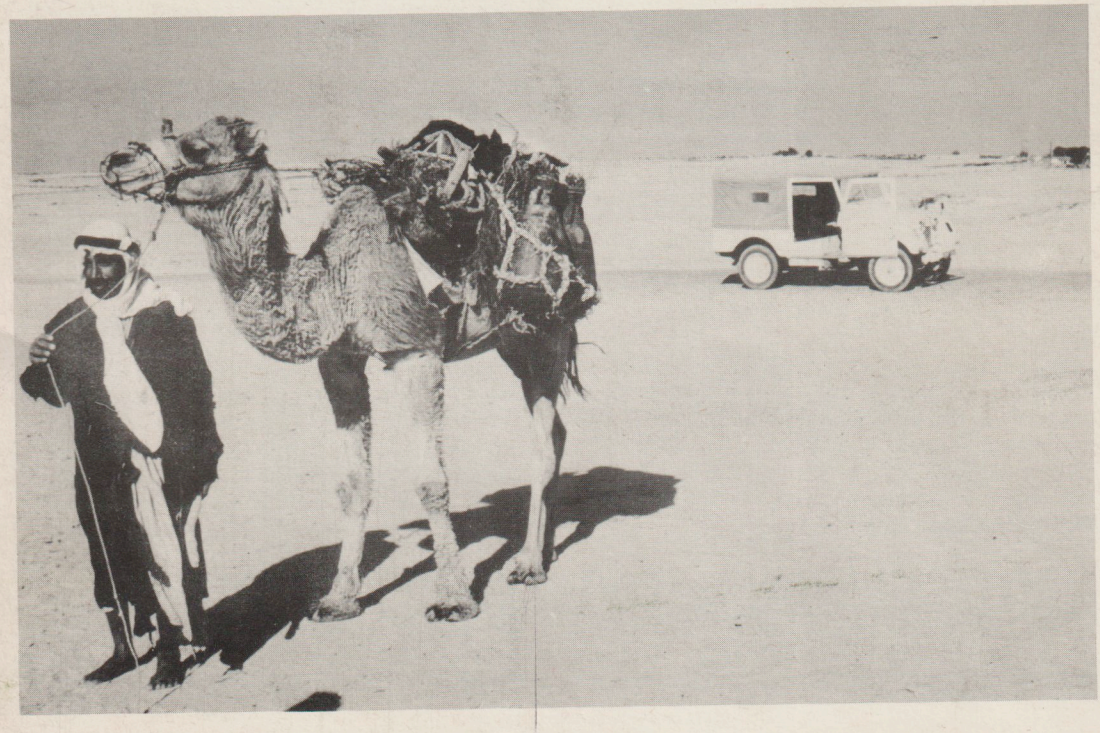
The G. MacDougall

ROYAL CANADIAN DENTAL CORPS

Quarterly



VOLUME 8 NUMBER 2 JULY 1967

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The RCDC Quarterly

Published by authority of Brigadier BP Kearney, Director General of Dental Services for the Canadian Forces

Editorial Board: Col JW Turner
Lt-Col G MacDougall
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Subscription Rates

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

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

Cover Photograph

Ships of the desert' - camel and UNEF jeep
Photo taken near Rafah Egypt (Gaza Strip) - 1959

FAREWELL TO THE DESERT

THE FINAL DAYS OF UNEF

Major NH Andrews, BSc, DDS

Background

Since the establishment of the United Nations Emergency Force in late 1956 with its RCDC Detachment under the command of Major PS Sills, an estimated one hundred RCDC personnel have served in the Sinai. To these men, the fact that the RCDC flag has been lowered in Camp Rafah for the last time will bring back fond memories understandable only to those who have served in the Middle East.

Upon his arrival, the newcomer could not hêlp but be impressed with the evident progress that existed in the Canadian camp at Rafah. Ten years of gradual improvement had made this camp into what one was happy to call "home". The clockwork routine of a smooth-running military organization was obvious and the spirit of cooperation and quiet efficiency of the professional Canadian soldier remarkable. This was the situation as it had existed for a decade and was that way during the first week of May 1967.

Previous articles in this publication by Majors Small and Kelland have given comprehensive coverage of recent history of the Middle East and to the establishment of UNEF and its function. Suffice it to say that Canada's contribution was logistic, communications and air transport elements; in fact, every army corps was represented. However, combat troops were a minority and emphasis was on support units which were all in Camp Rafah with the exception of RC Sigs in Gaza and 115 Air Transport Unit RCAF in El Arish. The troops who performed the actual border patrols on the Armistice Demarcation Line and the International Frontier were infantry battalions from: Sweden, based on Hill 88 in Gaza; Brazil, based near the town of Rafah; India, near the town of Dier el Balah; and Yugoslavia near El Arish. With the arrival of an Indian Dental Officer in late 1966 each national contingent had its own dental facilities. The Canadians had two dental officers, the senior of whom acted as Senior Dental Staff Officer UNEF and was responsible to the Commander UNEF for treatment policy and for the procurement of dental stores for all dental detachments in UNEF.

The Build-up

During the second week of May, Egyptian military activity in the area to the west of Camp Rafah became very evident but none of our group was qualified to say that this was anything more than normal spring manoeuvres. A casual drive to El Arish revealed much equipment which appeared to be in tactical position, and, to say the least, it was a very impressive display. This was probably our first indication that anything was about to happen, and even this was dismissed as merely a show of military power.

Border incidents involving Syrian and Israeli troops had grown to proportions which had become embarrassing to Syria and she was bent upon drastic retaliatory action. The other two major members of the Arab world, Jordan and Egypt, did not appear so eager in this direction but the pressure seemed to fall upon President Nasser of Egypt. Syria claimed he was "hiding behind the skirts" of the United Nations

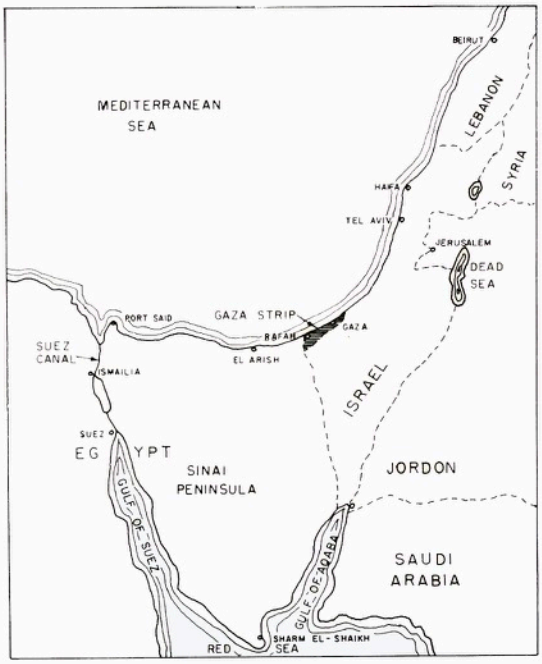
and had become complacent in his security, while Syria lost round after round to Israeli raiders on their unprotected border. This statement was derogatory to the leader of the Arab people and a blemish upon his reputation as leader. It is speculated that for this reason Nasser took the steps that he did, i.e. the blockade of the Gulf of Aqaba, massive troop movements up to the Armistice Demarcation Line and International Frontier and, ultimately, his request that UNEF be removed. It is felt that he thought that his request for the removal of UNEF would be denied. The theory is also held that Nasser did not wish to have a conflict but was pressured into this venture by the other Arab states. The results of the subsequent war seem to bear out the fact that he was not prepared for such an undertaking.

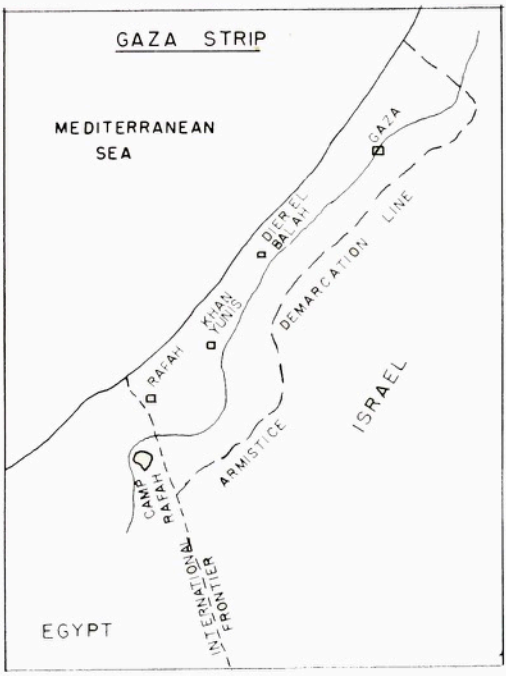
Withdrawal of UNEF

On 17 May President Nasser made representation to UNEF Commander, Maj Gen IJ Rikhye, for the removal of UNEF. Maj Gen Rikhye stated that he had no authority to grant such a request. The request was then passed to UN Secretary General U Thant in New York and the following day the order that UNEF would be withdrawn was received. A brief formal ceremony at King's Gate on the Egyptian-Israeli border at 1700 hrs on 19 May 67 saw the lowering of the last United Nations flag and signified the end of UNEF as a peace-keeping force.

