another valued officer has retired from the Corps in the person of Lt EI Tullis of RCAF Stn Trenton.

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RELEASES

The following releases have become effective since the last issue:

Cpl	DAM	Fisher(RCAF)	-	35 Fd Dent Unit
Cpl	MLG	Larue	-	RCAF Stn St Hubert
LAW	MJ	Roberts	-	RCAF Stn Downsview
AW1	CM	Fraser	-	RCAF Stn Trenton
AW2	JM	Scott	-	RCAF Stn Trenton
Mrs	B	Villeneuve(Pt V)	-	Quebec City

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POSTINGS

The following movement of personnel has taken place recently:

Major	C	Brown	- to FOB Winnipeg from 4 Fd Dent Coy
Major	IAC	MacDonald	- to HQ NWHS Whitehorse from HQ Cal Grn
Major	SW	Muller	- to HMCS Naden from HQ NWHS Whitehorse YT
Capt	MA	Abramson	- to HMC Dockyard from HMCS Shearwater
Capt	EW	Gazo	- to Camp Picton from RCAF Stn Trenton
Capt	WTH	Harley	- to HQ Cal Grn from HMCS Naden Esquimalt BC
Capt	DJ	MacPhee	- to HQ 4 CIBG from 1 RCR Fort York
Capt	LA	Reynolds	- to RCAF Stn North Bay from RCAF Stn Clinton
Capt	WF	Shaw	- to 1 RCR Fort York from HQ 4 CIBG
Capt	HC	Stewart	- to FOB Winnipeg from RCAF Stn Saskatoon
Capt	DA	Warrick	- to 7 PD London from Camp Ipperwash
WO2	EE	Mazerall	- to HQ 13 Coy RCDC Trenton from D Pers RCDC
A/Ssgt	DT	Murley	- to CBUME from HMCS Stadacona
Sgt	EL	Schell	- to 12 Dent Coy from CBUME
Sgt	DLG	Flesher	- to HMCS Stadacona from DGDS
Sgt	SG	Fraser	- to HMCS Stadacona from HMCS Bonaventure
Sgt	RD	Innis	- to RCAF Stn Goose Bay from RCAF Stn Uplands
Sgt	WS	Richardson	- to RCDC School from RCAF Stn Goose Bay
Sgt	KJ	Smallshaw	- to Pers RCDC from DGDS
Sgt	GH	Storms	- to 11 Dent Coy from CBUME
Sgt	AJ	Tait	- to QM Stores 11 Coy from 1 Dent Eqpt Dep
Sgt	RJJ	Tremblay	- to RCAF Stn North Bay from Camp Petawawa
Sgt	GW	Wilkinson	- to 2 RHC Fort St Louis from Fort Chambly
Cpl	DL	Fenton	- to RCAF Stn Winnipeg from RCAF Stn Saskatoon
Cpl	OW	Mandrusiak	- to RCAF Stn North Bay from Camp Ipperwash
Cpl	A	Pink	- to Ft Chambly 4 Fd Dent Coy from Camp Gagetown
Pte	CS	Brown	- to HMCS Naden from HL RCDC(S)
Pte	N	Cable	- to FOB Winnipeg from Fort Churchill
Pte	A	Girouard	- to CFH Kingston from HL RCDC(S)
Pte	DW	Griffiths	- to Edmonton from HL RCDC(S)
Pte	BF	Hannah	- to FOB Winnipeg from HL RCDC(S)
Pte	RS	Lindsay	- to 7 PD London from HL RCDC(S)
Pte	DF	Middleton	- to Camp Gagetown from HL RCDC(S)
Pte	LH	Pion	- to HMCS Stadacona from HL RCDC(S)
Pte	LA	Russell	- to FOB Winnipeg from HL RCDC(S)
Pte	JH	Thorburn	- to Camp Gagetown from HL RCDC(S)
LAW	JM	Giacobbo	- to RCAF Stn Cold Lake from RCDC School
LAW	DA	Turner	- to HQ 1 Air Div from RCAF Stn St Jean
AW1	MY	Smith	- to RCAF Stn Rockcliffe from RCAF Stn Comox

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TRAINING

Corps personnel have attended the following courses:

University of Michigan, Ann Arbor, Michigan

Minor Oral Surgery	- 26 Nov - 7 Dec 62	- Major TD Cobb - Maj RJ Bryant
Complete Dentures	- 7 Jan - 18 Jan 63	- Lt Col NA Butcher

