Doctor, TIC is another unique service of your Ticonium Laboratory.
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Occlusal Considerations in Preventive Care

In the past, the dental profession has not put as much emphasis on prevention as it has on "patch and repair." Fortunately, there is now a new emphasis on prevention, particularly along lines of plaque control, cancer detection, and nutritional counseling. However, since disease is multicausal, the approach to preventive care encompasses more than flossing and brushing.

To start with, a thorough examination plus an evaluation of the patient's medical status is imperative. Since disorders relating to occlusion exist in the patient is self-evident. Without a probe and radiographs a check for periodontal disease is preferable when restorative procedures are undertaken.

(1) An eye shield should be provided to protect the patient's eyes.

(2) A prophylactic pack is advised to prevent tooth fragments or pieces of filling material from passing down into the pharynx and possibly the trachea.

(3) To help in the retraction of the cheek and tongue and get a better field of operation, the rubber dam is advanced.

(4) A mouth prop should be used to keep the mouth opened steadily without any muscular strain or injury to the corners of the mouth.

The operative procedure under general anesthesia should be as complete as possible, with all caries taken care of in one sitting. This is important for it eliminates the necessity of undergoing further anesthesia. In recent years hospitals have allowed patients to be admitted for dental operations, usually in the early morning and discharging them in the late afternoon.

Medical histories of all young patients should be complete prior to they should be properly prepared for the procedure so as to forestall any psychic trauma. For ease of operation, the dentist should have the operating room setup similar to that of his own office. This cuts working time and makes for a smoother operation.

To further facilitate matters, most hospitals allow the dentist to bring his auxiliary help with him.

For readers who may wish to obtain copies of the dental journals from which articles in this issue have been abstracted, or to subscribe to such publications, information appears below.

DENTAL JOURNALS

The Journal of Prosthetic Dentistry (B) Annual Subscription, $1.00; single copies, $0.25.

The C.V. Mosby Company, 11850 Westline Industrial Drive, St. Louis, Missouri 63141.

The Journal of the Tennessee Dental Association, 210 23rd Avenue, N. W., Knoxville, Tennessee 37912. Single copy, $0.75; annual subscription, $5.

Oral Surgery, Oral Medicine, and Oral Pathology, The C. V. Mosby Company, 11850 Westline Industrial Drive, St. Louis, Missouri 63141.


The Journal of the American Dental Association is microfilmed by University Microfilms, 300 N. Zeeb Road Ann Arbor, Michigan 48106. US ISSN 0040-6716 TIC.

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To further facilitate matters, most hospitals allow the dentist to bring his auxiliary help with him.
Later in the day my secretary goes through the magazines and clips out the pieces I have marked to be saved and places them in appropriate files designated as: T1, T2, N, L, and A. The magazine is then discarded. Occasionally there are issues devoted to a single subject of particular interest and these are saved. Generally, my shelves are not filled with old magazines, which, though they may look impressive, are rarely referred to in most offices.

In order to further keep up to pace with current dental literature one should refer to the abstracts of articles and book reviews published in many dental journals, including TIC. One can seek out further information on a given subject by following up on the original source, whether journal of origin or the book reviewed.

Even with this system of selectivity and filing, it is difficult to keep up-to-date with all the publications but neither is one more than a month or two behind. A further advantage of the clipped articles is the ease with which they can be read and filed away for future reference. A sub-filing on subject matter can then be instituted. This makes it infinitely easier to locate a particular piece, say on impression taking or selective grinding, than to have to thumb through dozens of magazines or tear sheets.

Try this system, doctor. You will find it a time-saver, you will get more out of your magazines, and you will keep better pace with the ever-growing profession.

174 E. Mt. Pleasant Ave.
Livingston, New Jersey 07039

Do You Know What You’re Paying For?

by Harold J. Ash

D. Joe Hindsight, dentist, is a careful investor. He has a good practice. He belongs to his local society, gives generously to charities, and is kind to his kids. Everything considered, he is an asset to the profession. Yet, despite Joe’s professional savvy and shrewdness, he is blissfully unaware that for years he has been paying for dental equipment he has never seen, let alone used.

This real life mystery wasn’t cleared up until Joe retained a young accountant to help him with his records. Now this accountant has a dry sense of humor that asserts itself in odd ways. Right off, he learned that Joe has office fixtures and professional equipment, all the worse for wear, that was acquired in 1962.