The force was granted 45 days to complete its move and plans for an orderly withdrawal in this period were formulated. This plan was soon revised and scheduled to be completed within 30 days. This initial plan called for the gradual withdrawal of the infantry battalions first, with Canada having the last contingent to leave, the reason being that the Canadian Contingent held the UNEF Stores and their job was to collect all this material in Camp Rafah. Immediately, all warlike stores were recovered. These included most of the vehicles.

For all the excitement of these few days, life still went along normally in Camp Rafah even though there was a different purpose and personnel were doing extra duty shifts. There was still time for golf and swimming as had been routine for many years.





On Sun a.m. 21 May, massive troop movements from the El Arish area into the Gaza Strip took place and as Camp Rafah was on the main highway across the Sinai we were afforded a first hand look at what appeared to be the entire Egyptian Army. An estimated 80,000 soldiers and 400 tanks moved through our area in 48 hours. This became a little disconcerting to our men. A drive of 25 miles through the Gaza Strip to the city of Gaza revealed that this was considered a strategically important area as the countryside bristled with armament. It is also of note that on this same day our short wave communications were jammed as were news broadcasts from the BBC through a station in Nicosia, Cyprus.

The next day this same trip to Gaza revealed the disappearance of the Egyptian Army which had been so evident the previous day. It was assumed that they had moved down the International Frontier and had left the defence of the Armistice Demarcation Line between the Gaza Strip and Israel to the Palestinian Liberation Army, an organization comprised of Palestinian refugees who live in the Gaza Strip.

Work continued at Camp Rafah with the handling of stores. In general, Canadian stores were either prepared for shipment to our contingent in Cyprus, shipment back to Canada, or were written off. Items of Canadian dental equipment were sent back to Canada as soon as the overtaxed RCE "box factory" was able to supply the crates.

With the blockade of the Gulf of Aqaba by Egypt on 23 May tension mounted. Our travel was now restricted and we were confined to camp which, as it turned out, was to our benefit because propaganda was being disseminated in the area and nearly everybody had been supplied with arms.

On 23 May we were denied further use of the air-strip at El Arish which was intended to be our chief evacuation route. 115ATU RCAF was removed and the Egyptian Air Force moved in two squadrons of MIGs. Alternate means of evacuation were now set up. These included the dispatch of HMCS Provider from Canada, the US 6th Fleet on the Mediterranean and the possibility of airlift from Port Said by RCAF aircraft which seemed the most likely. Travel to Port Said would have been by rail, which, fortunately, never came to pass.

The Showdown

On 28 May Nasser blasted Prime Minister Pearson for his apparent support of Israel in the Gulf of Aqaba issue and declared Canadian troops in UNEF persona non grata so that, as of that date, the Canadian contingent was no longer part of UNEF and their role was undertaken by the other contingents. This, coupled with the fact that we were given 48 hours to be out of the country, turned what had been an orderly close-out into chaos. Canadian personnel worked around the clock to finish up the removal of the remaining Canadian stores and personal belongings. Four Hercules transport aircraft were made available immediately, but the job of evacuating some 700 troops and their belongings was too great a task for them within the time limit. A request for a 24 hour extension was granted and four more Hercules were dispatched from Canada for the trip to Pisa. For this purpose the use of El Arish air-strip was reinstated and road travel to El Arish from Camp Rafah was conducted under escort of the Egyptian Army. During the period 29-31 May the entire Canadian Contingent was evacuated to Pisa and then via Yukon aircraft to Trenton, Ont.

No doubt there were those who viewed the last two weeks in Egypt with mixed emotions; not that Canadian troops were unhappy to be home, but the fact remained that they had been evicted from Egyptian soil and had not completed the task which had been assigned to them for the withdrawal operation of UNEF. Notwithstanding this however, each and every member of the Contingent can be justly proud of the job done, the professionalism exhibited, and the contribution made by the Canadian Contingent which earned its recognition as the backbone of the United Nations Emergency Force.

Méthode simplifée de préparation de la coiffe en porcelaine

Major JOL Bourget, BA, DDS

Depuis son apparition au début du siècle, la couronne jaquette ou coiffe en porcelaine n'a cessé, grâce aux découvertes de la technique moderne, de s'améliorer et de s'imposer aux exigences tant du patient que du dentiste. La recherche a augmenté la résistance des porcelaines et mis au point un instrument de grande utilité pratique et psychologigue: la turbine à haute vitesse. L'expérience clinique a légué à l'omnipraticien d'aujourd'hui les critères ou commandements du succès, rendant ainsi ce service à la portée et à la satisfaction de tous. De nouveaux horizons s'ouvrent maintenant pour les cas d'occlusion difficile et de dents abîmées avec les nouveaux émaillages sur coiffe métallique.

Il va sans dire que la coiffe en porcelaine exige du dentiste plus de précision, plus d'observation et aussi plus de sens critique. L'expérience est un excellent maître, mais les circonstances empêchent très souvent son acquisition sûre et rapide. Aussi une méthode simple, éprouvée, mnémotechnique serait d'une grande utilité pour l'amateur et le débutant. La Faculté d'Art Dentaire de l'Université de Michigan à Ann Arbor, U.S.A., préconise une telle méthode et cet article a pour but de le décrire. Cette méthode comprend huit étapes:

1. Rétraction gingivale
2. Division de la surface labiale en six segments
3. Creusage d'un sillon central guide
4. Enlèvement méthodique de la surface d'émail au labial
5. Découpage du croissant incisif
6. Meulage par étapes de l'épaulement
7. Meulage de la surface linguale et du rebord incisif
8. Finition des parois, de l'épaulement, des angles et du rebord incisif

L'instrument de base est la turbine à haute vitesse. La finition générale est accomplie avec les fraises et meules conventionnelles et celle de l'épaulement avec les limes Bastian.

La stabilité et le contrôle digital s'avère de la plus haute importance avec la technique "d'enlèvement tissulaire accéléré" (turbine à haute vitesse). Certains doigts, les stabilisateurs, doivent s'appuyer solidement contre le maxillaire permettant à d'autres de contenir, de diriger ou d'arrêter les mouvements dits de précision des doigts essentiellement actifs. Ainsi seront evités les enlèvements tissulaires excessifs et les dérapages coûteux.

Pour l'uniformité de l'illustration, une incisive supérieure droite a été choisie.

L'attachement épithélial est un facteur anatomique d'importance, car il empêche l'infection de se propager aux tissus dentaires sous-jacents. Sa hauteur ondule au gré des variations de la profondeur du sillon gingival et l'expose dangereusement, en certains endroits, aux lacérations accidentelles de la fraise

extra-rapide, lesquelles entraînent souvent une récession gingivale irréversible avec sa séquelle de pathologie tissulaire et de perte d'esthétique. Pour éviter ces traumatismes il suffit de rétracter mécaniquement la gençive en insérant pendant 8 ou 10 minutes (la durée de l'enlèvement de l'émail labial) de petits filets de coton au fond du sillon gingival.

Diviser ensuite, imaginairement ou avec un crayon bien aiguisé, la surface labiale de la dent en six segments dont deux en hémi-croissants, Fig. 1.

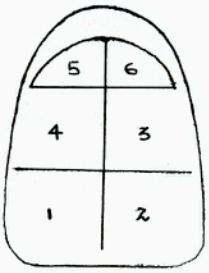
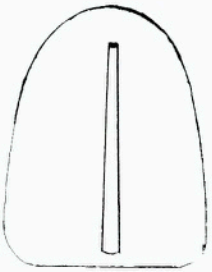


Fig 1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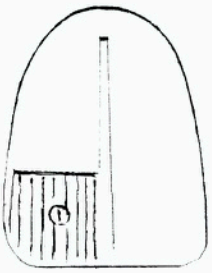

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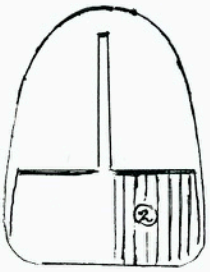

Fig 4

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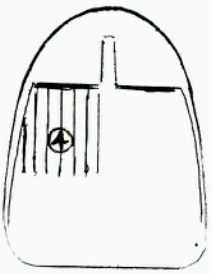

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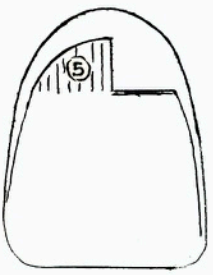

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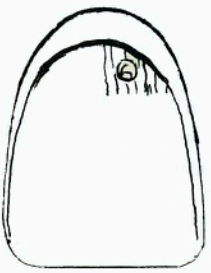

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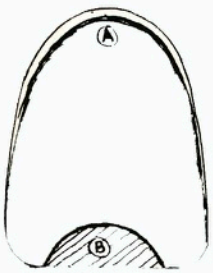

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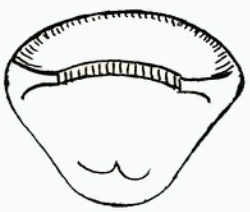
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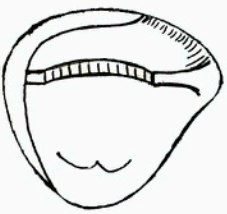
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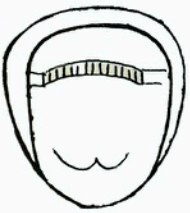
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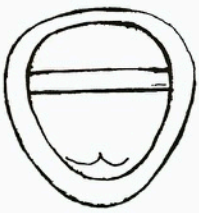
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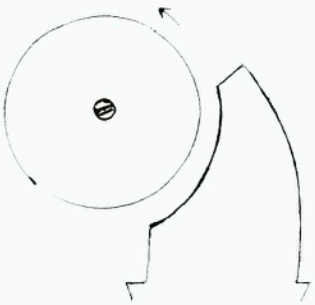
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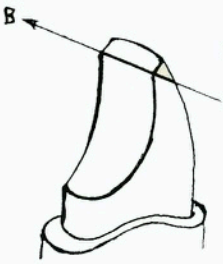

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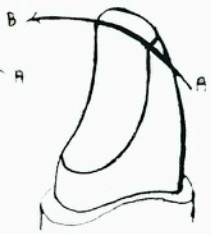


Fig 16

Prendre une fraise n° 169 ou 70 L et creuser méticuleusement sur la ligne médiane de cette surface un sillon gingivo-incisif de profondeur uniforme et ne dépassant que très légèrement le joint énamo-dentinaire. Ainsi s'établit une profondeur guide pour l'enlèvement des autres segments de la surface d'émail labial, Fig. 2.