TRAINING (cont'd)

US Naval Dental School, Bethesda, Md

Partial Dentures	- 7 Jan - 11 Jan 63	- Capt VM McMaster
Oral Pathology	- 14 Jan - 18 Jan 63	- Capt BA Gaudet

ENT Air Force Base, Colorado Springs, Col

Oral Surgery	- 3 Dec - 14 Dec 62	- Maj EJC Small

Ohio State University, Columbus, Ohio

Oral Medicine	- 21 Jan - 25 Jan 63	- Capt LA Reynolds

Civil Defence College, Arnprior, Ont

Emergency Health Ops and Adm	- 10 Dec - 14 Dec 62	- Lt Col GR Covey

RCDC School Courses

Dental Technician Clinical Group 4 - 13 Nov - 7 Dec 62

Ssgt	GEC	Bradley
Ssgt	MM	Fediuk
Ssgt	HEG	Franzgrote
Ssgt	JA	Fraser
Ssgt	R	Pelletier
Ssgt	JM	Tapp
Ssgt	JCA	Therrien
F/Sgt	DJ	Pierce

Dental Assistant Group 1 - 13 Nov - 14 Dec 62

Pte	RS	Black
Pte	HL	Boring
Pte	A	Girouard
Pte	JF	Giroux
Pte	GMR	Gravel
Pte	DW	Griffiths
Pte	BF	Hannah
Pte	DC	Hughes
Pte	HC	King
Pte	LPA	Lambert
Pte	RS	Lindsay
Pte	DF	Middleton
Pte	TR	O'Mara
Pte	LH	Pion
Pte	LA	Russell
Pte	RJ	Taillon
Pte	JH	Thorburn
AW2	RD	Armstrong
AW2	AM	Burdell
AW2	EL	Gunville
AW2	MA	Lawrence
AW2	SG	MacDonald
AW1	JE	Patterson
AW2	LF	Seraphim

1 Dental Equipment Depot

Dental Storeman Group 3 - 5 Nov - 30 Nov 62

Cpl	JG	MacPhee
Cpl	JA	Rochon

RCASC School, Camp Borden

Senior NCO Course - 29 Oct - 21 Dec 62

Cpl	H	Chamberlain
Cpl	WR	Dawson
Cpl	WA	Jackson
Cpl	G	Sapergia

Office Management Course - 12 Nov - 7 Dec 62

Sgt	SH	Lunnin

Command Junior NCO Courses

Cpl	TJ	Deloughery
Cpl	JAY	Ferland
Cpl	PD	Peterson

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VITAL STATISTICS

DIRECTORATE

The Directorate staff are pleased to have Brig Baird return to the office after his recent hospitalization at Toronto Military.

RCDC SCHOOL

Births

To Capt and Mrs WB Hudgins, a son Craig Vernon, born 2 Dec 62.

Marriages

Pte HC King was married to Barbara Joan Maguire at Ottawa on 15 Dec 62.

Hospital

Capt CA Casterton returned to Toronto Military Hospital on 1 Nov 62 for three weeks with a recurrence of pneumonia.

Major WH Murray and Mrs Murray were admitted to Collingwood Hospital as a result of injuries sustained in an automobile accident.

WO2 Bruce Morse was admitted to Toronto Military Hospital on 14 Dec 62.

NO 1 DENT EQPT DEP

Hospital

Cpl RW McDonald and Pte H Snutch recently spent two weeks in hospital.

11 DENT COY

Births

To Capt and Mrs LC Gray, a son John Francis III, born 25 Oct 62

To Cpl and Mrs RA Neill, a son Wade Allen, born 1 Nov 62.

To Pte and Mrs TJ Herrett, a son Robert Bruce born 13 Nov 62.

Deaths

Miss FM Twyman, deceased 29 Nov 62.

12 DENT COY

Births

To Major and Mrs TC Gaudet, a daughter born 11 Nov 62.

To Capt and Mrs CD Mollins, a son born 8 Dec 62.

Hospital

WO2 GM Armstrong has returned to work following a two-month rest in hospital and sick leave.

13 DENT COY

Births

To Ssgt and Mrs JCA Therrien, a son, Pierre Bernard on 22 Sep 62.

To Capt and Mrs WJ Sinclair, a daughter, Holly Ann Lyn on 15 Oct 62.