“According to your records,” soberly announced the accountant, “you’ve bought some new equipment. Where is it?”

“I’m not buying any equipment,” Joe firmly replied, eying the accountant as though he’d suddenly flipped his lid.

“Oh, but you are,” retorted the accountant. “What I can’t understand is why you don’t take delivery on it and get its use while you’re paying for it.” Then, fingering large bills for overhauling reception room furnishings and operatory equipment, he added: “You might even cut down on your repair bills.”

Then, Joe realized the hard facts of business life in 1974 in terms of Joe’s 36 percent income tax bracket.

Two years ago, Joe’s professional equipment was fully depreciated. Whence once his income tax returns carried an item of $800 a year depreciation on equipment and furnishings, there is now so much deduction. The result, his accountant patiently explained to him, is that his income subject to tax is $800 higher than if this charge were still reflected in his income tax return. If he gets new replacements and a shorter useful life is used to depreciate them, he will be able to deduct $1,000 a year in regular depreciation. If accelerated methods of depreciation are used, he can deduct even more in the first few years. Furthermore, he will get a deduction of $550 for investment credit directly deductible from his income tax bill in the year he purchases new replacements. This deduction alone would come close to, or exceed, the amount of probable repair costs on his present equipment and furnishings.

Because Joe does not have such a cost of doing business, his income tax bill is $258 a year higher than it would be otherwise. So, every year Joe is paying $288 as a penalty for using obsolete professional equipment and furnishings that don’t reflect favorably on his practice, and a penalty of $500 in loss of the investment credit in the first year of purchase of new equipment and furnishings for replacement. He is partially paying for new equipment and furnishings he can’t use.

By replacing all equipment and furnishings which have been written off with new and more efficient replacements, Dr. Joe Hindsight can get these at cut-rate prices due to income tax savings. Increasing efficiency in the practice will increase net earnings and help to offset rising costs due to inflation.

As a matter of fact, because of encouragement and advice from his accountant, Joe is now considering going to court to legally change his name. “I never did like the kind of name,” says Joe, “I’m petitioning the court to be known as Joe Foresight.”

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Endodontic Litigation

Malpractice suits against dentists have increased in recent years and, as opposed to suits brought against physicians, the increase has been alarming. In the past, most of the suits instituted were due to injuries occurring from the extractions of teeth, broken needles, and death or injury from the administering of anesthesia. The increase has been due mainly to the increase in endodontic practices. This increase is apparent because of better diagnosis, more endodontic treatment, increased full coverage, and the attempt to save more teeth. To help prevent litigation, the following suggestions are offered:

(1) Do a complete medical and dental examination with a full set of radiographs.

(2) Make the patient aware of the procedure and prognosis.

(3) Be sure the procedure is aseptic and proper sterilization methods are used.

(4) Give prophylactic antibiotics when indicated.

(5) Use a rubber dam to prevent ingestion of reamers and so forth.

(6) Do not use instruments that bind or are worn.

(7) Do not use motor-driven instruments until further evidence of their efficacy is presented.

(8) Only mild, non-toxic medications should be used and only reputable, practiced techniques.

(9) Continue taking education courses and con-
Abulcasis also practiced simple orthodontics and advocated filing teeth in order to correct occlusal irregularities. He recommended stabilization of loosened teeth with gold or silver wire. However, since he was primarily a surgeon, Abulcasis devoted little space in his writings to prostheses. But he did suggest that missing teeth could be replaced with cattle bone carved to simulate the missing tooth and wired into place with gold wire.

Drawings of the numerous instruments Abulcasis used accompanied his detailed descriptions of operative procedures. These are, perhaps, the earliest illustrations of dental instruments. Among those pictured was a set of fourteen scalers, a cautery with a tube for retracting and protecting the tongue, instruments for loosening the teeth before extractions, and elevators as well as various types of forceps for the removal of broken roots. Most of the illustrations of Abulcasis' instruments appear to be of rather crude tools which would seem difficult to use. However, it must be remembered that these drawings were copied repeatedly, and distorted inadvertently, by scribes. The only pictures we have of these instruments are those in texts published in the Christian world centuries after Abulcasis' death.