Enlever maintenant numériquement les autres segments d'émail avec la même fraise, Fig. 3, 4, 5, 6, 7, 8. Diminuer le croissant cervical et ébaucher l'épaulement labial à moitié ou à environ 0.5 mm, Fig. 9A.

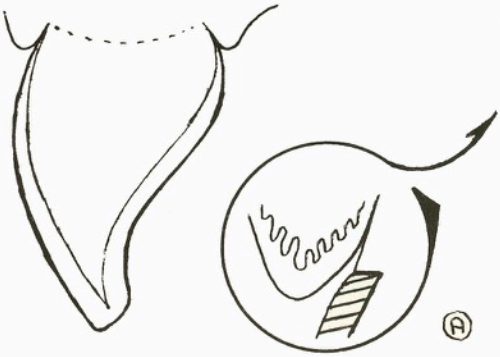
Avec la fraise No 169 ou 70L, découper un croissant à l'incisif et en arrêter la pronfondeur au quart de la longueur coronaire, Fig. 9B. On a ainsi formé une voie d'accès pour le fraisage de la partie cervicale, Fig. 10.

Découper ensuite la partie labiale et mésiale de l'épaulement, Fig. 11. la partie labiale et distale, Fig. 12, et finalement la partie linguale, Fig. 13. Conserver aussi large que possible la largeur mésio-distale. Tout l'épaulement est bien défini mais aucune finition n'est amorçée à ce stage.

Toujours avec la fraise No 169 ou 70L découper l'angle incisif en prenant garde de maintenir la paroi incisive parallèle à la facette d'occlusion normale de la dent, Fig. 14. La surface linguale de la dent se fait ensuite avec une meule de 5 à 6 mm de diamètre. Surveiller ici trois facteurs: 1) la courbe linguale de la pile est plus accentuée que la courbure naturelle Fig. 14, Fig. 17; 2) meuler de façon à obtenir une légère courbe mésio-distale Fig. 16 A-B, Fig. 15 A-B; 3) la hauteur du talon de la dent doit être sacrifiée le moins possible car elle contribue à l'aire cervicale de friction de la coiffe, Fig. 21, partie hachurée du schéma.

La dernière étape est la plus importante car elle est la clef du succès. C'est celle de la finition des parois, de l'épaulement, du rebord incisif et des angles. Il faut examiner minutieusement la pile et corriger implacablement toute déviation aux critères cliniques suivants. Les surfaces ou parois doivent être uniformes et lisses. Sinon, les corriger avec une fraise No 557 et des disques de papier sablé fin. La paroi labiale doit être légèrement courbe gingivo-incisivement et créer un angle aigu avec l'épaulement, Fig. 18 A; elle doit être aussi parallèle ou légèrement convergente avec la paroi du talon au lingual créant ainsi un anneau cervical de friction Fg. 21, région hachurée. La longeur idéale de la paroi labiale se situe entre les 2/3 et les 3/4 de la couronne naturelle, Fig. 19. Si elle est trop courte, la rétablir au moyen d'une coiffe métallique car, autrement, surviendront infailliblement des fractures en demie lune ou en croissant au gingival et du côté opposé au point de contact de la force. Si elle est supérieure on aura un éclatement de la porcelaine. Les parois axiales devraient être presque parallèles, y compris l'aire au talon des antérieures. Celle-çi joue un rôle important car elle assure avec le paroi labiale une seule voie d'insertion, Fig. 20, 21, et forme un angle droit avec l'épaulement. La paroi incisive est inclinée lingualement de façon à recevoir les forces d'occlusion à angle droit, Fig. 22. Pour la même raison la paroi linguale possède une double courbure, Fig. 22, 23, 24.

Les corrections de l'épaulement se font avec les limes Bastian, 1, 2, 3. Il forme un angle aigu ou droit avec les parois axiales, Fig. 18 A et B. Au labial il ne doit pas dépasser la moitié de la profondeur du sillon tandis qu'au lingual il n'est pas nécessaire qu'il y pénètre. L'épaulement labial devrait être nettement fini. L'épaulement lingual devrait être plus large que le labial surtout sur les canines. Sur les incisives inférieures il résiste mieux aux fractures s'il est terminé au talon et s'il ne fait qu'un angle aigu relativement à l'axe de la dent. Il est plus facile de prendre une empreinte d'un épaulement qui ne se rend pas jusqu'au fond du sillon gingival et les cas de récession gingivale sont ainsi évités. Les épaulements interproximaux, Fig. 13, peuvent être plus étroits, presque biseautés dans les cas de dépressions mésiales et distales avec les dents en forme de cloche. Ces épaulements semblent n'influer que très peu sur la force de la coiffe. Autant que possible, il est préférable de terminer ces épaulements presqu'au fond du cul-de-sac gingivo-dentaire de façon à obtenir labio-lingualement une surface plate.



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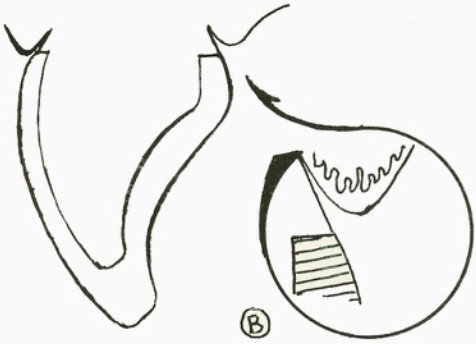

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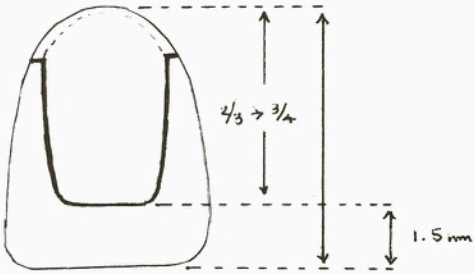

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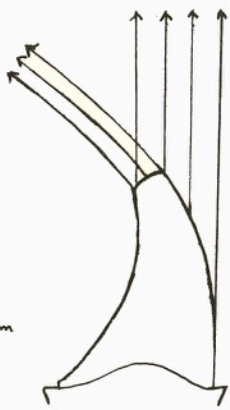

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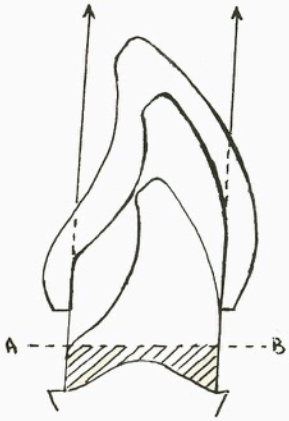

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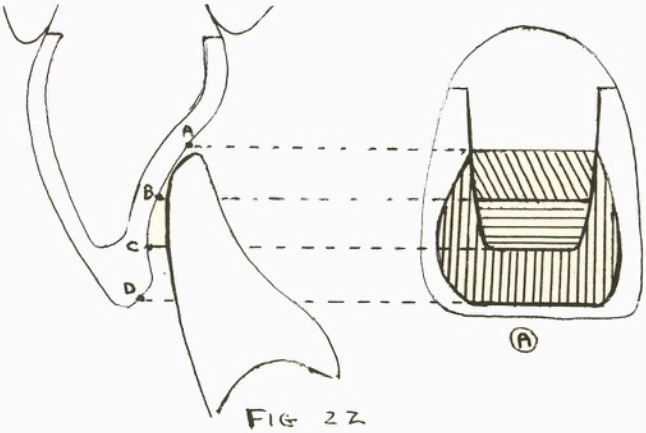

Fig 22

Fig 23

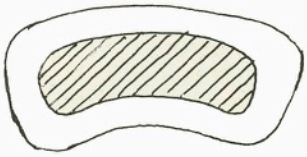

Fig 24

Il ne devrait pas exister d'<u>angles</u> avec les surfaces axiales. Les comparer à l'arc d'un oeuf, Fig. 23. La forme générale ne devrait pas être circulaire lorsque vue de l'occlusal. <u>L'angle incisif</u> devrait être situé aussi labialement que possible, Fig. 18. La paroi incisive, l'angle incisif et la paroi linguale sont finis en analysant l'articulation de la future coiffe, Fig. 22A: Aire A-B: zône d'occlusion

centrique: aire B-C: surface utilisée durant l'occlusion fontionnelle; aire C-D: surface fontionnelle active mais dangereuse parce que sans support dentinaire.