Hospital

Major	AG	Andrews	- 4 Jan -
Sgt	AC	Vout	- 14 Jan - 17 Jan 63.
Sgt	JA	Gagnon	- 13 Dec - 19 Dec 62
Cpl	JEN	Boucher	- 15 Nov 62 -
Pte	RS	Lindsay	- 12 Oct - 18 Oct 62.

14 DENT COY

Births

To Capt and Mrs JJPG Houle, a son Joseph Jean Francois, born 23 Sep 62 at Camp Shilo, Man.

14 DENT COY (Cont'd)

Hospital

Lt Col RB Jackson was admitted to Winnipeg Military Hospital on 26 Nov 62 and discharged the following day.

Capt JJPG Houle recently spent a month in Deer Lodge Hospital from 24 Sep to 21 Oct 62.

Sgt JRC Yeates was admitted to Deer Lodge twice recently and underwent surgery on his right knee. He was discharged finally on 23 Nov 62.

15 DENT COY

Births

To Cpl and Mrs Fret, a son Jeffrey John born 23 Dec 62.

Hospital

Sgt	EPH	Sprathoff	- 26 Oct - 13 Nov 62
Ssgt	GH	Couture	- 25 Oct - 31 Oct 62
Capt	JFA	Marcil	- 13 Dec - 18 Dec 62
Sgt	RG	Hopkins	- 8 Dec - 14 Dec 62

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DIRECTORATE NEWS

Corps Conference

The 13th Annual Corps Conference was held in Ottawa from 3 - 5 December 1962 under the direction of Brigadier KM Baird. Senior officers of the Regular Force units in Canada gathered to consider various subjects related to the operation of the RCDC. Colonel GB Shillington chaired the formal meetings at which several papers were presented and open discussions held. The Commanding Officers later conferred individually with officers of the Directorate Staff on matters of particular concern to their units.

A Sunday evening reception for all Directorate and visiting officers held at the home of Col IAL Millar on 2 December and a formal supper dance on 4 December at the Army Headquarters Officers' Mess highlighted the social programme.

New Senior Appointment

Colonel JF Edgecombe, OBE, ED, CD, DDS, FICD, who has served as Honorary Colonel Commandant of the Corps since January 1960, was recently named Colonel Commandant of the RCDC. This new designation for the appointment is in accordance with current policy in the Canadian Army and gives recognition to the most valuable and loyal service that Col Edgecombe has rendered to the Corps for many years.

Christmas Party

A large representation of the servicemen and civilian personnel from the Directorate and 13 Coy Ottawa area clinics attended the Christmas Party at HMCS

Carleton on 14 Dec 62. WO2 Max Fisk expressed the appreciation of all personnel to the officers who acted as hosts and, in the absence of Brig Baird, Col Shillington responded and wished everyone a happy holiday season. Col Shillington also took this opportunity to make a small presentation on behalf of everyone present to Cpl Gene Lalonde who recently took his release after 20 years with the Corps.

Service Messes at Home on New Year's Day

The traditional tour of the various Officers' Messes in the Ottawa area was made by several officers of the Directorate following their attendance at the Governor General's Levee. Among the units to extend hospitality on this occasion was No 54 Dental Unit RCDC(M) and best wishes for the New Year were extended by the Commanding Officer, Lt Col HJ Chartrand on behalf of all ranks of his unit.

Brigadier's Secretary to Marry

Under ordinary circumstances, Directorate announcements of approaching weddings are not tinged with regret. However, the circumstances are not considered to be ordinary, to wit:

We announce joyfully (albeit regretfully) that Miss Patricia Veronica Curtin will be married to WO2 "Del" Riddell on February 2, 1963 at Blessed Sacrament Church, Ottawa. The groom-to-be is currently employed at RCAF Stn Trenton with 13 Dent Coy.

"Pat" has been a valued member of the Directorate since November 1942 and her transfer to the Department of Household Science and Domestic Tranquility will undeniably have an effect upon those of us who remain.

Over the years, Pat has toiled arduously on behalf of the Corps and whether her station was with Central Dental Stores, the Procurement Section or within the Office of the DGDS, her loyalty, knowledge, unfailing good humour and willingness to give that little extra effort has been evident.

We will miss "Pat", that's for sure, but wherever duty determines their domicile, we hope she knows that the best wishes of all Corps personnel will accompany both she and "Del", for a long life of everything that is good.

