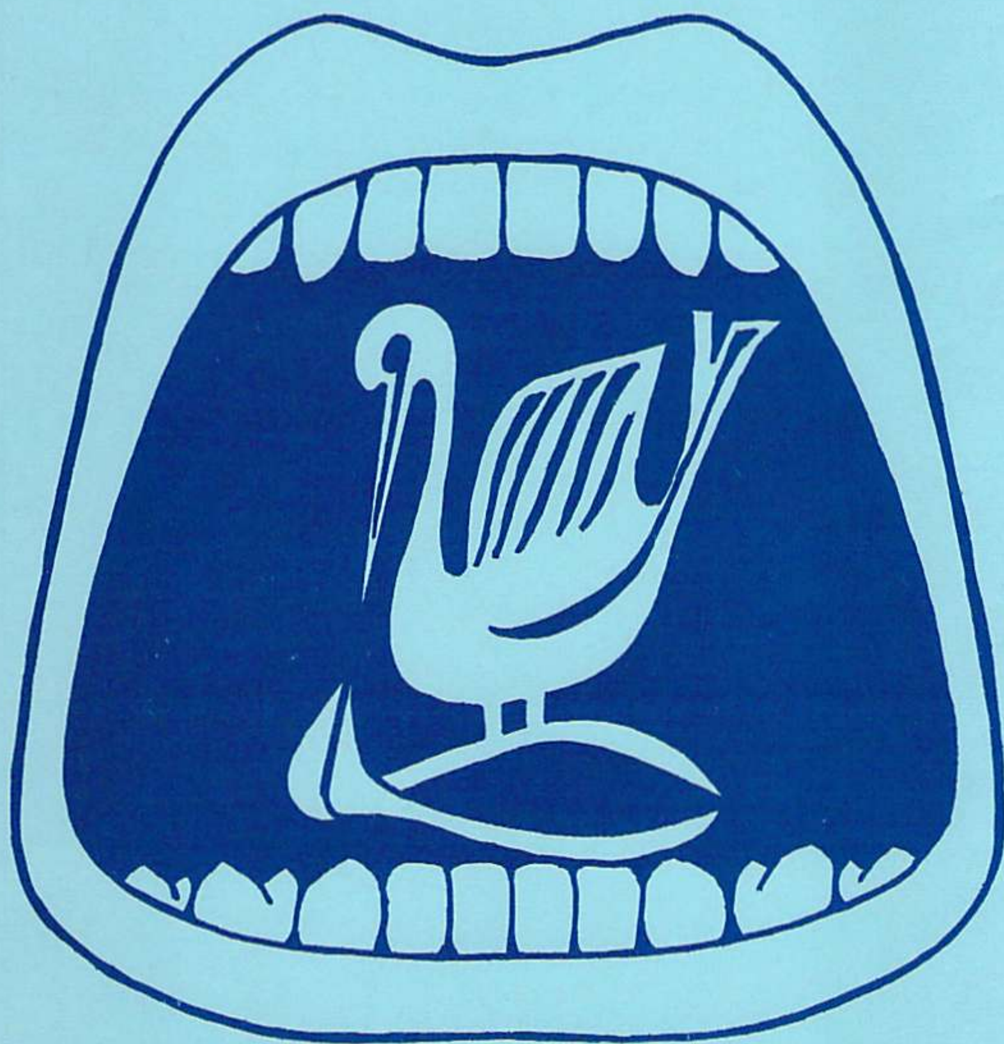
MOUTHPIECE



The magazine of

U. B.D. S.S.

EDITORIAL

To all the people who have been asking me all the time "When's the next Mouthpiece coming out?" here, it is, and quite a nice thick issue for only 5p, if I may say so.

I feel quite flattered, in a way, that there are people out there so anxious to read all the articles I write in order to fill the magazine up with something other than B.D.S.A. Committee Meeting Reports, and the like. On the other hand, I should appreciate it if those people who pester me all the time about the next issue, would stop talking for one minute and actually put pen to paper and contribute something themselves, then perhaps Mouthpiece would be published more often, or would be a much thicker magazine.

In order to encurage this, I have abandoned the lucky number idea that accompanied the Oral-B advert. Instead of taking a gamble whether or not you win one of these rather expensive toothbrushes, you can now make your toothbrush a certainty by writing articles for Mouthpiece: for each article or collection of small poems/funnies etc., that fill a page or two of Mouthpiece, you will receive a Perio. Dept. approved toothbrush as well as the usual prestige of having your article published in an 'academic' journal (payment on publication).

The other reason why I stopped the lucky numbers was because it was it was originally intended as an incentive to sell all the copies of Mouthpiece. I am sure most of you will agree that if we have to descend to this sort of level, similar to putting free gifts in Beano comics or Good Housekeeping magazines, in order to sell a dental school journal to its students, then it doesn't say much for those students. Fortunately, most of us are not like this, judging from the numbers sold in the past ... but, before you pat yourself on the back for buying a Mouthpiece, ask yourself how often you have helped the U.B.D.SS. - <u>your</u> society - of which this magazine is part. Have you ever helped clear up after a disco, or are you one of those that helps themsleves to the drinks behind the bar outside normal functions, when you feel like it? Do we have to have locks on <u>everything</u>? Have you ever bothered to write anything for Mouthpiece or are you one of those that won't even fork out 5P and buy a copy? I'd sooner give you a copy than hear some of the squirming excuses for not buying it.

To the few students, out of nearly everyone whom I asked in the common room, who helped to staple this issue together, I thank you, on behalf of those of us who actually bought a copy.

VOL. 4 No. 4

G. C. DOWNER
Editor of Mouthpiece.

U.B.D.S.S. AUTUMN LECTURE

TUESDAY NOVEMBER 11TH

BY DEREK SEEL

CONSULTANT ORTHODONTIST FOR CARDIFF AND S. GLAMORGAN

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The clinical lecturer pointed a the X-ray viewer.

"It is clear from this X-ray that the patient's lower right six has an acute non-suppurative apical periosontitis which accounts for the patient shooting through the roof every time I put pressureon it. Now, Miss Hepenstal what would you do in a case like this?

The student brooded for some time, andthen replied earnestly:

"I suspect, sir, that I might shoot through theroof too!"

A dentist was taking a walk with his wife when a vivacious young blonde waved to him.

"Who was your friend, dear?" enquired his wife.

"Oh, just a young person I met professionally," he explained airily.

"Professionally, heh?" cooed his wife. "Yours or hers?"

"This may hurt a little," said the dentist as he pressed the button on his electrically powered chair and approached with the syringe.

Suddenly the patient let out the most agonised howl.

"What's the mater with you?" said the dentist, "I haven't touched you yet!"

"Not with the syringe you haven't, said the patient, "but my right knee's jammed underneath your bracket table!"