Pour conclure, la porcelaine est très compressible mais résiste mal à la tension parce qu'elle n'a pas ou presque pas d'élasticité. La pile doit être préparée de telle façon que toute force appliquée sur la porcelaine soit supportée par les parois dentinaires à angle droit avec les lignes de force, ou à peu près. L'épaisseur ne corrige pas ses faiblesses.

Summary

Ever since its appearance at the turn of the century, research and technological advances in dentistry have led to constant improvement in both the ease of preparation and physical properties of the porcelain jacket crown. The development of the high speed turbine has contributed to making the preparation a standard procedure for the general practitioner; and new horizons have been opened in cases of badly damaged crowns and difficult occlusion by the newly improved metal bonded porcelains.

Needless to say, the porcelain jacket crown continues to offer a challenge to the dentist in that it demands precision and a more critical sense than many procedures. A simple yet proven technique taught at the School of Dentistry, University of Michigan, Ann Arbor, USA, is described in this article.

This method is divided into eight stages:

1. Gingival retraction
2. Scribing the labial surface into six parts
3. Placing a central groove as a warning depth
4. Methodical removal of the labial segments
5. Cutting out the incisal crescent
6. Preparing the shoulder
7. Removal of enamel from the lingual concavity and the incisal edge
8. Finishing the walls, shoulder, angles and incisal edge.

The basic instrument is a high speed turbine. Finishing is generally accomplished using conventional stones and burs, and Bastian files for the shoulder.

The tooth should be prepared so that all stress applied to the porcelain will be supported by the preparation as nearly as possible at right angles to the lines of applied force. Thickness of the jacket is not a requisite for strength.

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* ORAL BIOPSY - AN IMPORTANT AID TO EARLY DIAGNOSIS

Captain G.W. Hill, DDS

Introduction

Legally, the treatment of an oral lesion without the aid-biopsy can be construed as malpractice. However, it should not be necessary to hold this type of threat over the head of a professional man to convince him that he should use biopsy as a diagnostic aid with as much compulsion as he uses radiographs. Statistics indicate that too few dentists use this invaluable aid for the early diagnosis of oral lesions.

Biopsy can be defined as the microscopic and/or bacteriologic examination of tissue or other material removed from the living body.

In order to implement the correct treatment for a questionable oral lesion as soon as possible, early and accurate diagnosis is essential. This aim cannot be achieved without the use of biopsy, which is, generally speaking, a simple, rapid and painless procedure well within the capabilities of all dentists.

It must be emphasized, however, that it is the dentist's responsibility to recognize the existence of a lesion in the first instance and that in order to do so, a thorough examination of the oral cavity is a "must".

Indications for Biopsy

1. When careful examination fails to lead to a diagnosis

   It is by no means necessary to biopsy every lesion that is found in the mouth, because many lesions present little difficulty in diagnosis, e.g. Fordyce granules, torus palatinus, herpetic stomatitis. But when the clinician cannot readily recognize a lesion as being harmless, it should be submitted to biopsy examination.

2. Suspected precancerous lesions

   Suspected precancerous lesions should be submitted for biopsy examination. Potentially dangerous lesions such as leukoplakia fall into this category. Only biopsy is conclusive in determining whether white keratotic lesions are innocuous or not. Malignant changes are occasionally encountered in hyperplasias resulting from chronic irritation, so these should be examined microscopically.

3. Lesions presenting clinical signs of malignancy

   a. persistence

This article was given as a study group oral presentation by Capt GW Hill during the Captain to Major Qualifying Course 12 Sep-21 Oct 66.

b. progressiveness
c. induration
d. ulceration
e. fixation of the base

Lesions with these characteristics must be submitted to biopsy examination without delay.

4. Lesions failing to respond to recognized therapy in a limited period of time

Whether a lesion should be treated and observed, is determined by the presence or absence of an obvious cause, e.g. jagged tooth, ill fitting denture. Any lesion which does not respond to recognized therapy in a limited period of time (ten days to two weeks) should be biopsied.

Many clinicians feel that all abnormal tissue removed from the oral cavity should be examined by a pathologist. This includes periapical lesions, follicular and fissural cysts, hyperkeratotic lesions, chronic ulcers of the mucosa, swellings of unknown etiology, all lesions and hyperplastic tissue resulting from chronic inflammation.

Who should perform the biopsy

It matters little who does the biopsy as long as it is done correctly and without delay. The general practitioner should perform the biopsy when it is within his capabilities. It is universally agreed than an obviously malignant lesion should not be biopsied by the general practitioner. In cases of suspected hemangioma and in most deep-seated lesions involving the bone or deep areas of soft tissue, it is best to refer the patient to the surgeon who will treat the condition.

Precautions in obtaining specimens

The value of the biopsy procedure should be explained to the patient and his permission should always be obtained. Indiscriminate biopsy without a thorough history and clinical examination is to be discouraged.

1. Pigmented lesions which suggest the presence of melanin and purplish lesions which appear to be of vascular origin should always be excised - never incised.

2. The specimen should be removed with a minimum of manipulation to avoid possible spreading of tumor cells along lymphatic and vascular channels. The risk of spreading cells is secondary to making a definitive diagnosis.

3. Infection is seldom a problem.

4. The periosteum should be avoided whenever possible. It acts as a deterrent to tumor invasion into bone and to the spread of bone infection.

5. The tongue lacks a submucosa, is extremely vascular, and must be biopsied with caution.

6. Encapsulated lesions should not be incised if it is possible to excise them.

7. Surgery in previously irradiated tissue can lead to serious complications.

Biopsy Techniques

Armamentarium

(1) local anesthetic and syringe

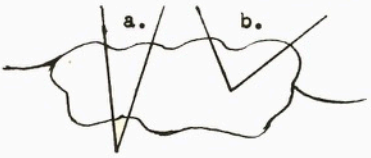
(2) topical antiseptic (colourless)
(3) scalpel
(4) long pointed surgical scissors
(5) tissue forceps which grasp but do not crush tissue
(6) sutures (preferably non-absorbable) and needle holder
(7) surgical sponges
(8) wide mouth bottle with 10% formalin about 15 to 20 X specimen volume

Types of Biopsy

(1) Excisional
(2) Incisional
(3) Aspiration

Excisional Biopsy consists of the complete removal of the entire lesion with an adequate margin of normal tissue on all sides. This is the method of choice and should be used whenever the size of the lesion permits.

Incisional Biopsy is indicated when the lesion is too large to permit removal of the entire specimen at the time of biopsy. A representative section of the lesion must be removed. Multiple small sections are preferable to a solitary biopsy. Sections should be removed from the margin of the lesion and some of the adjacent normal tissue should be included. Areas of necrosis should be avoided and the incision should be of sufficient depth to include the underlying tissues. Thin deep sections should be taken rather than large shallow ones. If several lesions are present, specimens should be taken from the most respresentative.



a. correct section

b. incorrect section (wide and shallow)

Aspiration Biopsy is used for large relatively inaccessible masses and for lesions which appear to be soft and semi-fluid. Aspiration is done by inserting a large gauge needle into the softer parts of the mass and withdrawing fluid and cells into the syringe. More than one sample may be necessary to demonstrate positively the nature of the disease process. This method is used most frequently to biopsy bone lesions and is of value in determining the presence of fluid in an apparently cystic lesion.

Comparison of biopsy and oral exfoliative cytology

Cytology is complementary to biopsy and not a substitute for it. It can be a valuable aid in the diagnosis of early cancer. Some of the indications, values and limitations of biopsy and cytology include the following:

(1) Biopsy is necessary for a definitive diagnosis of all neoplasms.

(2) Even with a positive cytologic diagnosis, a biopsy is required for final diagnosis.

(3) Immediate biopsy is indicated for lesions suspected of being malignant, for elevated lesions in which the surface epithelium is not involved, and for thick white lesions.

(4) Cytology is useful for epithelial cells only.

(5) Cytology is of value in influencing patients to consent to a biopsy and also as a follow-up for these patients who have been treated for oral malignancy by radiation.

(6) Cytology does not require anaesthesia.

Submitting the Specimen and the Case History

It is important that the pathologist receive the tissue in a condition which will allow him to make an accurate diagnosis. Hence, procedures that tend to distort the specimen such as the following should be avoided: injecting anaesthetic into the lesion, the use of electrosurgical equipment generating excessive heat, and the use of serrated forceps to grasp the specimen.

The specimen should be placed immediately into the fixative solution. A label stating the patient's name, the date, and the origin of the specimen should be placed on the bottle and not on the cover. If more than one specimen is removed from a patient, they should be placed in separate, clearly labelled containers. With aspiration biopsy, express small samples onto a piece of gelfoam and large amounts into a test tube containing fixative.