Abulcasis was the last great Moslem surgeon who devoted himself to the problems of dentistry. Not long after his death, Moorish culture itself went into a decline, to be followed by the eclipse of Moslem civilization and by the awakening of the European Renaissance. Fortunately, Abulcasis' writing made their way into the Christian world where they were translated and widely dispersed. This preserved for all time the wealth of dental knowledge, not only that of the ancient world which had been gathered by the Arabs, but also the original contributions of these great Moslem surgeons and practitioners—among whom Abulcasis ranks as one of the greatest.

--Ronald A. Monica, D.D.S.* and Bernard P. Levy, D.D.S.**

The Management of a Periodontal Patient

Various standards have been explained or what are considered to be successfully treated periodontal cases. The following discussion establishes a basis for determining the success of periodontal treatment, if certain criteria are followed. The management of a periodontal patient may be divided into several phases of treatment:

I. The Pre-Surgical Phase.
II. The Surgical Phase.
III. The Post-Surgical Healing Phase.
IV. The Re-evaluation Examination Phase.

In this discussion, the re-evaluation examination phase will be stressed since it is the most important phase for the practitioner to understand. It is the result of this phase that determines the success or failure of the other phases of dental treatment. After a reasonable length of time, usually four to six weeks upon completion of the planned periodontal treatment, a re-evaluation examination is performed.

The examination should include:

I. The measurement of pocket depth.
II. The re-evaluation of tooth mobility.

A. The original depth of the pockets.
B. The severity of the disease.
C. Local and systemic factors.
D. The age of the patient.
E. Anatomic landmarks.
F. Psychological and emotional behavior of the patient.
G. The patient's home care practices.

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Editor's Note: These three biographies, copyrighted by the Medical Heritage Society, are from the Pictorial History of Dentistry, a limited series of commemorative medals sponsored by the Society. Subscription rolls for this series are closed. Writing list information may be obtained from the Society at 20 North Wacker Drive, Chicago, Illinois 60606.

Women In Dentistry

The reproduction of a sixteenth century woodcut in Proskauer and Witt's Pictorial History of Dentistry shows beyond doubt that there were women practicing dentistry at early times. Some women must have been dental operators in the Middle Ages. A widow frequently carried on the business owned by her husband. Dental operators usually sold dentures and remedies for diseases of the teeth, and if they belonged to the barbers' company they also had a shop. Naturally when it was practicable the widow was allowed to continue the business.

In Paris after the edict of 1699 several women were recognized at St. Côme as equals for the teeth. Mlle. Marie-Madeleine Calais was accepted as expert in 1740 and continued to practice dentistry with her husband Leroy from 1750 to 1775. Another eighteenth century woman expert in Paris was Mlle. Hervieux. Two French women experts who practiced in London were Mmes. Descaux and Rauxcourt. Mme. Marie Delpeuch, a widow, was prosecuted in 1826 and ultimately acquitted for practicing dentistry without proper qualification. It was charged not only that she did not qualify as an officer of health under the law of 1803, but also that the Interdict of 1755 forbade women to practice.

At least several women practiced dentistry in England during the eighteenth century or early nineteenth. Some of them practiced all branches of dentistry, including prosthesis, and one featured the construction of obturators. Aaron Burr, during his exile in Europe, while in Hamburg, Germany, in 1811 visited a dentist to have a tooth extracted. "... drove off to the dentist's house," he reported, "and I was received with politeness, too much for the occasion, by a well-dressed gentleman and lady. The lady came up to me officiously and was about to apply her hands to my face. Wishing to get rid of her, I very civilly begged her not to trouble herself; that I had come to have a tooth drawn. 'Eh bien, Monseigneur, c'est moi qui vais l'arracher.' 'Vous, Madame?' 'Qui, moi.' 'Mais voyons, est-ce que vos petites mains ont la force?' 'Vous en serais convaincu et content.' It submitted, and she drew the tooth very quick and perfectly well.' (Copyright by the Bulletin of the History of Dentistry. Reprinted by permission.)

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In many advanced periodontal cases, the object of the treatment is to prolong the life of the dentition knowing well in advance that complete elimination of the disease is impossible. Post-surgical gingival pocket depth should not exceed 3mm and if it does, then a decision is made whether an area will have to be resected. Resurgerying an area may not be indicated due to the patient's age, physical and emotional condition. It is possible that gingival pockets exceeding 3mm may exist postoperatively. This condition may be maintained for years with excellent oral homecare and periodic periodontal evaluation.