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I should like now to thank Professor John Smith B.D.S., Ph.D., F.D.S., L.R.C.M., M.R.C.V.S., B.Phil., R.S.A., whose suggestions, encouragement, advice and enthusiasm throughout the formation of this advertisement, from conception to delivery, have been of great help. My thanks must go also to Dr. Peter Moron of the University Department of English for his assistance in proof-reading, and of course to Miss Amy Rowbottom for the secretarial work. Finally I must express my appreciation to the Editor and my publishers for their most valuable criticisms and patience. I should like to respectfully dedicate this to the furtherance of American Dental Literature.

ALFRED SWEETIE
University of Botswana, 1975

.. ..

A man presented himslef at his dentist's surgery with his gums and tongue covered in green blotches. The dentist had only just qualified and was completely mystified by the symptoms: even reference to his Shafer, Hine and Levy provided no enlightenment. He felt his status as a diagnostician to be in jeopardy.

"Tell me," said the dentist, "have you ever had this before?"

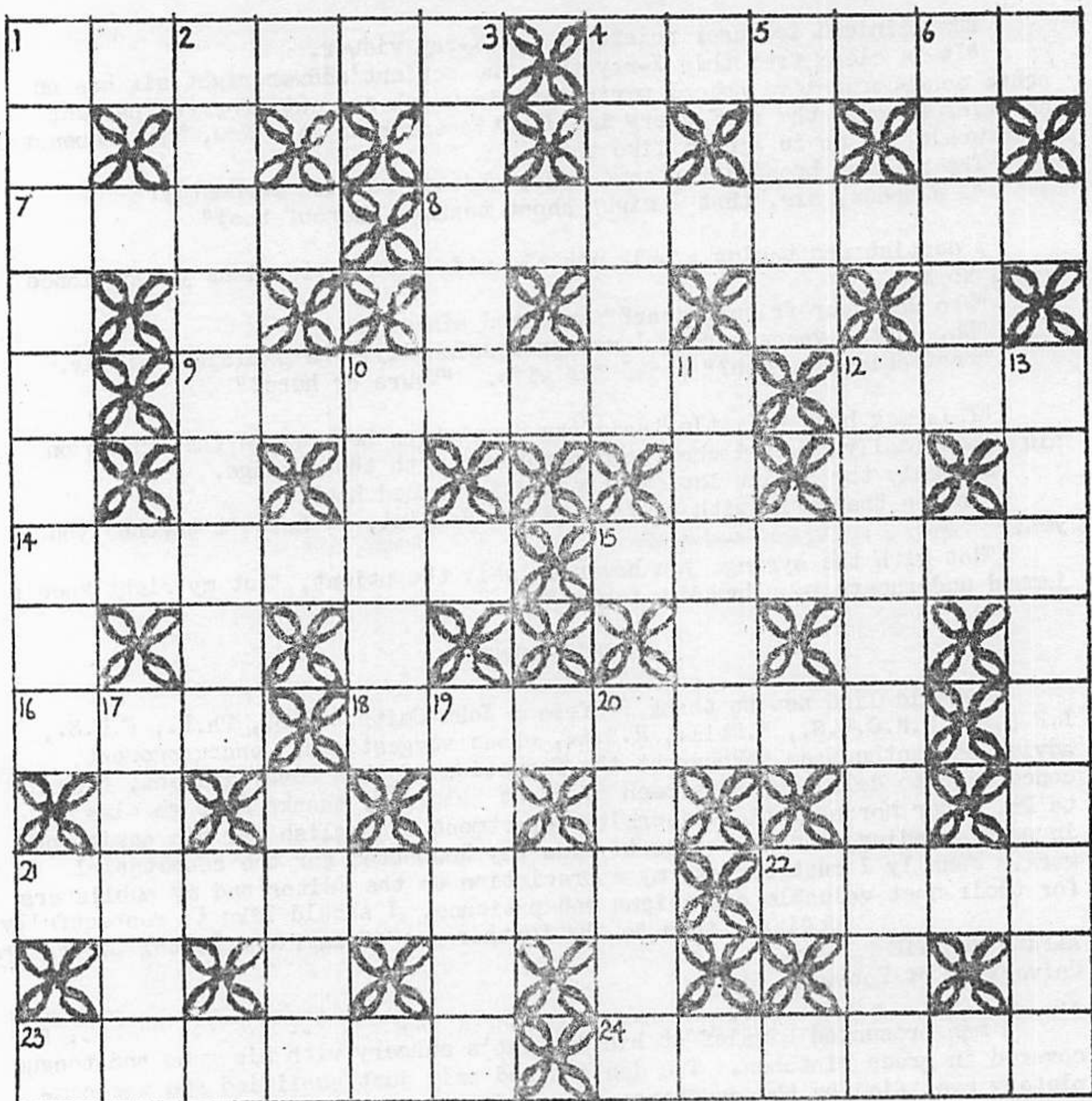
"I certainly have, Doctor," the patient replied impatiently. "I got it seven or eight times last year."

" In that case," announced the dentist, "I reckon you've got it again!"

CONSULTANT: a colleague who is called in at the last moment to share the blame.

OVERHEARD IN EXAM DEPT.

Dentist: And how often does this terrible toothache come on?
Patient: Every three minutes. Dentist: And how long does each attack last?
Patient: Oh, at least twenty minutes.



Mouthpiece Crossword

C L U E S

ACROSS

1. Pertaining to our chosen profession (6)
4. I scare to get our arch-enemy. (6)
7. A note from scent is upset, probably in a tree. (4)
8. Conquer (8)
9. Charlie is ... but is Arthur? (7)
12. The dental profession's governing body (initials) (3)
14. The god loses point from his axe and is studied in anatomy. (6)
15. Good control of this is essential during restorative work. (6)
16. Affirmative. (3)
18. Applied to fissures of newly erupted posterior teeth. (7)
27. Work should be ... before going on. (8)
23. Some surgical procedures can become this. Adrenaline helps the problem. (6)
22. Again loses first letter becoming a stimulant. (1,3)
24. These are the green wires in cables. (6)

DOWN

1. We have all let ourselves in for it! (9)
2. Changed spoons rode and were applied to nostrils. (4,5)
3. Palindromic description of floor of perfect classical class I cavity. (5)
4. Pelican one contains religious person. (5)
5. Massacre. (4)
6. A tooth for extraction should be...bucally and palatally before being delivered (5)
10. An operator ... the root canal during endodontic treatment (5)
11. Old name of African country whose main export is cocoa beans, (5)
12. We should do this on to the just prior to extraction. (4,5)
13. 13th letter plus scan tail upset for the demanders. (9)
17. Support for the blackboard (5)
18. Written piece. (5)
20. We do not want one on our Class II restorations. (5)

A N E C D O T E

Once upon a time an army commando came into casualty with a vague ache. On examination the dresser could find no obvious cause, and so he decided to try vitality tests. Ethyl Chloride gave no response on any of his teeth; next the pulp tester was brought into action. Even on the highest setting the dresser could get no response so a member of staff was asked: still no response. As neither of them knew what to do next the patient was sent downstairs with a nurse for some X-rays. On his way to the X-ray Department the nurse asked him if he was O.K..