A complete, orderly case history should accompany the specimen so the pathologist will have all pertinent facts to assist him in making a diagnosis. History forms are generally supplied by the pathologist.

The following information should be provided:

a. Name, sex, age, race and occupation of the patient.
b. Exact location of the lesion. Refer to common anatomic landmarks of the mouth. Diagrams are often useful.
c. Size of the lesion (length, width and depth).
d. Colour of the lesion (compared with surrounding normal tissue).
e. Shape of the lesion (general contour).
f. Type of attachment (pedunculated or sessile).
g. Mobility (determine by palpation whether freely movable or fixed).
h. Duration and rapidity of growth.
j. Symptoms e.g. pain, altered function, disability.
k. Previous treatment (medical, surgical, ionizing radiation).
l. Regional lymph node involvement (by palpation).
m. Submit radiographs when applicable (i.e. with intraosseous lesions).
n. Clinical slides and study casts may be submitted.

Biopsy Report

Because of regional differences in terminology (e.g. Leukoplakia) there should be no hesitation about frank discussion of terminology and clinical and histological features with the pathologist.

A negative biopsy report is not final and does not mean the clinician should forget the lesion. His responsibility is to continue to evaluate any lesion which is suspicious enough to biopsy and which persists or recurs. A negative incisional biopsy of a truly suspicious lesion always requires a rebiopsy. Complete excision or multiple incisional biopsies help to avoid this requirement. A negative report from an aspiration biopsy does not mean the absence of a neoplasm; aspiration must be repeated or open biopsy performed.

Summary

When confronted with a diagnostic problem that cannot be solved by conventional means, biopsy should be used. If the lesion seems innocuous, a slight delay to determine whether it will resolve with conservative therapy may be indicated. If it does not resolve however, or if there is any suspicion of malignancy, immediate biopsy is indicated.

An excellent rule to follow is - IF IN DOUBT - DO A BIOPSY.

This article was based on the following references:

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* OCCUPATIONAL HAZARDS

Captain PR McQueen, DDS

The occupational hazards of dentistry are taken for granted and most members of the profession are indifferent to them. This shouldn't be the case, particularly in view of the results of a survey conducted by the American Dental Association on thousands of retired dentists. The key finding indicated that 50% of retired dentists have been obliged to do so because of ill health. It is far from comforting to learn that the dental profession, as a group, has nearly the highest cardiac disease rate. Current statistics indicate that 54% of dentists die from cardiac diseases.

For convenience, occupational hazards are divided into two groups:

Physical	Mental
a. Cuts and abrasions	a. Stress
b. Respiratory	b. Noise
c. Optical	
d. Musculo - skeletal	
e. Radiation	
f. Poisons and drugs	
g. Skin reactions	
h. Aerosol effect	

* This article is based on a study group oral presentation by Capt PR McQueen during the Captain to Major Qualifying Course 12 Sep-21 Oct 66.

Physical

a. Cuts and abrasions - infection

The mouth is a large reservoir of organisms. The dentist works in this environment, encountering sharp teeth and using sharp instruments. The potential for minor cuts and abrasions is high and this of course opens a port of entry for infection. Fortunately, infections from this source seldom occur. The rubber dam minimizes the risk.

b. Respiratory

The dentist operating at close range is constantly enveloped in the patient's expired air which broadcasts bacteria and viruses in droplet form. The rubber dam and also the face mask help to protect the operator. Infection from this source is uncommon, a fact which may be attributed to the following reasons (which also apply to cuts and abrasions):

(1) saliva is somewhat bacteriostatic,

(2) individuals usually have enough resistance (and possibly acquired immunity) to cope with exposure to infection on this scale.

c. Optical

There are two main hazards involving the eyes - foreign objects and eye-strain. Sprays, water jets and high speed rotors place an envelope of enamel, calculus and amalgam fragments around the operator. If one does not wear corrective glasses, protective lenses should be acquired. Then too, while operating, the dentist works in a restricted area concentrating for long periods at short focal distances. Good lighting and regular eye examinations are essential.

d. Musculo - skeletal

All musculo - skeletal and associated problems stem from the fact that the dentist is usually confined to a small operatory, often leaning over the patient and holding unnatural postures for long periods of time. The chair-side stool is only a partial remedy. Alternating standing and sitting positions is advantageous and the operator should attempt to assume a posture which will keep his weight well balanced. Hard floors are to be avoided and good fitting shoes are essential. New developments in dental equipment are producing more conveniences and energy conserving devices than ever before, but this in itself will by no means provide a solution to the problem.

Probably the most common condition precipitated by occupational posture for dentists is stagnation of the blood supply in the lower extremities with resultant varicose veins and hemorrhoids. Preventive measures to stimulate circulation include: attempting to assume proper posture whether sitting or standing; alternating sitting and standing postures by planning a change in pace in office routine throughout the day; undertaking some compensating activity by means of a hobby or sport.

When members of the profession become recognizable because of characteristic infirmities (the curved spine, right shoulder droop, varicose veins etc.), this must surely indicate a lack of interest in maintaining good health.

e. Radiation

Most dentists, when queried about radiation state that they "have a

good unit and always stand back when taking x-rays". In a survey conducted by the American Dental Association in the Chicago area it was revealed that 40% of 177 dentists had faults in their technique and/or equipment. The outstanding feature concerning the radiation hazard is that damage is irreparable. There is no threshold or minimum damage, it is either non-existent or severe. A cell damaged by radiation may be destroyed or the production of a mutation may be stimulated. Indications that damage has occurred may not become apparent for many years, as was evidenced by most of the original researchers in radiology many of whom died prematurely or were severely burned.

A constant check on equipment and technique should be maintained by wearing a dosimeter film badge.

f. Poisons and drugs

Many of the drugs and materials used by dentists are poisonous and some can be absorbed either through the skin or by inhalation. Mercury is a good example of a material from which there is little risk of poisoning but with which long term accumulation is possible. In the early stages mercury poisoning is asymptomatic, but when more severe, the symptoms include mild headache, irritability and unwarranted fatigue. It should be realized that mercury vaporizes at room temperature and one part per million is the threshold dose. Prevention is simple; mulling amalgam in the bare hand is to be avoided and spilled mercury on counter tops or floors should be disposed of.

g. Skin reactions

The dentist depends upon his hands for his livelihood, and they are subject to abuse from constant washing and exposure to irritating drugs and chemicals. The antiseptic soaps commonly used remove the natural oils from the skin permitting abrasion of the keratinous layer, with resultant cracking, edema and inflammation. Dermatitis may be classified as one of the following types:

(1) Primary Dermatitis is characterized by redness, inflammation and itching and results from the breakdown of the keratinous layer as already described. Prevention is by employing mild soaps preferably without hexachloraphene, restricting vigorous washing, and by using gloves.

(2) Allergic Contact Dermatitis is caused by a reaction to some specific substance which in some cases is slowly acquired. Its induction may be expedited by primary dermatitis. Procaine dermatitis is an excellent example. When allergic to one substance, the individual often becomes allergic to other substances similar in chemical composition and structure. Treatment is by complete avoidance of the irritant. In order to prevent the induction of an allergy, minimal skin contact with drugs and local anaesthetics should be practised.

(3) Infective Dermatitis is characterized by the defensive mechanism of the skin becoming hypersensitive to a normally mild low grade infection, i.e. the skin becomes allergic to the infection. Blisters are common with this type of dermatitis.

h. Aerosol effect

Concern with this effect when using the air-turbine in the mouth is comparatively recent. By placing blood agar plates at various distances from the patient's mouth while the turbine was in use, pathogens were cultured. Maximum dispersal was at a distance of two feet, but pathogens were also present at distances up to four feet. It is interesting to note that when using

the turbine, although the rubber dam and evacuator were used, and even when not contacting the tooth, as long as the bur was rotating in the mouth an envelope of infection was created. It consists of minute air and water particles pushed from the mouth by the air turbulence. Tests were carried out to determine whether or not the aerosol effect could be reduced by using mouth rinses and it was found that when the patient:

(1) rinsed with water - 25% reduction

(2) rinsed with mouthwash - 75% reduction

Wearing a face mask is effective in protecting the operator but is not always practical. This comparatively new problem has not yet been satisfactorily resolved.

Mental

a. Stress

Stress cannot be discussed as an entity because it is linked with physical fatigue, physiologic ailments and overwork. Stress may be manifested in a variety of pathological conditions including hypertension, peptic ulcers, tremors, alcoholism, etc. It is important that the individual should become aware of the problem if and when it exists so that some outside activity or diversion can be undertaken to alleviate it.

b. Noise

Noise of the sound frequency produced by the air turbine and its possible effect on hearing has recently come under investigation. In earlier studies of dentistry and noise it was observed that sound of high frequency ameliorated the pain response. From these studies audio-analgesia was developed. However, as air-turbines were designed with ever increasing speeds, the question of possible impairment to hearing caused by prolonged exposure to the sound frequencies involved became evident. Briefly reviewing the hearing process, if sound is of the type which will cause pain, a reflex becomes effective to separate the malleus and incus, i.e. a circuit breaker effect. This natural safeguard may fail, however, since the ear can suffer permanent damage from sounds too weak to cause pain. Sound frequencies produced by the air-turbine happen to fall into this category and if used for 7-8 hours per day approach this threshold. Since in practice they are not used continuously, hearing impairment is not likely to occur.