II. Tooth Mobility

Tooth mobility may sometimes be reduced or completely eliminated by treatment; although this is not always predictable. Treatment should not be considered a failure if some mobility remains post-surgically. Some of the factors that influence post-treatment mobility are:

A. Pre-surgical mobility.
B. The extent and pattern of bone resorption.
C. Clinical-crown or root ratio (tooth morphology).
D. Occlusion.
E. Intrinsic or extrinsic factors.
F. Morphology of gingival tissue.
G. Height of the alveolar bone.
H. Width of the periodontal ligament space.
I. Biologic status of the supporting tissues.
J. Systemic health of patient.
K. Age of individual.

The prognosis is better when the cause of mobility can be eliminated or controlled. Every tooth has some degree of movement. The prognosis of a tooth that can be rotated or depressed is poor compared to one that can be located buccofacially or mesiodistally.

As stated earlier, some mobility may remain after treatment. Moderate or advanced mobility may remain unchanged due to one or several of the reasons stated above. High mobility of Class 3 or more is an indication for fixed splinting. Fixed splinting may change an unfavorable prognosis to a favorable one.

III. Tissue Color and Gingival Contour

Some patients lack adequate dexterity and motivation, so as an aid to the patient's home oral physiotherapy, favorable gingival contour will be an asset rather than a liability. Our objective is post-surgical architecture that closely resembles normal healthy gingival tissue.

Normal gingiva is pale pink which varies according to the degree of vascularity, epithelial keratinization and pigmentation. Attached gingiva is firmly fixed to the underlying bone and is immobile. The marginal contour should slope coronally to end in a thin edge with the mesial distal margins scalloped in form. Slighting is generally present; but varies among individuals and it may be absent following surgery.

IV. Radiographs in the Prognosis of Periodontal Disease

A. Gingival pockets.
B. Soft-to-hard tissue relationship.
C. Tooth mobility.
D. The morphology or osseous deformities.
E. Specifically distinguish between the successfully treated case and the untreated case.
F. The presence or absence of an exostate.

New radiographs need not be taken following periodontal treatment period was usually long. If extensive restorative therapy is to follow, then radiographs may be helpful in determining the cariogenic status of the dentition.

If the patient is to be discharged without further therapy, radiographs need not be taken for at least two years, since time is essential for new bone formation. A complete radiographic survey annually is usually recommended after the initial two-year period.

The resorption of bone may be visualized radiographically in the interseptal regions, but this evidence is not proof that gingival pockets exist postoperatively. The radiographic appearance of the alveolar process is not proof that gingival pockets are present, nor does the absence of bone resorption rule out the existence of gingival pockets. Pockets may have been eliminated by therapy before the radiographic appearance changed without changing the appearance of the alveolar process.

Radiographs do not indicate whether the involvement is on the bone or on the gingiva, or both. The location of deformities can be determined with a periapical probe.

The radiographic appearance of the alveolar process does not always show adequate repair in successful periodontal therapy, since lost marginal bone cannot be restored and fusion in involvement may not be filled with new bone. The intraosseous deformity is an exception. Therapy can encourage new bone growth, but radiographs cannot distinguish between an intraosseous and an intrabony deformity.

The diffuse radiolucent-appearing area of bone undergoing active resorption will be changed to a homogeneous appearance after successful treatment. This sometimes gives a false appearance of vertical bone growth and osseous regeneration after treatment of deformities with one or two osseous walls, where she achieved one of the major steps in her progress toward recognition: she was elected unanimously to membership.

The resolution inviting Miss Hobbs to membership stated these salient judgments: "...The profession of dentistry has nothing in its pursuits foreign to the interests of women..." and "It is due to the profession at large, that we make a formal declaration concerning the position we have assumed in our action." Dr. Taft, who was present at that historic meeting, sensed the timeliness of the Iowa resolution and persuaded his Ohio faculty to accept Miss Hobbs at the College in November 1865. Because of her preceptorial training and practical experience, she was required to attend only one session. On February 21, 1866, Lucy Beaman Hobbs became the first woman in history to receive the diploma conferring the D.D.S degree.