"Oh yes," he replied, "but that last thing didn't half hurt - I nearly had to yell out!"

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MOUTHPIECE:-

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From a letter from Groucho Marx to Harry Kurnitz:

'I liked the piece in the January issue very much, and as soon as I can go to the dentist I will read the February issue.

Incidentally, this dentist of mine is a gay fellow, a bachelor. Instead of stocking his anteroom with the National Geographic and articles on Soil Conservation, he has Confidential, Rave, Holiday, "Fanny Hill", "Call House Madam", and "A House is not a Home".

His assistant, who cleans the teeth before the Master deigns to step into the horror chamber, is a part-time whore, and can be seen soliciting between Burbank, Glendale and Maywood on Wednesdays, Saturdays and Sundays. On those days the dentist is absent. He has either winged to Las Vegas to lose the exorbitant sums that he extracted from me, along wth my teeth, or is surf-riding in Acapulco.

The whole dental professeion, in addition to being corrupt, is a dubious one. When you open your trap in a dntist's office, and he seems to peer down your gullet, the chances are he's not even looking there. He's trying to estimate (rapidly) who made your sports coat and whether the jewellery you're sporting is the real thing or some thin plate you borrowed fom your wife.

I heartily disapprove of dentists goint to Vegas, Acapulco, or any other famcy resort. A dentist should stay in his office with his part-time whore, his glittering macines, his inlays and that goddamned abrasive that he slaps on your fangs at the end of a day's grinding.'

---oOo---

THE AFFLUENCE OF INCOHOL

I had these bottles of whisky, 18 in all, and was told by my wife to empty them or else!

Having agreed, I proceeded with the unpleasant task.

I drew the cork of the first bottle and poured the contents down the sink with the exception of one glass which I drank.

The second bottle was treated in exactly the same way: I drew the cork and poured away the contents and kept back a glassful to drink.

I pulled the bottle from the cork of the next and drank one sink out of it, then I threw the rest down the glass.

Cont.

The Affluence of Incohol cont.

Pulling the sink out of the next gass, I poured the cork down the next bottle.

Then I corked the sink with the next gass, bottled the drink and drank the pour.

When I had everything emptied I steadied the house with one hand: counted the glasses, corks, bottles, and sinks with the other, ammounting to 29, and as the house came by I counted them again.

Finally, I had all the houses in one bottle, which I drank.

I'm not under the affluence of incohol as some tinkle peep I am, and I'm not half as thunk as you might drink.

I fool so feelish I don't know which is me and the drunker I sit here the longer I get .... Hic! .... Burp!

---oOo---

THE FUTURE OF THE DENTAL SMOKER

As all will know who read the Aylesbury Hean Swines gazette and this month's Mouthpiece Weekly, a Review Group has been set up under the capable administration of Ken Marshall. A meeting was held a fair time ago to discuss possible ideas for the next Dental Review. A unanimous decision was made to hold some sort of 'Smoker' in the near future, like August 1979, so that we would have nothing to do with it. This was declared, however, a silly idea, so hard luck, people, it looks like you're set for a firther three hours cringing in your seats watching a bunch of loonies trying their best to be funny.

Even though this 'review' would not take place until next Christmas, it would be nice to know how many people are interested. This would, of course, tell us who the talented people were so that we could excluede them from the programme and get all the praise ourselves - oh what a give-away! So if anyone feels that they have a claim to fame would they like to see me along with any ideas they have, songs, sketches and the like.

Not only are we interested in putting on a review, we are also planning some form of cabaret for the Dental Ball. It is not clear what context this will take but certainly a stand-up comic, impressionists (not Des O'Connor or Rolf Harris), magicians and singers will be needed. So if you think you could be another Frank Sinatra, I should go away and practice and while you're doing that, push off. Acts including balancing gibbons on your head, juggling Annona Wynne/

The Future of the Dental Smoker cont.

whilst playing 'oranges and lemons' on a row of lower-incisors on a one-way hovercraft, will not be accepted because I'm already doing that. Magical acts like making the hospital disappear, however, and changing the staff into garden gnomes, will be greatly appreciated.

Don't be shy. Throw away your inhibitions and give them to me, as I collect them.

Before we have another meeting of his so-called clever-Dick review group, we should like to sum up with something concrete (it's these exams you know) so if you have any ideas, just let me know. This, of course, doesn't apply to the student masses only, members of the staff are most welcome to air any views they might have, whether they would like to take part in any sketch or not. So if any of the staff or technicians are reading this article, I didn't really mean that about the garden gnomes, on the other hand if you're not reading it, I mean every word!

.. .. Phil Key

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.. ..

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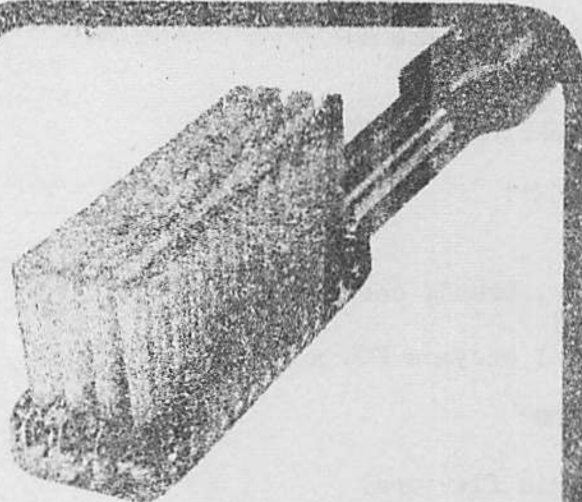

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L E C T U R E S -

a review of current thinking

The existence of the pathological organism, the Lecture, has recently been implicated in the aetiology of such diseases as lecturephobia (L.P.), lecturemania (L.M.), lecturia, etc., as froup of diseases often referred to as the lecturitides. Previous workers have tended to limit their studies to either the psychiatric or physical manifestations of these diseases. According to Bordum and Tedium (1), the lecture organism is responsible for both L.M. and L.P.. The term organism is used advisedly, for although Abstruse and Phutile (2) claim to have isolated an organism, L. soporifica, their work has yet to receive confirmation (3). Recent work has given the hope that brain biopsy of the deep grey matter (4) and differential immunofluorescence (5) may yet demonstrate the relationship between the physical and psychiatric lecturitides.

The classical description of the psychiatric lecturities (L.M. and L.P.) was given by Epheet (6), a review of whose findings we summarise here.

LECTUREMANIA

Description: A tendency to spend willingly four afternoons per week in a darkened over-heated room with fellow sufferers, independent of the weather outside.