Members of the profession should be made aware of the possibilities of trauma as higher speed turbines are developed with the concomitant higher frequency sound.

Summary

Some of the reasons for half of the members of the dental profession retiring prematurely from practice have been reviewed. Hazards only recently recognizable have been discussed and it seems certain that more will develop with further sophistication of equipment. Perhaps the most important lesson to be learned is to be keenly aware of the hazards that exist, because ignorance of them is the greatest hazard of all.

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Recent statistics reveal an alarming increase in the number of reported cases of primary and secondary infectious syphilis. This, coupled with the evidence that not all cases are diagnosed or reported, demands that the dentist have a greater awareness of this disease, not only from a diagnostic standpoint, but also from the standpoint of personal safety.

- Oral Surg, Oral Med & Oral Path. 21:350-535, 1966

US NAVY CORRESPONDENCE COURSE PROGRAM

In 1962 the U.S. Navy invited participation by RCDC officers in the complete US Naval Dental School Correspondence Course Program. As well as supplying all course material, the USNDS kindly offered to undertake the administrative details including the grading of assignments and the issuance of a letter indicating satisfactory completion.

The courses are prepared by certified specialists well versed in the latest developments in dentistry and the highest standards of professional practice. Course content is based on widely accepted dental textbooks and on texts written by the staff of the US Naval Dental School. The courses are not intended to replace other training courses but to provide continuing education for those officers who desire to augment their professional knowledge regardless of location or level of experience.

Since acceptance of the US Navy offer the courses have proven to be very popular and are highly regarded by those RCDC officers who have participated. Thirty RCDC officers serving in Canada and abroad are currently undertaking this training. To date ninety-six courses have been completed in the following subjects:

Oral Diagnosis	- 21
Endodontics	- 14
Operative Dentistry	- 13
Oral Surgery	- 13
Periodontics	- 11
Prosthodontics	
Part I Complete Dentures	- 4
Part II Partial Dentures	- 9
Part III Fixed Partial Dentures	- 6
Removable Partial Dentures	
Planning and Design	- 5

In 1966 the Correspondence Course Program was completely revised and new courses introduced. A brochure outlining these courses has been distributed to all RCDC units. Two courses, Oral Surgery and Operative Dentistry, are still in the process of revision and will be available during 1968.

The privelege of enrolment is greatly appreciated and has proven beneficial to all participants. In the case of junior officers it has been especially rewarding as it has allowed them to determine and develop their interest in a specific discipline of dentistry.

In addition to their value in increasing professional knowledge these correspondence courses exemplify the excellent liaison and co-operation which has been established between the US Naval Dental Corps and the RCDC.

Clinic Management Course Held at RCDC School

A Clinic Management Course (or "workshop") was held at the RCDC School from 30 May-1 Jun 67 with 20 RCDC officers from clinics across Canada participating.

The main objective was to permit the interchange of ideas on clinic management between experienced and capable dental officers in charge of clinics; the information gained to serve as a basis for developing future courses on this subject for less experienced officers. The course was also designed to provide participating dental officers with information useful in managing their own clinics. Problem areas in the field of clinic management were discussed and defined so that recommendations could be submitted to DGDS.

The format of the workshop was the round table discussion with 16 of the participants presenting papers on various aspects of clinic operation and management. Following each presentation the meeting was open to full and frank discussion with recommendations noted for submission to DGDS.

Lieutenant Colonel DH Protheroe, chairman of the workshop, set the theme with an opening paper entitled "The Dental Treatment Problem and Possible Solutions". Methods of closing the gap between dental treatment needs and resources were discussed and the various facets of this problem were dealt with in the papers that followed. The philosophy of preventive dentistry was presented and the value of this approach to Service dentistry outlined. The employment, training and staffing of RCDC clinics was the subject of several papers, each dealing with a specific trade grouping and its part in the over-all operation of the clinic.

From the managerial point of view, public relations, trade structures, confidential reports and treatment returns were subjects which were considered.

The workshop's greatest value lay in the frank discussion held between long term dental officers who drew on a wealth of experience in producing their topics.

This is the first course of this type conducted within the RCDC and it proved to be a highly productive three-day activity.

The RCDC News

Division News

Brig BP Kearney, Director General Dental Services, attended the meeting of the Board of Governors of the Canadian Dental Association 8-12 May.

Lt-Col G MacDougall inspected Militia dental elements in London, Toronto, Brandon and Victoria as judging officer for the RCDC Militia Efficiency Competition held annually in Militia Units across Canada.

Brigadier AG Rowell, Director of Dental Services Australian Army, visiting Canada en route to Viet Nam was the guest of the Division Officers at a luncheon 19 June.

The Director General attended the Fédération Dentaire Internationale meeting held in Paris 5-11 Jul in conjunction with a visit to 4 Fd Dent Coy with the Brigade in Europe 12-15 July.

Lt-Col WR Thompson, Maj JVP Chatwin and Maj CA Casterton presented papers at the Clinic Management Course - RCDC(S) 30 May-1 Jun 67.

11 Dent Unit

No 11 Mobile Clinic on Display

No 11 Mobile Clinic has been fully equipped (with an Encore Unit etc) and repainted. It will be included with the Armed Forces Centennial Caravan which will tour remote areas of Alberta from 2 Aug-30 Sep 67. Officer Cadet P Wooding and Sgt Green BA will be in charge during August. Capt V Lanctis and Cpl Schulz EJ will handle the September detail.

Commissioned from the Ranks

Canadian Forces Headquarters recently announced the promotion of WO2 Johnston C. to the rank of lieutenant.

Heartiest congratulations are extended to Lt Johnston who joined the Service in 1943. Since the War he has served with 25 CFDU (Korea) and 35 FDU (France) along with various postings in Canada. He will move from Victoria to 1 Dent Unit in Ottawa, where he will take up his new duties as laboratory officer for the RCDC.

Postings and Retirements

Personnel of the Edmonton area gathered recently to wish "God Speed" to Maj "Chuck" Sivell, Sgt Ken Shergold, Sgt Ron McDonald and Miss Mary Ward, all of whom are leaving on posting. On that occasion best wishes were also tendered to Capt Gerry Purcell who has taken his release and opened a practice in Mission City, BC. The party was rendered particularly nostalgic (according to the news submission, even though the participants look far from nostalgic in the accompanying photo) in honouring Harry Hodkinson who recently retired after 27 years of service with the Corps.

From Left to Right:

SSgt Harry Hodkinson, Sgt Ron McDonald, Miss Mary Ward, Capt Gerry Purcell, Major "Chuck" Sivell and Sgt Ken Shergold.

Miss Warnock retired as a dental assistant on 23 May 67 after many years of service with the RCDC at HMCS Naden. All Corps members who knew Mae wish her many years of happy retirement.

Special Events

Col and Mrs GC Evans attended the Graduation Exercises for their son Michael on 2 Jun 67 at the Royal Military College, Kingston.

Sports

Sgt Paul Fox in Calgary had a "mixed" run of luck recently. He was so deadly

with his putter that he walked off with low gross in a local tournament and won an umbrella. His prize was later stolen at another golf course.

Belated congratulations are in order to SSgt and Mrs Gerry Shand whose team won the mixed bowling championships at Cold Lake.

12 Dent Unit

Conferences and Meetings

Col SG Bagnall, Lt-Col FD Charman and Capt JR Robertson attended the Maritime Provinces Dental Convention in Moncton 7-9 Jun 67. Lt-Col Charman's table clinic on Pin Amalgam Restorations and Capt Robertson's on Apicoectomy were well received by those attending.

Duty Cruise

Capt JG Thompson and Sgt Arsenault JB comprised the dental element aboard the Cape Scott on her last cruise to Bermuda during the period 25 May-16 Jun 67.

Special Events

The Naval Assembly held in Halifax during the period 21-26 Jun was most impressive. It brought with it many requests for emergency dental treatment for military personnel of visiting foreign ships.

An informal party was held at the Snack Bar, Gorsebrook, to bid farewell to several personnel leaving the unit. The CO presented a travel clock to each departing member, perhaps an appropriate gift on such an occasion.

Col SG Bagnall (with his family) was the first representative of this unit to visit Expo 67, having done so during the month of May. He reports that it was extremely interesting - but a little on the cool side for camping at that time of year.

Sports

Capt CJM Boston, DO at Greenwood, owns a sailboat and has invited dental personnel to enjoy an afternoon of sailing. Anyone interested in getting a good wetting is welcome.

In Halifax, the Garrison Golf Club has been practically "taken over" by the Corps with Maj AT Hinch as President, Capt M Kostyniuk as Secretary and Capt JF Mullins as Statistician.

13 Dent Unit

Meetings and Conferences

Maj WH Murray addressed the Bay of Quinte Dental Society on the subject of Endodontics. The Meeting was held at CFB Trenton 19 Apr 67 with over 20 dentists in attendance and the speaker was well received.