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THE RCDC SCHOOL NEWS

Exchange Officer Promoted

His many friends throughout the Corps will be pleased to hear that Cmdr RR Troxell, US Navy (DC), currently on an exchange posting and serving as Chief Instructor at The RCDC School, has received his promotion to the rank of Captain, effective 1 Jan 63.

Commandant and CI attend Corps Conference

Colonel CE Purdy, Commandant and Captain RR Troxell, Chief Instructor, journeyed to Ottawa in early December to attend the annual Corps Conference at which Colonel Purdy presented a paper entitled "The Dental Team Concept".

Maj Murray and WO2 Morse Injured in Traffic Accidents

Maj WH Murray, Senior Dental Officer, RCAF Station, Camp Borden was seriously injured in a three-car accident near Stayner, Ontario on 16 Dec 62. He was in his car being towed by another car which was struck by an oncoming vehicle. He suffered a broken pelvis and back injuries and is under treatment at Sunnybrook Hospital in Toronto. Mrs Murray who was riding in the tow vehicle was thrown through the windshield and received scalp lacerations and two fractured vertebrae. The driver of the tow vehicle was killed.

WO2 EB Morse was involved in a three-car pile-up a block from the School and received an injury to his left knee-cap which will necessitate a long period of hospitalization and rehabilitation.

Xmas Party

The officers of the RCDC School entertained the remainder of the school staff at a Christmas Party in the Common Room of the School on 20 Dec 62.

Maj Sills Big Winner

The CFMSTC Officers' Mess was the location for a mixed Mess Dinner followed by a Turkey Bingo on 7 Dec. Although nearly all of the RCDC School officers and their ladies were in attendance, the only winner was Maj Paul Sills. This, in itself, is not unusual but when he won two turkeys and narrowly missed on a third, perhaps it should be reported.

"The RCDC Toastmasters' Club is Now in Session!"

This phrase has followed the crack of a gavel every day of the week at The RCDC School since 14 Jan 63. It serves to open meetings of Public Speaking classes held daily for the candidates of the officers' clinic course and bi-weekly for the DT Cl Gp 3 course. The two classes are under the direction of Capt RR Troxell and Maj DH Protheroe, respectively.

The need for instruction in public speaking at the School has long been recognized and it was felt that a modification of the meeting format used by the Toastmasters' International organization, with which Capt Troxell was familiar, might meet the requirements. Basically this is a study group method for developing ability in public speaking.

The format was developed and introduced during the recent Technical Dental Therapist and DT Cl Gp 4 courses. It proved so popular and successful that it was decided to incorporate Toastmaster Club meetings into the 1963 course programme. The photograph (next page) shows members of the first RCDC Toastmasters' Club.

Perhaps the most unique and valuable feature of the Toastmasters' Club meetings is that each member participates in every meeting. This frequent practice rapidly develops the member's competence as a public speaker and increases his confidence and his ability to think on his feet. It is thrilling to watch a person change in a very short period of time from an apprehensive, knee-knocking, tie-straightening, stammering, suffering novice to a surprisingly accomplished, confident and articulate individual.

Considerable attention has been given to the physical surroundings and equipment. The conference room table, the podium, the gavel and stand, and the seating arrangements provide an appropriate atmosphere. One of the essentials

of a toastmasters' meeting is a timing mechanism to ensure that each participant performs his task within a specified period. This mechanism consists of a series of lights; green indicating the speaker may continue, amber showing there are thirty seconds remaining and red denoting overtime. The red light shines for thirty seconds after which a very loud bell sounds, making it impossible for the speaker to continue.

CHARTER MEMBERS OF THE RCDC TOASTMASTERS' CLUB

Clockwise from the Speaker FS Pierce DL are: WO2 Thorsson H, WO2 Daw RH, Ssgt Pelletier R, Ssgt Franzgrote HEG, Ssgt Fediuk MM, Ssgt Bradley CEC, WO2 Batten TL, WO2 Sherry JM, Ssgt Therrien JC, Ssgt Fraser JA, Ssgt Tapp JM, WO2 Lobb EM, and Major DH Protheroe. The President of the Club, Captain RR Troxell was away when this photograph was taken.

There are ten duties assigned for each toastmasters' meeting, three of which are permanently carried out by RCDC School staff; the remainder are rotated amongst the candidates. Perhaps the best way to describe these assignments is to relate the proceedings of a typical club meeting.