Incidence: Principal age range: 18 - 25 years. Although the population at risk has sex ratio of about three males; one female, the sex ratio of sufferers is about 1 : 1.

Aetiology: This is largely unknown, although some workers implicate an early deprived cultural background.

Presentation: Patients are pale and weak due to lack of sunlight and exercise. Prolonged polygraphia leads to hypertrophy of the right thenar and index finger muscles. The patient's conversation is limited to a discussion of his/her symptoms and may be associated with reading hand-outs in bed.

Diagnosis: This is largely on the clinical picture, but some find measurement of the mean cerebral quotient (M.C.Q. for short) useful - a high score indicating a positive diagnosis, though some workers dispute the reliability of this test.

Treatment: Mild cases are best treated conservatively with reassurance and a prescription for some light reading (7). For more advanced/

/cases a more radical approach may be called for - one that has been tried with mixed success is to send the ptient abroad for three months ('an elective') in the hope that a change of culture may be of benefit. This practice should perhaps have a wider application.

Prognosis: In general the longer the period of affliction the worse the prognosis. Complete cures even in advanced cases have, however, been recorded but some advanced cases of completely moribund minds have been seen.

Associated conditions: (1) Myopia.
(2) Generalised myopathy with wasting.

LECTUREPHOBIA

Description: A feeling of cokplete boredom and lethargy on entering a darkened hot room for an afternoon. Attacks are particularly likely to occur when the weather is good.

Incidence: The same range and population as for L.M. but a sex ratio of approximately two male: one female.

Aetiology: Some workers doubt whether this is a disease at all, but simply regard it as a normal reactive state induced by many years of exposure to lectures.

Presentation: Patients are usually in good general health, but on entering a lecture theatre, a misting-over of the eyes, a drooping of the lids and shoulders, and a slow shuffling walk (lecture ataxia) become apparent. Patients complain of an overwhelming desire and tendency to fall asleep, especially if subjected to a barrage of hand-outs and/or a soporific voice.

Diagnosis: As for L.M. this is largely clinical, but some regard a low M.C.Q. as a useful pointer - it is probably even less reliable than a high M.C.Q. for L.M..

Treatment: In the short term, removal and revival with a cup of tea will usually be successful, though occasionally symptoms may persist for the rest of the day. In the long term, relapses are more than likely, unless exposure ceases. Paradoxically, an elective as for L.M. may prove helpful for a while, but post-elective relaps is a well-documented phoneomenon.

Prognosis: Excellent if re-exposure is avoided.

Associated conditions: Narcolepsy.

cont.

LECTURES - review cont.

The physical lecturides are rare except for lecturis (known in the XIXth century as the "Lecturer", scourge of many a medical or dental school). In their recent paper, Borrow, Knoates and Reid (8) described the opidemiology of this disease. They studied 1,342 affected individuals and came to the following conclusions about lecturia:-

Heredity: Cases occurring in members of the same family have been recorded, but it is not yet clear whether this is environmental or due to sme sort of genetic predisposition.

Sex: 75% male; 20% female; 5% dubious.

Age distribution:

5%	30 years and under
25%	30 - 50
45%	50 - 90
20%	70 - 90
5%	90 and above

N.B. Care must be exercised in dating affected individuals, since the disease seems to cause premature ageing.

Predisposing factors: (1) A professorial chair.
(2) Chairmanship of a course committee.
(3) Both.

Clinical Presentation: A proportion of cases will tend to
(a) talk to the blackboard
(b) talk to their waistcoat
(c) both.
Some workers also consider a stooping stance and poorly fitting suit as virtually pathogenic.

Associated conditions: (1) Aphasia - found in about 5%.
(2) Delusions of grandeur - found in about 10%.

In conclusion, it may be said that much work remainsto be done in elucidating the precise relationship between the lecturides, and their exact pathology. The authors, however, would like to suggest that the day is not far removed when lecturis, L.M. and L.P. will be recognised to be but different manifestations of the same clinical syndrome - the Lecture Syndrome.

1. Bordum and Tedium: B.M.J. (1972) 115, 642
2. Abstruse and Phutile: B.J. Bact. and Virol. (1970) VIII, 69.
3.
4. Burr and Needle - personal communication (1973).
5. Divine Communication: J. Transcend. Med., Nov. 1973.
6. Epheet, U.S.: Mania and Depression in Education. Gnome Press (1965)
7. Walton, Su.,: Horace Sippog and the Siren's Song.
8. Borrow, Knoates and Reid: J. Nursery Ed. (1964) CXIV, 619

For "MOUTHPIECE", Summer 197[illegible]

ENVIRONMENTAL LEAD DETECTION IN BRISTOLIAN TEETH

Dental scientists are interested in possible links between caries and several trace elements present in the diet. Environmental scientists are aware of the record that toxic trace elements leave in teeth as they form. Several studies, where shed deciduous teeth were analysed, have shown geographical or secular trends in levels of lead, cadmium and radioactive strontium. In the U.S.A. a five-fold difference was seen when comparing levels of lead in such teeth from suburban and ghetto children living in the same city.

When the lead smelter at Avonmouth was closed during the early part of 1972 blood-lead analyses were called for and several hundred children were monitored. Several analytical studies within the University were then providing relevant data for the "Sabrina Project". Within this framework there was a welcome offer from inorganic chemists* to analyse teeth for a number of trace metals, including lead, and the city's Chief Dental Officer approved the collection of teeth at several school dental clinics within the urban area.

We were gratified to find such similar values for these metals in a group of teeth analysed in the summer of 1973 to those we had found in the previous summer. When the locations of the donors were plotted on the Bristol map(see opposite) they were found to be equally divided by a line running through the centre of the urban area towards the Avonmouth industrial complex. The map shows the locations plotted as 40 "above-average" and "below-average" values, the distributions in the two sectors being 14:6 and 6:14. But the mean concentration of lead in teeth from those living in the area to the north and east of, the dividing line was 30% greater than that for the area to the south and west. This was not the case for the other six metals analysed in all these samples.

The area with the higher tooth lead values is the one that would be expected to be exposed more to pollution carried by the prvailing wind. However, it is likely that this effect would be superimposed on a more uniform uptake of lead from diet and from petrol combustion. Whatever the reasons we have a case for continuing this environmental monitoring in future years.