Lt-Col JM Smith spoke to the luncheon meeting of the London and District Dental Society 13 Apr 67 on the subject "Oral Cytology". The talk was given at the request of Drs HA Hunter and DL Anderson of the University of Toronto Faculty of Dentistry in order to encourage greater use of the technique in the London area. Excellent slides were provided by the Faculty.

Course Award

Pte James TA was sent a Junior NCO course award in the form of a small plaque as the top Junior NCO of 4 Troop Course 6702, with congratulations from Col CA Greenleaf, Commandant of the Combat Arms School.

13 Dental Unit Centennial Golf Tournament

This tournament was sponsored by 13 Dental Unit as its Centennial project. It was held at Trenton Friday 23 Jun 67 with 56 RCDC golfers participating.

Sgt Hill WE of 1 Dental Unit, Ottawa, won 1st Low Gross in "A" flight, with Lt-Col GE Windsor of Canadian Forces Base Petawawa as runner-up. AVM Hull, Commander ATCHQ was the "A" flight low net winner. Other major prize winners were: Capt MB Fisk low gross "B" flight and Capt VO Bergland low net; Cpl RW Danyluck low gross "C" flight and WO2 VR Kidd low net.

Brig Kearney opens the tournament by driving the first ball. (left elbow straight?)

(L to R) Col RGH Cunningham, Col GR Covey, Col LG Craigie (partially hidden), Brig BP Kearney, Brig KM Baird (ret'd) and AVM AC Hull.

Retirement

Sgt Vout AC has retired from the Dental Corps after 26 years of service. He was presented with a candelabra from 13 Dental Unit following the Centennial Golf Tournament banquet. Best wishes from his friends in the Corps go with "Al" and his family for a happy and successful future.

14 Dent Unit

Special Events

The Annual Posting Party for this Unit was held at the Recreation Centre CFB Winnipeg 12 May 67. Farewells were said to: Majors Bob Bryant and Lee Reynolds, Captains John Girard and Michael Harach, SSgt Storms JM, Cpl Boles MN (RCAF) and Cpl Bristow GB. To SSgt Yeates JR and Sgt Fenton DL who were taking their release it was farewell and the best of luck.

15 Dent Unit

Dental Public Health

A Dental Public Health program is being written into the Cadet curriculum in Camp Farnham this year. It will consist of lectures and demonstrations; and since the cadets come from all across Canada it is felt that this is an excellent opportunity to "spread the word".

Visit

Brig G Rowell, Director Dental Services Australian Army, visited Montreal 21 Jun 67. Col Cornish escorted and arranged appointments with the Deans of both Dental Faculties. Brig Rowell was most impressed with the new clinic accommodation at the University of Montreal.

Retirement

Maj PH Guevremont was dined out of the RCDC at a formal mixed dinner 9 Jun 67 at CFB Montreal Officers' Mess after 22 years of service in the Dental Corps. Major Guevremont took his DDPH while in the Corps and has been very active in this field in 15 Dental Unit. Best wishes go with Paul on his retirement and in his new career in La Belle Province.

Col Cornish (l) is shown presenting Maj Guevremont with the RCDC crest (framed)

Sports

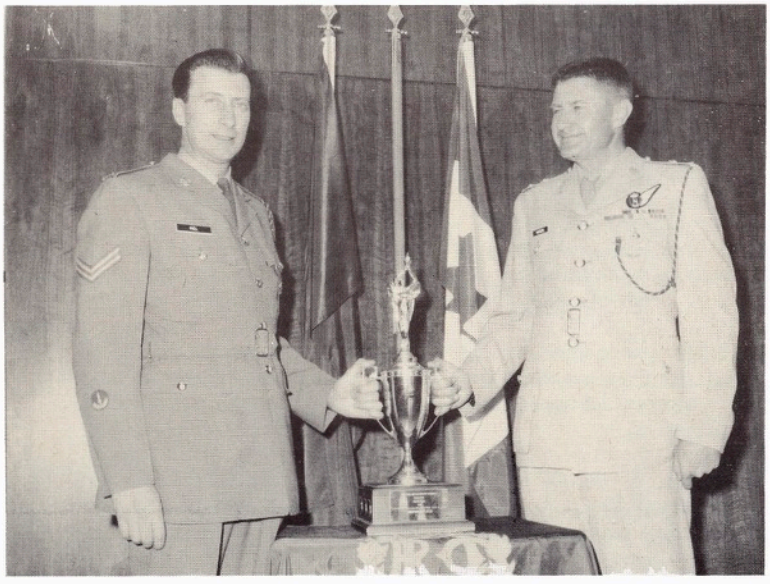
Capt RF Cooper captured the Men's Singles Badminton Trophy in a tournament held at RCAF Mont Apica. He also teamed up with Mrs Cooper to win the runner-up trophy for Mixed Doubles.

Training

Dental Laboratory Technician Level 6 Course
8 May - 23 Jun 67

Front row L to R - (staff) Sgt Hossdorf J, Capt DD Robertson, Lt-Col PS Sills, Col Col Covey, Lt-Col DH Protheroe, Sgt Rothwell KS.
Back row L to R - (on course) Sgt Werkmann AE, Cpl Stenbaugh RH, Sgt Hughes AJ, Sgt Bleakney JC, Cpl Sabine-Pasley CS.

Dental Assistant Course Trophy



The Dental Assistant Course Trophy, donated by Lt-Col DH Protheroe, was awarded for the first time 19 May 1967.

Cpl Riel JAG was the successful candidate and is shown receiving the trophy from Lt-Col Protheroe.

Conferences and Meetings

Maj AG Taylor spoke to the Grey-Bruce and Dufferin Dental Society on 5 Apr 67. His subject was "Crown and Bridge Application with Pin-reinforced Amalgam Restorations".

Corps Anniversary Celebrations

The 52nd Anniversary of the Corps was celebrated with a very successful all ranks dance on 21 Apr 67.

The other Corps Anniversary function was a Church Parade, the order of dress being Blues with medals. A total of 14 officers and 42 ORs attended, including staff and candidates.

Special Events

The Dent A Course candidates held a party for the Training Wing Staff on 18 May at the Huron Club. Games, refreshments and food were enjoyed by all.

At the TGIF on 9 Jun, the Comdts of CFMTC and RCDC(S) did a mass "mug out" for all officers leaving on posting during Jun/Jul. Incidentally, the silver mugs have crests of both CFMS and RCDC engraved on them and they make rather a unique momento. Lt-Col Protheroe, Maj Kelland and Lt Carrier were presented with their mugs on this occassion.

An all ranks RCDC(S) staff party to say farewell to all departees was held on 16 Jun. Departing officers were presented with RCDC(S) plaques and suitably engraved mugs for the ORs. In addition, a special gift of an attache case was presented to WO1 EB Morse on his retirement. There were nine presentations made that evening, liberally interspersed with refreshments.

Sports

The RCDC(S) held its Annual Golf Tournament on 14 Jun. Cpl John Clint was the low gross winner with an 80 and was presented the JW Fletcher Trophy by Col Covey. There were 25 participants including three CFMTC guests.

On 21 Jun nine of the RCDC School's "best" participated in the Annual Golf Tournament of the Grey-Bruce and Dufferin Dental Society at Owen Sound. Majors Wright and Marion were the only winners in the group. All were made welcome by President Tackaberry and his committee and enjoyed an evening meal with our confreres to the North.

1 Dent Eqpt Dep

Special Events

No 1 Dent Eqpt Dep paraded as a separate unit for the Base Commander's Annual Inspection Parade held on 9 Jun 67 with three officers and 14 other ranks on parade.

The technical repair section prepared the RCDC display for Armed Forces Day held at CFB Petawawa on 9 Jun 67. The display proved to be quite an attraction to the public. A terrific rain and wind storm during the display blew the roof off one of our cubicles, adding to the excitement.

No 1 Dent Eqpt Dep along with 3 Dental Clinic held a very successful beach/barbecue party on 29 Jun 67. The party was held to say farewell to members of both units departing on posting during the summer months.

Sports - Cpl Boulianne bowled a three game cross of 933 while participating in unit bowling.

FLASHBACK

This photograph is X years old and helps to form part of the record of our Corps history. Some of the members in the photo (believe it or not) are serving in the Corps today and others have recently retired. You are invited to attempt to identify as many as possible and guess when the photo was taken. Answer on page 27. NO CHEATING!

1 Dent Unit

Conferences and Meetings

Captains Andrews and Tukums attended the CDA-ODA Convention in Toronto while on annual leave. Capt Tukums was the winner of the prize for "hobbies" and Mrs Tukums was chosen Queen of the Ball. It should be explained that Capt Tukum's hobby is jewellery making and as a result of his success at the CDA-ODA Convention, he has been invited to display his collection at the Canadian National Exhibition Hobby Show this fall.

Special Events

A farewell party was held at CFB Rockcliffe on 16 Jun 67 for personnel from this Unit on posting during the summer period.

Retirement

The farewell party held at CFB Rockcliffe on 16 June was also used as an occasion on which to honour Capt A Van Ryssel on his retirement. "Van" has served with the Corps for approximately 28 years and gained the distinction in Nov 60 of

becoming one of the first post-war laboratory officers. He was presented with a silver tray from No 1 Dental Unit.

He was also feted by RCDC officers in the Ottawa area.