The president, who is a staff member, declares the meeting open and has two minutes to make his opening remarks, introduce the Toastmaster of the Day and turn over the meeting. The Toastmaster of the Day, a candidate, controls the meeting and initially has four minutes to speak, during which time he establishes the tenor of the meeting and introduces the Table Topic Master of the Day. The Table Topics Master has selected a Table Topic of the Day prior to the meeting; the other participants are not aware of the subject until he announces it. He has two minutes to describe the topic and introduce the first Table Topic Speaker. The Table Topic Speakers are candidates who are not scheduled as main speakers or critics. Each Table Topic Speaker has one and one-half minutes to talk on the Table Topic of the Day and the Table Topic Master has thirty seconds to introduce each speaker, at the conclusion of which he returns the gavel to the Toastmaster of the Day who then introduces, in one minute, the first main speaker.

There are two main speakers, each of whom presents a prepared five-minute speech of his own choice within a given category. For example, the first is "The Ice Breaker" during which the speaker introduces himself to the audience. The second time he is called upon as a main speaker his topic is "Be in Earnest" for which speech he selects a subject about which he feels strongly. The Toastmaster of the Day introduces the main speakers and thanks them when they have finished. He then introduces the Master Evaluator and delivers control of the meeting to him.

The Master Evaluator, a member of the staff, introduces the first individual critic, a candidate, who presents in two and one-half minutes a constructive criticism of the first speaker. Following a similar criticism of the second speaker by a second critic, the Master Evaluator presents a general criticism of the meeting to point out where participants have made errors or given praiseworthy performances, and to suggest improvements. He then returns the meeting to the Toastmaster of the Day.

The Toastmaster of the Day now asks the Toastmaster Timer, a staff member, for his report which consists of the actual time in seconds taken by each participant. After the Timer's report, the Toastmaster of the Day introduces the Mystery Word Whisker Counter and asks for his report. This individual has been secretly recording the "word whiskers" or faulty mannerisms such as grunting (and-uh or ah-h-h), hesitations, etc and reports the number of times each participant erred in this way.

Finally, the Toastmaster of the Day thanks the participants and returns the meeting to the President who makes his closing remarks and adjourns the meeting.

During the meeting, all participants are addressed by their title-of-the day. Learning to handle with facility such ponderous titles as "Mystery Word Whisker Counter" or "Mr. Table Topic Master of the Day" is an exercise in itself. Members quickly learn that the framework of the meeting, wherein the speakers change frequently and in a pre-determined manner, creates a fast-paced and enjoyable hour. The "discipline of the clock" is instilled in each member until the race with time becomes a challenge in itself. Characteristically, new members approach the meetings with the agonized thought: "I hope they don't call on me", only to discover that before long, the attitude has changed to: "When are they going to let me talk?" Camaraderie is rapidly established as the members share intellectual (and traumatic) experiences with their fellow participants.

In the opinion of the writers Captain Troxell and Major Protheroe, the "Toastmasters' Club" is the most painless method available for developing ability in public speaking. The remarkable enthusiasm displayed by the candidates participating in the first class elicits the opinion that this subject will become a significant addition to the curriculum of the School.

RCDC SCHOOL RAISES FUNDS FOR CHAPEL WINDOW

Two of the projects which were undertaken by the staff of the RCDC School and their wives to raise funds for an RCDC window in Trinity Chapel are depicted above. A semblance of the proposed window is shown hanging on the wall of the RCDC booth at the annual chapel bazaar with Mrs CE Purdy and Mrs PS Sills offering for sale many of the attractive items which were designed and created by the ladies under Mrs RR Troxell's direction. Pictured on the right is Col CE Purdy watching Pte DE Fraser draw the winning ticket for the framed RCDC crest. Incidentally the crest was won by Cpl DT Gardner of the Directorate.

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NO 1 DENTAL EQUIPMENT DEPOT NEWS

Sports

Major Fletcher, Ssgt Sullivan, Ssgt Davison and Cpl Rochon all managed to win turkeys during the festive season. Competitive Bowling and Curling has its compensations for some.

Cpl McRoberts might be classed along with members of the Polar Bear Clubs as he has made two dives in the Ottawa River, 9 and 16 Dec 62 with other members of the Camp Petawawa Skin and Scuba Diving Club.

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11 DENT COY NEWS

Vancouver Paper Writes Sketch of Recent Corps Transfer

The following article has been extracted from a recent issue of the Vancouver Daily Province:

"A familiar figure with the United Nations Force in the Congo two years ago was a Canadian soldier who could be seen busily sketching the local inhabitants during his off duty hours.