The postion of a degree encouraged her to seek a metropolitan location, and she opened an office in Chicago. There she married a Civil War veteran employed by the Northwestern Railway, James M. Taylor, who soon began to study dentistry himself under his wife's preceptorship. Chiefly because of the cold climate in Chicago, Dr. Hobbs sold her practice in November, 1867 to Dr. Edmund Noyes. Lucy's husband became her partner and they set up a joint practice in Lawrence, Kansas where they experienced a happy and prosperous association until his death in 1886. Lucy Taylor resolutely maintained her practice almost until her death on October 29, 1910 at the age of seventy-seven.

Dr. Lucy Beaman Hobbs strove valiantly in her own cause and thereby become a beacon of hope and courage for hundreds of American women whose careers in dentistry she had directly and indirectly guided and aided.

ISLAM'S GREATEST SURGEON WHO ALSO PROVIDED DENTAL TREATMENT

Abulcasis (ca. 936-1013)

His writings on dentistry in these books were among his greatest contributions. He laid the groundwork for modern periodontology by recognizing and stressing the need for thorough dental prophylaxis and by devoting a chapter to "the scraping of the teeth." Abulcasis thus accorded this subject as much importance as other surgical procedures while Christian physicians were still irrationally instilling worthless materials into the gingival sulci in an attempt to tighten loosened teeth.

Abulcasis was probably the most advanced dental surgeon until modern times. Since the Kuran forbade dissection and the mutilation of a corpse, surgery languished. It was used only in extreme cases. As a consequence, the extraction of teeth was avoided generally as too hazardous an operation. But Abulcasis did not hesitate to perform this needed service, and his instructions for the removal of teeth are essentially similar to those we use today.
important results stemming from her pioneering par-

career. A slogan was soon developed—"A clean tooth never decays." This was promulgated throughout the dental society with campaigns organized to save teeth through tooth-brushing. When improvement did not always follow from tooth-brushing, efforts to promote a medical hygiene public were redoubled. Later, special medicinal agents were incorporated into powders and pastes with which to brush teeth. These, it was hoped, would neutralize the acid or destroy the mouth bacteria causing caries. This started the toothpaste industry on its path of tremendous growth in the United States.

W. D. Miller was admired by the dental profession and was considered the outstanding scientist of his day in dentistry. In 1885, the University of Michigan conferred on him an honorary Ph.D. and in 1902 the University of Pennsylvania presented him with a similar Sc.D. Four years later, he was appointed Dean of the School of Dentistry, at the University of Michigan. Dr. Miller returned to the United States to accept this position—but death intervened. While visiting his birthplace in Alexandria in July, 1907, he suffered an attack of appendicitis and died following the surgical operation.

With John F. Miller was more than a practicing dentist, researcher and teacher, he was recognized as a leader and organizer in the dental profession. He did much to promote dentistry in Germany; he was president of the National Dental Association of Germany, the Association of Dental Faculties of Germany, the American Dental Society of Europe and later the Federation Dentaire Internationale.

The inclusion of Lucy Beaman Hobbs in the medallic history series is based on several factors, not only of personal accomplishment but also of significantly important changes stemming from her pioneering participation as a graduate student of her profession. Lucy Hobbs is a well-deserving symbolic representative of the women who, over many centuries, have contributed to the development and growth of dentistry.

Lucy Beaman Hobbs was born in Ellensburg, New York on March 14, 1833. The death of her mother began her campaign to become a dentist. But none of the dentists whom she visited would consent to accept her, Miss Hobbs requested the guidance of the kindly Dr. Jonathan Taft, Dean of the Ohio College of Dental Surgery, who permitted her to study in his office until she found a preceptorship with Dr. Samuel Willoughby Wardle.

In 1861, her preceptorship completed, she applied for admission to the Ohio College of Dental Surgery. Following her rejection, she began a practice on March 14, 1861 in Cincinnati without a degree, as was common in those days. However, the far-reaching economic effects initiated by the outbreak of the Civil War in April, 1861 added greatly to the difficulties she would have normally encountered as a woman practitioner. Thinking that the western states would offer a more appreciative hospitality to women, she moved her practice to Iowa.

Miss Hobbs' fine character and her efficient work, which netted her $3,000 in her first year at McGregor, Iowa, were also rewarded in the regard shown to her by the male dentists of the area. Lucy Hobbs was invited by Dr. Luman C. Ingersoll, president of the Iowa State Dental Society, to attend its 1865 meeting.