Col LG Craigie (1) is shown presenting Capt A Van Ryssel with the RCDC crest (framed)

Capt Van Ryssel has accepted an appointment on the staff of the Dental Faculty, University of Manitoba. Best wishes from the Corps go with him and his family.

4 Fd Dent Coy

Conferences and Meetings

The dental officers of 4 Fd Dent Coy continue to sponsor monthly professional meetings to which RADC and USDC officers are invited.

On 21 Apr 67 the US Army dental officers of Rothwestern dental clinic near Kassel were hosts for the meeting. Lt-Col Louis H Guernsey USDC gave an excellent presentation on "Surgical Principles as applied to Oral Surgery".

On 25 May 67 the meeting was held in Fort Henry with a presentation by Maj JF Begin RCDC on "Infection and Sterilization", and one by Capt Motley USDC on "Pin Reenforced Restorations". A Canadian Centennial film was shown in the evening.

The NCO Study Group meeting on 25 May 67 was devoted to the new system of cataloguing dental stores with WO2 Bennett leading the discussion.

Special Events

On 28 Jun 67 the annual rotation party was held in the Old Red Patch Club in Soest. Souvenir gifts were presented to the 11 members of the unit departing in the near future. Sgt Reid and his committee arranged an excellent banquet and dance.

Capt Griesbach won the 4 CIBG Centennial Slogan Contest with his entry - "4 Brigade On Guard for Liberty Celebrating Unity". The prize, perhaps appropriately, is a one-week holiday with his family at the US Armed Forces Recreation Centre in Garmisch.

Sports

Capt Swanzey was the captain of a combined British-Canadian Judo team which competed in Amberg, Bavaria Jun 19-23. This competition was part of the Anglo-German week celebrations. The competitors were billeted in German homes where Capt Swanzey had ample opportunity to practise his developing mastery of the German language.

35 Fd Dent Unit

Dental Clinics in France Close

The dental clinics at Marville and Metz were officially closed in June 67. No 1 Clinic (Marville) has been reopened at Lahr, Germany.

Canadian Forces serving within NATO were obliged by the French Government to vacate French soil by June 1967. No 1 Air Division Headquarters has been re-located at Lahr in the Black Forest area of Germany.

Meetings and Conferences

Lt-Col Brick and Capt CM Mason attended the 19 May meeting of the West German Dental Society held at Ramstein.

Farewell Parties

A unit farewell party was held in honour of the following members who are being rotated to Canada this summer:

Maj WK Dickie, Maj BA Gaudet, Maj Y Kamachi, FS Torrens CMB, Sgt Jermain EA, Sgt McCurdie HM, Sgt Wadden GM, Cpl McMillan SJ and Cpl Pringle JM.

Lt-Col Brick was tendered a unit farewell party at which time Maj Dickie on behalf of all members of the Unit presented him with a gift with the Black Forest motif.

A retirement party was held for Lt ES Moore, who will be returning to civilian life in August after more than 25 years with the Dental Corps.

Dent Det Cyprus

Clinic Accommodation

Capt DG Wilson, the DO with the Canadian Contingent in Cyprus, reports that the new clinic is "in excellent condition providing a comfortable working office despite the hot weather". Reporting on the new facilities in his monthly liaison letter, he stated that "the clinic and laboratory facilities are very adequate, approaching closely the standards in Canada".

Leave

Capt Wilson and Sgt Wilkinson travelled to Germany via a Canadian Yukon service flight.

Sports

Sgt Wilkinson was a winner in the doubles snooker competition in the Sergeants' Mess. (obviously, a mis-spent youth!)

Answer to "Flashback"

Date of photo - 1947. Place - Halifax

L to R back row - Pte Weaver DE, Sgt Moore GJ (recently ret'd Capt), SSgt Cartwright DG (serving Capt), WO2 Armstrong GM, Sgt Hussey T (recently ret'd), Sgt Cross AG (recently ret'd WO2).
L to R centre row - Cpl Gardiner DG, Unknown, Cpl Batten TL (serving WO1), Capt EP d'Entremont, Capt WA Shannon, Capt SG Bagnall (serving Col), Cpl MacDougall WD (recently ret's SSgt), Pte MacKenzie JC.
L to R front row - Cpl Hughes AJ (serving Sgt), Pte Marchand JF, Cpl Paquette TRC, Pte Wentzell JS (serving WO2).

In Memoriam

Canadian Forces Headquarters announced with regret the death of Major EW Gazo on 26 Jun 67.

Major Gazo enrolled as an Officer Cadet in the ROTP in 1956 and graduated from the University of Toronto with a DDS in 1960. He served in Trenton and Picton, Ontario before going to Germany with No 4 Fd Dent Coy in 1964. After his return to Canada he served in Ottawa and his last appointment was as Senior Dental Officer at the National Defence Medical Centre.

Major Gazo leaves his wife Pat and three children Stephen, Andrew and Michael. Deepest sympathy is extended from the RCDC to all members of his family.

A full military funeral was conducted from the Chapel at CFB Rockcliffe, with interment in Ottawa.

Professional Training

US Naval Dental School - Bethesda, Maryland, USA

Major	RE	Dyer	- Periodontics	- 1 May-16 Jun 67
Capt	PR	McQueen	- Periodontics	- 1-5 May 67

University of Michigan - Ann Arbor, Michigan, USA

Major	JOL	Bourget	- Operative Dentistry	- 24 Apr-5 May 67

Training

RCDC School - Canadian Forces Base Borden

Dental Laboratory Technician Level 6 - 8 May-23 Jun 67
Sgt Bleakney JC, Sgt Hughes AJ, Cpl Sabine-Pasley CStC

1 Dental Equipment Depot - Canadian Forces Base Petawawa

Conversion Course - 10 Apr-2 Jun 67
Sgt Posyluzny SD, Sgt Duve EA, LSgt Green BA, Cpl Longford MD, Cpl Strasdin JA

RCS of S - Canadian Forces Base Barriefield

Sr NCO Course - 19 Apr-30 May 67
Cpls Hardy DH, Garnham RA, Lindsay RS, Hill JF, Veinot RD, Gratton JR, Davies DJ, Wormington RC, Looker WB

Welcome to the Corps

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

Cpls - Busse A, Parent TJ, Swiatkebich VH, Hache MJV, Gilkes BA; Ptes Clarke RM, Allain JG, Allen DG; LAW Acres CJ; AW2 Lamoyne BA

Promotions

To Major - JPA Legendre, CM Mason, DR O'Hara
To Capt - MB Fisk, ME Blasetti, DI Brown, DGJ Chausse, TM Clark, ED Cragg, JFD Cormier, DA Devine, RM Depledge, TJ Erskine, SJ Dion, YJA Gagnon, WA Gray, BLP Hart, NS Misura, CW Kearns, GL Lepage, JW Montgomery, HA Pankratz, WJ Percival, GRJ Pinsoneault, GC Post, TC Ringland, GJ Sharpe, RJ Shirkey, DA Stewart, GS Wilkins, BW Yates, JJ Jacques, WD Fiolek
To Lt - C Johnston
To Sgt - Ellis D, Wadden GM
To Cpl - Beauchamp, CJN, Mehler PJ, Vasek JJ

Retirements and Releases

Major PH Guevremont
Capts NA McFarlane, RW Chernesky, GE Purcell, A Van Ryssel, GA Johnson, MH Harch
WO1 EB Morse
WO2 Young CA
SSgts Hodkinson H, Ryder GP, Yeates JRC, Keogh GF
Sgt Vout AC
Cpl Clark JDW
Pte Bernard PB, Evans RV

Vital Statistics

Marriages

Capt JEG Joubert to Miss Laurence Leblanc, Capt TM Clark to Miss Susan Lea Morrow, Capt WD Fiolek to Miss Leona Sharon Starritt; Cpl RM Haiplik to Miss Gloria Hilda Yvonne Crocker, Cpl JGJ Labrosse to Miss Micheline Champagne, Cpl ZWJ Mitrikas to Miss Joan Elizabeth Patterson, Cpl RG Duffield to Miss Ann Maggs; Pte MJ Craig to Miss Victoria Carolyn Zakotuk; Pte EAJ Morin to Miss Cecile Anne Marie Deveau; Pte JMM Arbour to Miss Bernice Marie Ronsome; Miss MC Gareau to Mr S Madore; Miss MA MacWilliam to F/L EE Osler.

Births

Son - Maj & Mrs HJ Marion; Capt & Mrs GDV Dippel; Capt & Mrs JML Rochefort; Sgt & Mrs HC King; Cpl & Mrs NB Sharp; Cpl & Mrs GM Anderson; Cpl & Mrs TR O'Mara; Pte & Mrs J Vanhemert.

Daughter - Capt & Mrs ICM Wambera; Cpl & Mrs PJ Armstrong; Cpl & Mrs CStC Sabine-Pasley; Cpl & Mrs DH McKay, Cpl & Mrs BF Hannah

Deaths

Canadian Forces Headquarters announced with regret the death in hospital of Major EW Gazo June 26, 1967.

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* CORPS MEMBERS ARE REMINDED THAT THE ANNUAL RCDC GOLF TOURNAMENT WILL BE HELD AT CAMP BORDEN 22-23 SEP 66.

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