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TIC

IMPRESSION

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mined facts provide the basis for all decisions regarding service-connected and non-service-connected dental disabilities.

It is obvious from the conditions of eligibility outlined that the great majority of veterans must apply for dental benefits within one year of discharge, and, if found to have service-incurred dental disabilities, may be treated only once. Formerly veterans were eligible for both initial and repeat treatment of service-connected dental conditions regardless of whether or not they were disabling to a compensable degree. Within the last three years the provisions cited have been imposed by law and Veterans Administration regulations.

The changes in eligibility standards initiated by revision of VA regulations and later enacted into legislation have been responsible for a major reduction in outpatient dental services. Since very few peacetime veterans can establish eligibility, the program will reach a low ebb after the wartime veterans, who apply within a year of discharge, have their one-time treatment furnished.

This brings us to one of the most significant developments in dentistry this year. Every dentist will read the following paragraph with great interest.

Under the previous regulations, during the period 1946-1955 more than 6,000,000 applications were made by veterans for either initial or repeat treatment. These applications resulted in 4,200,000 examinations and 3,331,000 treatment cases. Of these cases, 1,987,000 examination and 2,747,000 treatment cases were completed by private dentists participating in the "home town" program. By comparison, only an estimated 80,000 of those who apply will be authorized treatment during fiscal year 1956, with a further reduction to approximately 60,000 during fiscal year 1957.

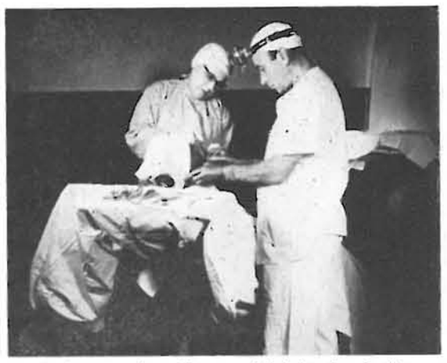
Every dentist will ponder the total implications of so drastic a reduction in this service.

The outpatient dental program of the Veterans Administration has been of special interest to the private dentist since more than 60,000 private practitioners have participated in the VA "hometown"-dentist part of that program. In discussing this service a VA spokesman said: "It is economically wise for the individual veteran and the VA to utilize fee dentists in those communities where VA facilities are not available or where undue hardship might be imposed on the veteran in reporting to established VA clinics."

With few exceptions, the private practitioners participating in this program have given their wholehearted cooperation and support. This has been a major factor in its success, for it is clear that the quality and efficiency of the "home town" outpatient program rests squarely upon the professional ability and professional integrity of the American dentist.

A paraplegic patient gets into a dental chair at the Veterans Administration Hospital, Hines, Illinois.

An X-ray room prepared for tuberculous patients at the dental clinic of the Veterans Administration Hospital, Houston, Texas.



Oral surgery in a Veterans Administration facility.

NEXT MONTH — VA INPATIENT PROGRAM

P.O. Box 350
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A MAGAZINE FOR DENTISTS, DENTAL ASSISTANTS, AND DENTAL HYGIENISTS

October 1956 Vol. XV No. 10

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The great challenge of phonetics

Speech Problems and the Dentist

by Melvin M. Meilach, D.D.S., and Dona Z. Meilach

EDITOR'S NOTE: TIC readers are invited to send in case histories from their own practices on this interesting subject, on which there is very little literature available at present.

Maybe you, as a dentist, never think of dentures as an "occupational hazard." Yet, in many professions such as radio, acting, lecturing, and salesmanship, too many people suffer with bad teeth longer than necessary for fear that dentures will result in speech difficulties.

A New York City dentist cites the case of an air force announcer whom he recently fitted with full dentures. The patient had a sibilant *s* and the pilots kidded him about his new sound effect. He became self-conscious and changed his method of articulation. Before long, the pilots complained his messages were garbled and repeat instructions wasted valuable seconds required for the precision timing of his job.

The announcer complained to the dentist that his speech difficulties were a result of the dentures. When the dentist adjusted the plates he tried to convince the announcer he would have to get used to them. The third visit found the patient still dissatisfied—he was beginning to doubt the efficiency of the denture and the ability of the dentist. The dentist felt he was altering the denture and sacrificing the bite and esthetic quality for the sake of speech. A knowledge of phonetics and study of speech habits might have saved this dentist and his patient considerable distress.

When patients complain of speech difficulties, how can you tactfully handle them?

Doctors Von K. Frowine and Henry Moser suggest you explain that you have combined esthetic values and functions in the most desirable proportion in accordance with the dictates of the case.

Any unnecessary change of the denture would destroy this balance. You should then make your patient realize that learning to use dentures in speech is as necessary as learning to use them in mastication. If it takes the average patient a few weeks to master his dentures in mastication, why shouldn't he need an adequate period of time, or even professional help, to master the denture in speech?

Speech therapists agree this approach is a good one, for speech is a learned process. Speech, like other learned functions such as swimming or driving a car, may be improved and, in many cases, perfected with practice and coaching.

The fact that speech is one of man's greatest faculties is known by virtually everyone. The fact that dentists can play a role in speech correction is known by relatively few.

Speech studies prove there is a direct relationship between dentition and speech. Dental conditions that may cause faulty articulation include nearly any and all dental abnormalities. The most prominent are improperly contoured surfaces of restorations, rotated teeth, malposed teeth, missing teeth, malformed jaws, malrelationship of jaws, peg-shaped lateral incisors, and spacing between the teeth.