A crestral lamina may or may not be seen on the radiographs after therapy; this depends more on the topography of the bone and the angle of projection of the roentgen rays, than on the degree of success achieved by therapy.

V. Electrical and Thermal Tests

It is often possible that the vitality of several teeth may be in question following surgical intervention. The primary purpose of the electrical and thermal tests is to determine the vitality of suspicious teeth. Ethyl chloride or ice may be used to test for cold sensation and hot gutta-percha for the sensitivity to heat. The thermal tests do not give any indication of the degree of the degenerative process. The electrical pulp tester gives far more reliable information, but has its limitations.

VI. Occlusal Re-evaluation

The elimination of occlusal disharmonies should be performed before, during and after the planned periodontal surgery. The initial occlusal adjustment should be accomplished during the pre-surgical phase of therapy. If there is significant mobility, gross adjustment should be performed prior to surgery.

If marked mobility persists, then temporary splinting is completed before undertaking the surgical phase of treatment. The final occlusal adjustment, if necessary, is performed after surgery and following any minor orthodontic therapy.

VII. Prognosis

A provisional prognosis of questionable teeth may be made before treatment. It is equally important to re-evaluate the prognosis during surgery and again following the healing phase.

Prognosis should not be determined only by the level of remaining bone. The topography of the surrounding bone is more important than the actual quantity of bone remaining. The radiographic density of the bone may be deceiving, because extremely dense bone may be less resistant to periodontal breakdown than less dense-appearing bone. Less densely calcified bone may be more favorable for the stability of teeth serving as abutments for removable or fixed bridges.

The many intangibles that enter in the prognosis of a case are best described as therapeutic judgment. Some factors that determine the prognosis are:

A. Age of patient.
B. Extent and type of disease process.
C. Etiology.
D. Occlusal factors.
E. Cooperation of patient.
F. The number and distribution of remaining teeth.


Therefore, the prognosis of a case may be summarized as dependent upon:

A. The experience of the operator, his ability to examine carefully and interpret his findings.
B. His judgment concerning the healing capacity of the patient.
C. A knowledge of histology and wound healing.
D. The technical ability of the referring doctor.
E. The patient's cooperation.

VIII. Concept of Cure

No comprehensive formula can be given in the evaluation of the treated periodontal case in order to arrive at a concept of cure or failure. One role that may be helpful is "any tooth or collection of teeth that have become capable of functioning in health may be considered to be cured of disease."

In periodontics, as in all healing arts, the result of treatment is relative. Occasionally, the situation becomes hopeless and some teeth may have to be extracted or complete dentures may become necessary. The degree of success is a variable that depends upon the diagnostic and clinical ability of the therapist, the cooperation of the patient, the objectives of treatment, the systemic status of the patient, and the advancing state of the basic biologic principles and restorative procedures upon which all therapy rests. If the useful lifetime of the dentition has been significantly prolonged, then treatment is successful.
In a sampling of 123 dentists, they were asked what three subjects interested them the most in postgraduate courses. About 65 percent favored crown and bridge as their first choice. Periodontia and endodontia were equally their second preference, followed by implantology, pedodontia, orthodontia, and oral surgery. . . . We’ve got disposable cups, towels, anesthesia cartridges and needles, contra-angles and spatulas. Now there’s a throw-away oral thermometer. . . . Chewing on toothpicks, long frowned upon, may not be such a bad idea after all, if it’s the right type of wood. At least the natives of an African village have been shown to have a significantly lower rate of dental caries which is attributed to the habit of chewing on wooden sticks that are felt to possess a decay-inhibiting substance. . . . Coffee, considered taboo for children, has been shown to have a calming effect on hyperactive children when taken at breakfast and lunch, reports the Hall Psychiatric Institute in South Carolina.