* Andrew Burkitt, M.Sc.
Graham Nickless, Ph.D.
(Reader)

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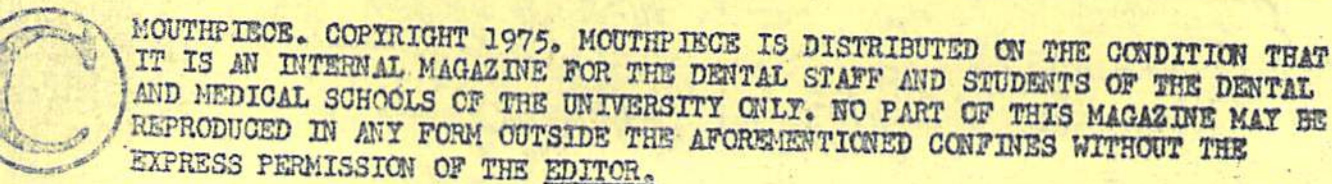

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OCULAR HAZARDS TO PATIENTS DURING DENTAL TREATMENT.

In common with other occupations concerned with the drilling, scraping or polishing of brittle materials, dentists run a constant risk of foreign bodies entering their eyes. Although it has been suggested that protective glasses should be worn both by practitioners and assisting technicians, delicate intra-oral procedures may be rendered more difficult by the deposition of spray and debris on the lenses. Every dentist is aware, however, of the risks of minor ocular injuries and conjunctivitis secondary to the introduction of infected material into the conjunctival sac. In this article some of the hazards of dental treatment to patients are discussed, and suggestions offered concerning precautionary measures which may be taken.

Foreign Body Injuries.

In the standard sitting position the likelihood of tooth fragments or scale striking the patient's eye are remote, as particles projected upwards are protected by the roof of the mouth, or fall well away from the patient's face. With the more recent adoption of the prone position and the dentist working, to a large extent, over the patient's face, particles forcibly ejected from the mouth are more liable to fall into the open eyes of the patient. Such materials, being of low mass and velocity, are not liable to penetrate the ocular coats, and are normally removed by the blink reflex and hypersecretion of tears occasioned by ocular irritation. Nevertheless, such an episode can prove embarrassing to both dentist and patient.

Work performed with the patient placed in the prone position does, however, carry very real hazards. If sharp instruments are carried across the face and are inadvertently dropped, ocular perforation is a distinct possibility. Corneal perforation with damage to the crystaline lens resulting

in permanent disability have been reported on such occasions. Unsterile instruments piercing the ocular contact, furthermore, may result in intraocular infection. Chemotherapy is rarely successful in preventing severe ocular damage, as the optical media are avascular and form an ideal culture media for pathogenic organisms.

Trays containing heavy bottles and noxious fluids are often positioned above the patient's head to facilitate the work in progress. A clumsy movement, therefore, is all that is required to precipitate such containers and contents on to the patient's face or eyes, possibly resulting in severe ocular damage.

It is suggested, therefore, that when work is to be performed with the patient in the prone position the patient's eyes be adequately protected on every occasion, that sharp instruments should never be passed across the patient's face, but always brought in from the side, and that trays be positioned so that there is no possibility of their contents falling on the patient.

Ocular Hazards of General Anaesthesia.

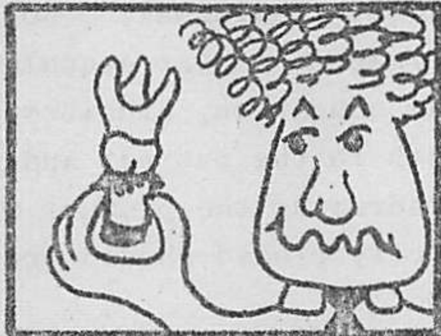
Lid closure may not be complete in patients under general anaesthesia, especially if there is any degree of ocular protrusion, as in dysthyroid disease, or paralysis of the lid muscles as in a Bell's Palsy. Exposure keratitis, or worse, a corneal abrasion, can occur as a result of drapes being pulled across the unprotected globe. Such injuries may become infected and result in temporary or permanent corneal injury. If there is any doubt about adequate lid closure, taping together of the lid prior to the commencement of surgery is a simple and worthwhile procedure.

Loss of Vision and Diplopia Following Mandibular Blocks

There have been several reports of transient loss of vision in the eye on the same side as the injection site, and of patients complaining of double vision after this procedure. The mechanism is believed to be due to entry of the needle tip into the inferior alveolar artery. In a small percentage of patients the blood supply to the globe does not come from the ophthalmic artery, but a branch of the middle meningeal. In these individuals local anaesthetic agents introduced into the inferior alveolar artery pass retrogradely into the internal maxillary artery, and thence to the middle meningeal. No patient has been reported to have permanent ocular sequelae following such an episode, but this condition, albeit rare, can prove very distressing both to the patient and the practitioner. The practice of withdrawing the plunger of the syringe when the needle is correctly placed should prevent this situation from occurring.

In this short communication a number of the ocular problems which may happen to patients undergoing dental treatment have been outlined. It is easy to forget the need to protect delicate structures close to the operative field, though this is often a very simple matter. The fact that such ocular accidents are rare in no way absolves the practitioners from over-all responsibility for any injuries incurred while the patient is under treatment.

Mr. J.C. Dean Hart
Bristol Eye Hospital.



SOLUTION TO CROSSWORD

ACROSS
1) Dental 4) Caries 7) Nest 8) Vanquish 9) Darling
12) G.D.C. 14) Thorax 15) Saliva 16) Yes 18) Sealant
21) Assessed 22) A gin. 23) Bloody 24) Earths

DOWN
1) Dentistry 2) Nose drops 3) Level 4) Canon 5) Root
6) Eased 10) Reams 11) Ghans 12) Grip tight 13) Claiment
17) Easel 18) Essay' 19) Ledge

A MOUTHPIECE EXCLUSIVE INTERVIEW WITH MATRON ON HER RETIREMENT

"What sort of interview was this going to be?" was the first thing that entered my head, as I was ushered into Matron's office, desperately trying to think of an opening remark that would sound reasonably intelligent on the samll tape recorder that was to record this conversation. I did not know at the time that Matron had just come up in the lift with Frances, the orthodontics department receptionist, and a nurse, saying how nervous she was because of the interview with Mr. Downer. I think I should have appreciated it if I had, then perhaps I might not have dropped the cassette recorder and spilt the batteries all over the floor. An understanding smile spread across Matron's face, and as I stuffed the batteries back into the remains of this source of acute embarrassment I sensed that we were now both perfectly at ease - I had made my "intelligent" introductory gesture!

Mrs. Moore, known by her maiden name as Sister Davidson, came to the Bristol Dental Hospital in January 1953, three years after her marriage, when there was only a total of 36 clinical dental students and 40 chairs in the hospital. Her only previous contacts with dentistry were the predictable cases of toothache that came into the B.R.I. Casualty Department where she was the Casualty Sister for six years. After this, she went abroad as a ship's sister on the maiden voyage of the new 'Orchides' in 1948 when the ship broke a record by reaching Australia in three weeks. This spell of maritime nursing was followed by posts in many hospitals and clinics before Sister Davidson arrived here at the Bristol Dental Hospital to fill the vacant position of Sister-in-Charge.