He was Pte Denis C Hughes, a talented amateur portrait artist with soft pastel and oils and at that time a member of the Royal Canadian Army Service Corps.

Hughes, now serving with the Royal Canadian Dental Corps at Camp Chilliwack, spent eight months in The Congo in 1960.

His character portraits were so popular he gave most of them away to his subjects and returned to Canada with only a few sketches to show for his artistic efforts among the Congolese.

However, in addition to his pictures he brought back the memories of a close brush with danger when he and several other Canadians were trapped in the back of the post office at Leopoldville by Congolese who mistook them for Belgians.

Hughes and his comrades showed the Congolese their identification cards but none of the natives understood English. The Canadians eventually were saved by Congolese police.

His talent is well known at Camp Chilliwack where he has done a series of portraits of the officers who have served as Camp Commandants during recent years. The portraits were all drawn from photographs.

On some he had to draw in uniforms as the officers in question were in civilian clothes when their pictures were taken.

He started drawing as a boy in Portsmouth, England where he was born and lived until he was 17.

'I had no formal training' he said. 'Nothing more than I learned in school. It was mostly what I picked up over the years.'

He joined the British Army at 18 and served in France and Germany. He was demobilized in 1947 but re-enlisted in 1948 in the Royal Ordnance Corps as a driver instructor and served three years in Egypt.

He came to Canada in 1953 and served in the RCAF for three years, then joined the Canadian Army after a short spell as a civilian in Vancouver.

He's married and has two children, Ronny, 7, and Nancy, 6, who attend Watson Road Elementary School.

Hughes now hopes to turn his talents to sketching portraits of native Canadian Indians.

'They are people with interesting faces' he said. 'European faces are not bad but they don't have the character. The native people show their age in their features'."

Curling

With the curling fever reaching its peak, we are wondering whether Sgt Moore is talking to anyone now or not. His team had a perfect end at the Calgary Garrison Club on Dec 20th.

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12 DENT COY NEWS

"Doc" Left at the Dock

Arriving at a station to find that the train has already departed can be disquieting enough, but to return to dockside to discover that your ship has already sailed can create sheer panic. This happened to Capt Lachapelle and Cpl Bleakney who, along with 25 RCN officers and men, were left behind in Portmouth, England when HMCS Bonaventure sailed earlier than scheduled. These personnel returned to Halifax aboard HMCS Nootka and earned their passage through participating in certain watch-keeping and message-centre duties.

Bowling

Congratulations are offered to the Gagetown Clinic bowlers who finished in fifth place with an average pinfall of 203 in the Command Bowling Tournament.

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13 DENT COY NEWS

Administrative Officer Retires

A farewell party was held on November 8th at Trenton in honour of Lt Ed Tullis on the eve of his departure to the Personnel Depot for retirement procedures. Colonel Leman presented Ed with an electric sander (to help smooth the road to civvy street?) on behalf of the RCDC personnel in the Trenton area. After 22 years with the Corps, Ed left with many memories mingled with a host of best wishes from us all.

Ipperwash Clinic Closes

The departure of 1 RCR on rotation to Europe reduced the treatment commitment at Camp Ipperwash to nil. The dental clinic will remain dormant until next summer at which time it will be re-opened for the Army Cadet Camp.

Duty Trips to Radar Sites

Capt JSE Doiron and Cpl JEN Boucher proceeded on a four-week TD trip to RCAF Station Falconbridge in mid-November. Unfortunately Cpl Boucher had to return to Petawawa on medical grounds before the tour was completed but Pte GED Hayes replaced him.

In December Capt JSE Doiron and Cpl WR Dawson went on a three-week TD trip to RCAF Station Foymount.

Capt EW Gazo and Pte TR O'Mara will be proceeding to RCAF Station Moosonee for a five-week TD trip commencing the end of January.

Long Service - Part V Dental Nurse

November marked the 12th consecutive year that Miss Florence Evans, Part V Dental Nurse, has served the RCDC in No 2 Clinic, RCAF Station Clinton.

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14 DENT COY NEWS

Commanding Officer Heads Community Chest Campaign

Lt Col RB Jackson was appointed Chairman of the Winnipeg Garrison Community Chest Campaign which was conducted during Sep to Nov inclusive. The campaign was an unqualified success and went over the top one week before the target date. No 14 Dental Coy was the first unit in the Garrison to exceed its quota and receive the "Gold Feather Award".