Don’t-Lose-Any-Sleep-Over-It Dept.: If your last dissatisfied patient aired her complaint to just two people and each of these persons told others about it in turn, then in just a matter of hours, everybody in the country would hear about that “filling that fell out”! . . . Nothing-New-Under-the-Sun-Dept.: With the popularity of trading stamps, dentists have been heard to joke about giving away stamps for fillings, etc. But in 1903 some dentists in Indiana were actually offering trading stamps for each dental visit! . . . Wonder why Americans are constantly dieting and worrying about gaining weight? Well, last year about 800 million gallons of ice cream were consumed in the country and that means some 3,710,400,000,- 000 calories! . . . If you’re thinking of investing in a Broadway show, the odds are about 10 to 1 against a return on your money. Of course, if you pick a hit the return in a modest investment can bring a handsome profit. “Godspell,” which was a relatively inexpensive off-Broadway musical, has earned over $4 million for its investors in a few years. Touring companies throughout the world, plus a successful film version, brought in the profits . . . Thirty percent of American orthodontists have more than one office and only 10 percent have been in practice for more than 25 years . . . Hospital charges are highest in California, New York, and Connecticut . . . The Archives of Oral Biology reports that Kanamycin, applied to the buccal surfaces of teeth at least once a day for five-week intervals, can reduce dental plaque and gingivitis in children who do not brush their teeth. . . . During the past year, three major publications, Harper’s Bazaar, Parents’ Magazine, and Reader’s Digest, printed major articles on dentistry. At the same time, it is estimated that nearly 25 million people viewed ADA dental health films on television . . . If your patients are uncertain about the effects of x-rays on their health, the ADA Bureau of Dental Health Education has an excellent four-page leaflet, Dental X-rays and Your Health, that can be obtained at the rate of 100 for $2, or 500 for $9.50. . . . One of the costliest toothaches in history occurred when Sir Hubert Wilkins attempted to cross the North Pole under the Arctic ice in subarctite. Just 300 miles from the Pole, a crowman became so violent when he developed a terrible toothache that he damaged a vital part of the submarine apparatus. As a result, they had to turn back and the mission was scratched at a cost of $200,000.

FOOD FACTS AND FALLACIES

As dentists, we should know better, but many of us are still taken in about food myths. Just to set the record straight here are some common facts and fallacies about food:

1. Mixing certain foods, such as drinking milk after eating pickles, can cause distress. Not so. As long as foods are not harmful when eaten singly, the order in which they are ingested has no detrimental effect.

2. Hot bread is hard to digest. Not so. Hot bread is harder to digest than cold bread. It's just that hot bread is more difficult to chew; so people tend to swallow it without chewing it.
teral teachers and researchers are needed each year to maintain present student-faculty ratios and existing dental research.

The Research Dilemma

Some of the world's greatest medical discoveries have been made possible by private funding. Both the Salk and the Sabin anti-polio vaccines, for example, were developed through private funding from the National Foundation-March of Dimes. In dentistry, however, many promising research projects lie idle because of a lack of funds. They cover a range of problem areas, including the nutritional implications of tooth decay, the control of pain, and new methods to prevent the occurrence of dental disease.

Much dental research in recent years has had to depend on government financing. But this is an unstable source, subject to fluctuation from year to year. An example of the instability of federal funding is the drop in the proposed budget for general dental research from $55,212,000 in 1972 to $38 million in 1974.

Private funding is needed now in all areas of dental research for deserving projects which can make important contributions to the prevention and relief of dental disease. It is through private funding, moreover, that the continuity and the highest possible standards of research can be maintained.

Dental Health Delivery

Many special projects are needed so the profession can begin to solve some of the serious problems in the delivery of dental care. Many people lack access to care because there are inadequate numbers of dentists in the community. This is often the plight of the poor, the institutionalized, the aged, the handicapped, and residents of rural and inner-city communities.

There is a great need to find new ways to bring the dental health message to the public. Dentists need to find new methods of motivating patients to maintain good oral hygiene. Those who neglect their dental health by not seeing a dentist also need strong motivation.

National Objectives of AFDH

Now and in succeeding years the American Fund for Dental Health is dedicating itself to the achievement of the following objectives:

1. Impressions that allow for a retentive base.
2. Obtaining the correct vertical relation of the incisors.
3. A centric occlusion in harmony with the centric relation of the denture.
4. Toast is less fattening than untoasted bread.
5. Raw meat is healthier than meat that is well done.
6. A perfectly balanced occlusion.
7. Proper extension of the borders and correct contour of the polished surfaces of the denture base so that normal activity of the musculature of the lips, cheeks, and tongue help to stabilize the denture rather than displace it.