At that time there were just two staff nurses. Unknown to her one of them had already applied for the job, and Sister Davidson was welcomed here with the comforting news that if the staff nurse didn't get the job, the students would riot! We know the outcome, of course, and the students didn't riot. What of the staff nurse? She married a dental student and left when he qualified, so that solved that problem.

It was tough going at first for someone used to bedpans and bandages to be thrown in the deep end amidst such strange jargon as Eaglebeak, Hawk's Bill, Pelican, Parrott, and Hornbeak forceps! She must have thought the place was some kind of aviary, and so she was understandably cagey about it all in the beginning. Time soon flies, however, and one of the many things she noticed whilst she was here was a friendly, personal atmosphere among all levels of a highly professional team. It is a situation where the staff, students and nurses all have a reciprocal respect, and in order to preserve this Christian anmes should not be used in he clinic, nor should anyone be addressed by his/her surname only, without the courtesy title of Mr., Miss or Mrs.. Little things like this all count.

One of Matron's first students here was Mr. Treweke. Three other/

/students that she has seen pass through the dental hospital are now professors, and in order to spare their embarrassment, their names are not mentioned here. She remembers one of them sitting his final exam, in which some practical task had to be performed e.g. casting a gold inlay or restoring a tooth amalgam or silicate etc. After a few minutes there was a despairing wail for help emerging from a chair, and when she came across, she saw a worried-looking student standing next to his patient, with the remains of a dental engine and cord-arm trailing on the floor from the handpiece which he was holding in front of him. "I think it's not working as well as it should be!" was all he could think of at the time. It seems that dental units have broken down since time immemorial, so things haven't changed much.

Another of these three select students provided her with entertainment of a much more spectacular nature: to her horror, she saw a bracket table suddenly burst into falmes. What was more mystifying was the sight of this dental student standing next to his burnt offering, with his arms folded and a look of calm but studious interest on his face as he supervised the spectacle. Before anyone had the chance to have a nervous breakdown he announced authoritatively that he had just read that the best way to sterilize a bracket table was to alcohol it and set light to it. (We are left to assume that Matron pointed out to him that it may not be the most practical way.)

The third student came up to the store in cons. one morning, looking very pale and asked: "Er ... Can I have a, er, swab please?" When Matron asked what he wanted it for he said "Er ... nothing ... just thought it might be useful ... well, actually the House Surgeon wants it, I think ... quickly!" Following the student soon led Matron to his patient who was pouring blood from a lacerated tongue resulting from a runaway, unguarded diamond disc.

Matron's Parting Advice to Students: Always keep your sense of humour because there always is a funny side to everything even if it is 5.00 p.m. and the patient has just destroyed an afternoon's hard labour by biting the marginal ridge off an extensive pinned amalgam in front of an external examiner with indigestion, so that you have to put a temporary dressing in, but your entire cabinet has just fallen on the floor and spewed its contents and the nurses are glaring at you because it's late and they want to get away ... Remeber there's always a funny side! Always stay calm and always try to be fair. Remember the Dental Nurse who has been helping you; a little coutesy and a thank-you go a long way.

Matron's Parting Advice to Staff: Although the temperature often rises/

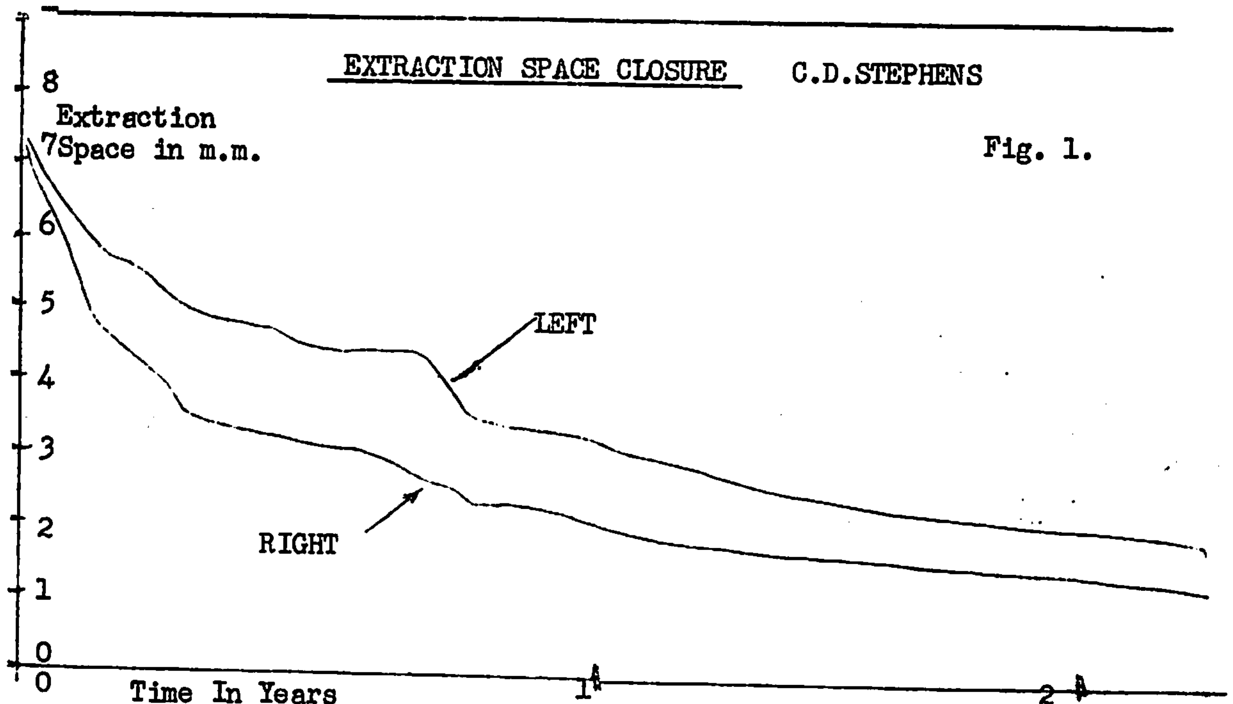
/and there are many other worries and committments, always count to ten rather than say something to an erring student that you would regret afterwards. Remember that although harsh words in an ordinary everyday context do not cause too much damage, they are a major catastrophe to a student, when they come from someone wielding ultimate sanction.

Matron's Parting Advice to Nurses: Courtesy to students and staff is a reciprocal thing. Cleanliness does count, and if after you qualify here you decide to leave nursing altogether, you will at least make an excellent housewife! If you decide to marry a dental student, as so often happens, then go into general practice so that you can help him organise his own practice with your experience gained from other dental surgeries.

It would need many volumes of Mouthpiece to accomodate just the most outstanding aspects of Sister Davidson's varied nursing career, but even in this short interview I felt that there was far more to her than any of us may perhaps have realised. Someone once said that one of the hallmarks of a good man is his eagerness to train a successor - with 274 D.S.A.s having passed through her hands since Matron came to this hospital, one must consider hat she has amply fulfilled this condition.