Christmas Party

An enjoyable Christmas Party was held on 20 Dec 62 at RCAF Station Winnipeg with all RCDC and associated personnel in Winnipeg attending.

During the course of the evening the winners of the unit Bowling League "Turkey Roll" were awarded their prizes.

The evening was devoted to dancing and merry making after which a delicious buffet dinner was served.

Duty Trips and Visits

Lt HF Doyle visited No 7 Dental Clinic RCAF Station Saskatoon on 1 Oct 62 to check out Capt HC Stewart on closing of that clinic.

On 6 Nov 62, the CO No 14 Dental Coy and Administrative Officer, Capt GJ Moore visited RCAF Station Gypsumville, Man, a Radar Site under construction, to inspect dental facilities and obtain information as to build-up of personnel.

Curling

With the opening of the new Fort Osborne Curling Club, under the Presidency of Major Leon A Richardson, personnel of the Winnipeg Garrison have commenced the season activities with many of this unit participating. Plans have been completed to afford all curlers and neophytes of 14 Coy an opportunity to take part in the "roaring game" as an organized unit sport.

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15 DENT COY NEWS

Dental Officers Attend Montreal Fall Clinic

Lt Col Butler, Lt Col Anglin and Major Ramsay attended the Montreal Dental Club Fall Clinic 29 - 31 Oct 62. Many questions were asked and answers given regarding the DOSP and training conducted at the RCDC School. This interest was, no doubt, fostered by the RCDC exhibit and the military uniforms.

Holiday Season Activities

Christmas was the occasion of an excellent party held by RCDC members, wives and friends at RCAF Stn St Jean. New Year's Eve, of course, was the occasion for many more excellent parties whereat 1962 was drowned.

Duty Trips and Visits - Radar Sites

Lt Col Butler and Capt Jacob visited RCAF Stn Lac St Denis and RCAF Stn La Macaza 11 - 12 Oct to arrange treatment for personnel. Following this visit, Dr Jekyll and WO2 Stokes proceeded to RCAF Stn La Macaza to examine and categorize personnel. Using these priorities, patients will be transported to Lac St Denis for treatment.

Capt Sugars and Cpl Boulanger proceeded to RCAF Stn Moisie 5 - 30 Nov 62 to provide treatment at this isolated location.

Capt Jacob and Sgt Hopkins proceeded to RCAF Stn Chibougamau 28 Nov to arrange for installation of clinic equipment at this new radar site.

Sports

Curling, skiing and bowling are again prominent in the sports picture, and this year we have a Judo enthusiast in the person of Cpl Fret.

Major Guevremont, Ssgt Tapp, Cpl Jermain and Pte Thompson constitute the RCDC entry in the St Jean station bowling league and are vying for top position. WO2 Moore is currently the holder of the high average in the HQ Quebec Command league.

Lt Col Butler is setting the pace in this the first year of the HQ Quebec Command Curling League.

Capt Jean Vincent became the first and we trust, the only casualty of the ski season when, during the Christmas holiday, he suffered a twisted knee. Regular Army skiing is under the able direction of Capt Harrison.

The Winter Carnival and Quebec Command Sports Meet will be held at Camp Valcartier from 5 to 8 Mar 63. The above array of sportsmen indicates that the RCDC will be ably represented.

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4 FD DENT COY NEWS

Coy DOs Hold Seminar

The dental officers of the unit held a seminar on 14 Nov 62 under the chairmanship of Maj JVP Chatwin. One of the speakers, Capt RH Headley, recounted his impressions of the Capt to Major Qualifying course which he attended recently at The RCDC School.

Curling

A rink skipped by Capt Kelly won the third event in a Yuletide Bonspiel sponsored by the Fort York Curling Club. Two other rinks skipped by Lt Col Evans and Capt Shaw were eliminated while Maj Chatwin held on with his team and finished runner-up to Capt Kelly in the third event.

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Defence Minister Inspects Detachment

On 8 Dec 62 the Minister of National Defence and Mrs Harkness inspected the Canadian Dental Detachment. Shown here is Mr Harkness inspecting the men's quarters with Colonel DH Rochester, Commander CBUME, and Major Kelland.

Medals Parade

A Canadian Dental Detachment parade was held on 10 Dec 62 at which UNEF medals were presented to Sgts Dumas and Fox.

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