COMMUNITY DENTISTRY

At a time when widespread dental services are more urgently needed in our society and when Congress is debating national health service plans, Dr. Clifton O. Dunnmott, associate dean of the School of Dentistry at the University of Southern California, has written an important and compelling book, Community Dentistry. Whatever one's views, the successful implementation of community dentistry depends upon the practitioner of general dentistry. This book presents "...the conflicting forces which make living in the modern world confusing and difficult, yet at the same time, fulfilling and challenging." Only by an understanding of the roles played by the producer and consumer of health services, and of the role of the disadvantaged Americans can one begin to comprehend what community dentistry really means. All this, plus a review of the "new concepts of dental practice designed to improve delivery systems of dental care are examined, their assets portrayed and their liabilities noted."

Community Dentistry is published by Charles C. Thomas, Springfield, Ill., and is a monograph in the Banister-Robinson Division of American Lectures in Dentistry.

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Every member of the dental profession would be quick to agree that in the concern for man's total health one of the less well-recognized needs is for good oral care, the province of dentistry. The importance of dental health has not been brought to the attention of the American public forcibly enough. Nor is the private sector, for the most part, aware of the great need for financial support of dental education and research, the mainsprings of good dental care. Increasing awareness and support of those needs is the challenge and the charge of the new American Fund for Dental Education. This culminated in the change of name to American Fund for Dental Health.

During 1973 the groundwork was carefully laid to meet this challenge with a broadening in scope of the interests of AFDH's predecessor, the American Fund for Dental Education. This culminated in the change in name to American Fund for Dental Health to reflect the new directions. The Fund's plan of action includes many new programs and new efforts to achieve objectives that are vitally important to the dental health of the American public and to the dental profession.

Three Main Thrusts:

Education, Research, and Health

The Fund will continue and increase its support of the nation's dental schools through various programs of student aid and faculty support. This will include assistance to dental and dental auxiliary students—hygienists, assistants, and laboratory technicians.

In meeting new objectives, it will also be involved in generating urgently needed funds for research in the treatment, prevention, and cure of dental disease. It will also be channeling major efforts in a third direction: to improve the dental care delivery system. This effort has already borne fruit with a $4.7 million grant from the Robert Wood Johnson Foundation, administered by AFDH, to train dentists in treatment of the handicapped.

The American Fund for Dental Health is now the primary agency for fund raising in dentistry. It has assumed the fund-raising and research granting responsibilities of its predecessor, the American Fund for Dental Education, as well as the American Dental Association Health Foundation.

People-Oriented Programs

All of the Fund's efforts will be conducted at both national and local levels, with the assistance of volunteers who will personally solicit the Fund's sources of support. This will require many more volunteers and a much stronger emphasis on personal solicitation. Over the years, the dental profession and dental industry have been two of the Fund's major sources of support, and it will continue to rely heavily on these two sources to further its goals.

Commenting on the potential of the new AFDH, President Donald J. Galagam, D.D.S., who also serves as Executive Director of the American Association of Dental Schools, said: "Last year 15 of the leading national health agencies raised $324.6 million in private, voluntary support for education and research. This was a 12 percent increase over the $289.9 million raised in 1972. Among these organizations, dental health was conspicuously absent from the roster of major health organizations. Through the American Fund for Dental Health we now have the potential to bring to dentistry the major support that has been so long needed—both within the profession and in its relations with the public it serves."

Needs in Education

Dental schools and their students are suffering from the financial demands of providing and obtaining a dental education. In four years of dental school, for example, the cost to the student of tuition, equipment, and living expenses can run as high as $25,820 for a single student or $36,200 for a married student; and this is with minimum living expenses. Dental education is one of the most expensive of all health professions to the student.

Also by financial pressures caused by the upward inflationary spiral and cutbacks in government funding, many of the nation's dental schools are financially distressed. There are now 58 operating dental schools. The majority, 34, are supported by public funds; 16 are supported by private funds; and eight by both private and public funds. In the past two years two private schools have been forced to close because they could not afford to continue to operate.

FacultyVacancies

Many dental schools are understaffed because they can't get enough qualified teachers. In 1973 the ADA Council on Dental Education reported 483 faculty vacancies—positions that had been provided for in school budgets. The Council also reported an additional 515 unfilled vacancies because of lack of funds. According to the American Association of Dental Schools, at least 200 scientifically-trained dentists (Continued on Page 10)