We all wish Matron every happiness in her retirement. We shall miss her very much.

Note: Miss Martin, a theatre sister from the East Grinstead Hospital is Matron's successor. She is B.R.I. trained, and will not be known as a 'Matron' but as a 'Nursing Officer' (under the Salmon System).



EXTRACTION SPACE CLOSURE

Most extraction spaces close to some degree. In orthodontic treatment we usually require part of the extraction space for the relief of dental arch crowding and hope or expect the remainder to close by forward drift of the buccal teeth. Quite what mechanisms are involved in extraction space closure is the subject of much speculation. Is it the same process as "mesial drift" which compensates for interproximal attritional wear?[1] Does growth play a part or does space closure continue in adult life? Does the mesial component of occlusal forces produced during chewing cause mesial drift or are such movements[2,3] too samll or too intermittent to be effective?

Investigation on higher animals is not very helpful as none have the degree of crowding which is seen in man. Investigations with human material are few. The only longitudinal studies have been carried out at University College Dental School[4] and here in the Orthodontic Department. Both agree that there is dramatically faster spontaneous space closure during the first three months after extraction and there is considerable variation among individuals. Later space closure seems very constant for an individual (Fig. 1.) and there is much less variation among individuals. The next step is to look at adults who have extraction spaces to see if they are still closing. Quite apart from this it will be interesting to see whether posterior tooth eruption or increased occlusal force can produce an increased rate of space closure.

I require volunteers who have residual spaces in the lower arch! A liking for alginate and chewing gum is desirable but not essential, a cheerful disposition would be an advantage. High pain threshold will not be needed.

How about Messrs. MacDonald and Hayward for a start?

C. D. STEPHENS
Orthodontic Department

1. Begg P.R. & Kesling P.C. (1971) Begg Orthodontic Theory and Technique Philadelphia, W.B. Saunders & Co.

2. Picton D.C.A. (1962) Archives of Oral Biology 7 151 - 159

3. Picton D.C.A. & Moss J.P. (1974) British Journal of Orthodontics 105 - 111

4. Robertson N. et al. Unpublished.

LIFE IN THE SCHOOL DENTAL SERVICE

Firstly, what is the School Dental Service? Taken literally, it is the dental service to Schoolchildren, previously run by Local Authorities, and now organised by Area Health Authorities (A.H.S.) for the N.H.S., It is, however, more than this. It is available to all priority groups - schoolchildren, expectant and nursing mothers, and the peschool child. A.H.S. prefer to call it the Community Dental Service, as future plans may well involve extenxion of its outlook into such fields as the handicapped and geriatric. The whole range of dentistry is involved, from crown and inlay work (bridgework is a rarity) through prosthetics and orthodontics to the routine conservation and extractions. This in fact, as in any practice, is the bulk of our work. The real difference between the Community Service and General Practice is that we are paid a salary, have paid holidays and sick leave, and consequently have less worries as to where the next penny is coming fom - although the salaries leave something to be desired!

What about careers? Well, there certainly used to be a ladder to climb, starting at Dental Officer, through Senior Dental Officer to Area Dental Officer and eventually to Principal Dental Officer. Now the top position is Area Dental Officer, then comes the mystical beast the District Dental Officer (required April 1 1974 onwards) and then just Dental Officers. Suggestions aimed at making this better are with the D.H.S.S. and might emerge some day. The service has recently had a reputation for being staffed by young lady graduates who left after a short time due to pregnancy and marriage - not necessarily in that order - but in actual fact we have been receiving applications from experienced practioners who have become disillusioned with the general dental service.

What to do? Every dental officer has an area which is estimated (by past experience) to provide enough work for a year. Sometimes this is not accurate and it may be two years or more between school inspections. This leads to further problems - each child requires more treatment and it consequently takes longer to complete, and so the interval between inspections lengthens. This does not offer a service to the Community and ways have to be found to combat it. It may mean more staff in an understaffed area; this again may be held up for lack of finance or even suitable premises. It may mean reviewing the treatment given with the dental officer concerned.

Treatment is carried out in either fixed clinics or mobile units, with equipment which may range from almost antique to brand new, dependent very much on the Authority concerned. Some old Local Authorities, seriously understaffed, spent thousands on new equipment and premises hoping to attract staff; others kept the old equipment and put new in new Health Centres, thereby expanding the Service. The new A.H.A.s are rapidly reviewing the equipment

Life in the School Dental Service cont.

and replacing the antique. My own surgery, for instance, has 1950 equipment installed and £3,000 worth of new equipment wither in the storeroom or on order. The old equipment, incidentally, has never let me down in the 8 years I have used it; the new electronic stuff doesn't respond to a kick like the old did, and engineers' visits are expensive (and more frequent). Many of you have seen the mobile unit; it is towed from school to school by Landrover and usually parked where requested. One day, during the oil shortage, a tanker was due at the school and the driver parked one van in the playground temporarily and went to get he other. The first had gone when he got back! It had rolled down the slope of the playground onto the grass (which sloped more), down the hill andround the corner at he bottom. Luckily it didn't go through the fence and on to he railway line. The driver now puts the corner jacks down whenever he leaves a van.

Life is what you make it. I have worked in a clinic where I could (and did) read a book a day and two during school holidays, even though the appointment book was full. It is also possible to see 15-20 patients a session in a mobile - and do conservative treatment for all. I have found much more satisfaction in a busy clinic - and also much more response from parents and ptients alike. Treatment has to be modified to suit each case and situation. For example, to attempt a pulpotomy on a deciduous tooth when treating a school by mobile is probably inappropriate as treatment for the whole school is sometimes complete within a day or two - not sufficient time for most pulpotomies. Also it has to be remembered that in rural areas it is unlikely that dental treatment will be obtainable with any certainty for at least a year, and anything doubtful must be seen in that context.

Interested? If not, why not? Come and see me any Friday, and bring your criticisms, questions, etc. I'll try to help.

D.K. Stables

----oOo----

Many Junior students here at the Dental Hospital have been asking what the term A.N.K. means: Mouthpiece magazine feels that it is its duty to lighten their darkness. We always try to be helpful!

Normal Appointment: A.N.K. - 'as not kum.

Appointments in the Children's Department: A.N.K. - Another nasty kid.

ARE WE SUCCEEDING OR SURVIVING?

As members of a university we represent less than 10% of our age group, and a smaller proportion of the total population. Like it or not, this makes all students members of an elite. But on what grounds were we chosen for this privilege? Was it our academic ability? Was the decision based on the report provided by the headmaster of our secondary school? Or perhaps the selection committee thought us "nice chaps" who would fit in well and make up the numbers. And once at University, what are we here for? Idealists might suggest that university education aims to propogate knowledge; to develop the individual's creative abilities; to explore and widen our concept of life; and to give an opportunity for young people to examine themselves in relation to society. Those pursuing a vocational course enter further education for more concrete reasons, often the chance of improving status prospects and earning ability being a major consideration. Then having completed a number of years'study what determines the standard of the degree awarded? Is it our performance in the final examinations, or the work done over a number of years? Is it whether we attended the lectures, or whether we got on well with the professor? Does it matter whether or not we make some contribution to the department we are associated with?

There is one thing that links these three fundamental questions, and that is our ability to find the formula for survival. At present the educational system is geared in such a way that those who find the formula and are prepared to adhere to it are those who receive the honours in the end.

We learn about survival in education at primary school, and the lesson is learnt in a stimulus-response manner. Do what is expected of you, and all is well. Do not annoy the teacher or ask awkward questions. Unfortunately the criteria are set by the staff of the school and each has their own standards. Thus to survive one has to remember what suits each individual teacher.

The trend continues to secondary school, andit is here that the greatest threat to creative ability and inquisitiveness occurs. Even woodwork is lowered to the level of knocking a few nails under the watchful eye of the instructor to make a coffee-table identical to those made by the other people in the class. The tightly packed 'O' and 'A' level syllabi leave no room for any diversion, so should interest arise in some aspect of physics, or an era of history, or the local geology, it cannot be encouraged as it may jeopardise the completion of the material required by the Examining Boards.

What is required, and is actively rewarded, is the compliant individual. Getting in to "the XV" or playing in the cricket team may be a good ploy in the survival game, and by playing the right cards, appoint-

-ment to the post of prefect will follow. By follwoing the formula of survival one can get a good headmaster's report and then one can procede to the next stage (Collect a grant of £470, and then increase, as you pass GO).

By the time we each university we are fundamentally conformists. Growing your hair only counts as a gesture, as getting to the university is the proof that the survival game has been played. So many hope that further education will provide a chance to regain the ability to create and be original that had been lying dormant for so amny years, but how wrong they can be. The powers of survival are put to the test yet furhter, especially in those who have come straight from school. One of the first problems to be surmounted is that of making new friends, and to gain acceptance of the group may mean taking part in sport, resorting to eccentricity, putting on a preudo-intellectual face, or adopting the badges of one of the many sub-cultures. Allied to this is the readjustment to being away from the family home. The years spent at university are fequently those when many form their first deep personal relationships and it is also an opportunity for many to experience sexual relationships for the first time. All this undoubtedly places strain on the student, and on top of this there are the demands of the degree course. The multiplicity of examinations produced by some departments encourages the survival attitude, and the non-academic pressures often mean that only the work and reading that has to be done is completed. It could be argued that in the science courses, or in the vocational trainings such as law, medicine, or our own dentistry, there is little opportunity for originality and diversity, but is such an argument correct? Many depertments have introduced project work and assignment tasks to encourage students to follow up their ideas and to develop an indiviaual and original approach to their subject. What do we have in the dpartmnt of dentistry? A succession of MCQ tests and exams consisting of short written answers that gauge the ability to regurgitate passages from textbooks. Undoubtedly the guaranteed way to produce an enquiring rind, able to sum up a situation and to modify known techniques to suit the circumstances.

So what do we have at the end of it all? A number of graduates, most of whom will have mde the break from home without too much trauma; many of whom will be engaged, married, or who will have formed a significant reltionship with someone; and who have a degree. Most of the knowledge they acquired will be sonn lost as it was only learnt to pass finals. What have they gained frm university? Very little more than they would have gained in three years elswhere. Those follwoing the vocational courses will have picked up the basic knowledge and skills needed to start their careers, but they will fit a somewhat stereotyped pattern.

Succeeding or surviving? cont.

What is the answer? Short of a radical change in the whole consept of education, it amy seem there is little that can be done. The primary schools are experimenting with lerning through playing and individual tasks, thus giving mush more opportunity for each child to explore and follow through the things that interest him or her. However, while the play remains "directed play" and the teacher is the "director", this is an artificial way of making the child learn by doing. There is very little that is creative about it. Secondary schools will be stifled so long as employers and further education demand 'O' and 'A' level passes. These encourage survival, thus countering any inquisitiveness left after eleven years of age. A.S. Neill, who was well known for his Summerhill School experiment, wrote, "All prize-giving and marks and exams sidetrack proper personality development". Perhaps the universities have the best opportunity to bring out what is left of their ability to create, to think searchingly and to make original contributions to knowledge. An important step in doing this would be to discourage young people from going to university straight from school. At least a year should lapse before embarking on a degree course, giving the individual a chance to break fom home-life, to look at society and life fom outside the sheltered environment of school, and to examine and question the purpose of further education. The universities must rethink their courses, as many are, and try to direct attention away from the survival orientated type to one that gives credit to originality. Praise should b given to everything covered that falls outside the basic course requirements. Examinations need to be rethought, but not just rethought as tends to happen now, but concerted efforts made to eliminate the "spelling-test" type of exam as much as possible. Courses such as dentistry and medicine are obliged by law, and the various professioanl bodies, to cover and test a basic amount of knowledge. However, there is scope to encourage students to discover things for themselves, and every opportunity should be followed up. Elective periods and project work are two examples of opportunities to enable the student to search his own abilities, but if these are to be used in assessment, it is the originality that must be emphasized. In this way the survival game can become played down so that it is minimal.

An idealist attitude, may be, but when we ask ourselves how often our ability to reason has been put to the test, or howoften we ask the question "why?", then it becomes clear how much we are just the survivors.

Stephen Lisney

--oOo--

There were two Irishmen in a car. The passenger had a bomb on his knee. "What happens if it goes off?" he asked. "Don't worry, we've got another one in the boot."

The chair I sat in, like a padded cell,
Kept me from fleeing; the seat was studded hide,
The light so brilliant, and the marble gleaming,
That my senses reeled. The drills were diamond tipped,
Which buzzed like drunken wasps on summer eves.
Then as I gazed into my dentist's precious eyes
She probrd my pearly darkness with silver mirror
Held in hand as delicate and finely-formed as porcelain
butterflies.

Enthroned in dazzling white she sat
Monopolising beauty.
And barely breathed the honeyed-air which
Hovered as suitors for a princess's hand.
All the while doe-eyed young vestal nurses
Fresh as daisies in an early morning rain
Blinked in wonder at her slightest motion.
Syringes flashed like light'ning epees in the astonished air,
While with numbed consciousness, open-mouthed,
I watched my charming torturess.
With such delicious ease she moved
My mouth did water at her fingertips
And all my being welled within my frame
To feel her pressing gently on my trembling lips.
Thus for an endless demi-hour I lay
Transported from all earthly cares and sights
As every energy gathered at one point
To leave a hole in nature.

A. Patient.