Webster defines phonetics as "the science of speech sounds considered as the elements of language . . . the study of their formation by the organs of speech and their apprehension by the ear. . . ." It is becoming increasingly important for a dentist and dental specialist to have some concept of the ways speech sounds are made, for some of the organs of speech are those in which the dentist is mainly concerned: the teeth, the mouth, the lips, and the palate. The production of sound and articulation also involves the breath, lungs, pharynx, larynx, glottis, and vocal cords, but these organs are not usually the dentist's concern.

The English language is divided into forty-four phonetic sounds. The positions of the tongue against the teeth, the palate, the mandible, and so forth, determine the way these sounds will be made.

Pronunciation of the various phonetic sounds will cause the mandible to assume a certain position in relation to the maxilla. Some phonetic sounds will cause the mandible to be very close to the maxilla (such as the *s* and *c* in the words *sit, basket, yes, cent,* and *cider*). The sounds *wh* in *what* and the *a* in *father* will cause the mandible to be far from the maxilla. Other sounds create various differentials in between the closest level and the widest level of the mandible. It is interesting to watch for the various levels of the mandible on television singers.

By studying the positions of the mandible in relation to the maxilla you can get an accurate measurement of the verticle dimension. The relationship between vertical dimension to phonetics may be better understood by observing the speech and language habits of a patient. Doctor Harry A. Young says 90 per cent of full denture difficulties are due to failure in obtaining the proper centric relation (vertical dimension).

The tongue plays one of the most important roles in articulation. Because of its flexibility it can quickly conform to new contours of the teeth or palate. Some prosthodontists use a soft upper palate when fitting dentures. This permits the tongue to form natural contours on the upper palate before the final teeth are processed. Children with dental anomalies that cause speech defects can often be easily trained to use their tongue to compensate for the deviation from the normal.

In speech formation, the upper front teeth are used with the lower lip or the tongue to form several sounds such as *f* or *th*. The lower teeth are less important though they share in the modification of sounds like *s* and *sh*.

The lips act in the formation of frictional sounds either with the upper teeth or with each other. They provide one of the means of closing the mouth to the passage of breath as with the letters *p, b* or *m*.

Observation has shown that patients with perfect teeth may have some speech difficulties. Others, with anomalies or bad malocclusion, will speak clearly. Every case must be considered individually. Some case histories indicate a dental defect which causes a speech difficulty can also lead to a psychological disturbance.

For example; a twenty-one-year-old girl with a broken incisor was overly conscious of how the tooth affected her appearance. She spoke with her mouth half closed and rarely smiled. Eventually, she presented a dental, speech, and social problem.

If the phonetic phase of a restoration has not been carefully considered, the denture can seriously affect a person's livelihood and personality. Actually it is an occupational hazard if a telephone operator cannot enunciate distinctly because of the denture; if a busy executive has difficulty dictating to his secretary; and if a speaker, constantly on the lecture plat-

associated with the eligibility requirements for outpatient dental service. Here are the facts about the groups of veterans who are eligible for outpatient dental care.

FOR VETERANS OF WARTIME OR KOREAN SERVICE:

1. Those having a service-connected compensable dental disability or condition may be authorized any dental treatment indicated as reasonably necessary to maintain oral health and masticatory function. (To be awarded compensation, the veteran must have incurred, in service, injury or disease resulting in a condition which is 10 per cent or more disabling.) Veterans in this class may receive repeat episodes of treatment upon application.
2. Those having service-connected non-compensable dental disability or condition shown to have been in existence at time of discharge or release from active service may be authorized any treatment indicated as reasonably necessary for the "one-time correction" of the service-connected dental disability. These veterans must apply within a year of discharge to be eligible to have the service-incurred noncompensable dental disabilities, such as carious or missing teeth, treated once.
3. Those having a service-connected non-compensable dental condition or disability resulting from combat wounds or service injury and former prisoners of war may be furnished repeated treatment for their service-incurred dental disabilities, and there is no restriction upon time of application.
4. Those having a dental disability which is professionally determined to be aggravating an associated service-connected disorder may be furnished such dental treatment as may be required to aid in the treatment of the basic service-connected disability.
5. Disabled veterans taking vocational training under Public Law 16 may obtain dental treatment of oral conditions that, untreated, would interrupt such training.
6. Spanish-American War veterans may receive any dental treatment that is indicated to retain masticatory function.

FOR PEACETIME VETERANS:

Peacetime veterans to be eligible for outpatient treatment must have been discharged from service for a service-incurred disability or be in receipt of compensation for a service-incurred disability.

The determinations of service-connected and non-service-connected dental disabilities are made, not by the VA's Department of Medicine and Surgery, but by the agency's Department of Veterans Benefits. However, the decisions are based upon facts developed, recorded, and certified by dentists. For example, when a veteran applies for dental treatment or compensation for an alleged dental disability, the Department of Veterans Benefits obtains his preinduction examination, his dental treatment record during service, and his discharge examination record. From these records the Department of Veterans Benefits makes a determination of which teeth are service-connected, or whether a generalized dental disease which may be legally treated was present at discharge. If a service-connected situation is established, determination of the treatment needs of the case is then made, followed by authorization of the phase of treatment to which the veteran is legally eligible. Thus it is clear that professionally deter-

Veterans Administration Hospital, Madison, Wisconsin.

Veterans Administration Hospital at Fort Hamilton, Brooklyn, N. Y.

Part 2 of a four-part series

VA Dentist

by Joseph George Strack

In the initial installment in this series, the scope of the dental program of the Veterans Administration was outlined in terms of a year's operations: More than 570,000 patients admitted to VA hospitals; and in the outpatient dental program, 200,000 examined and 165,000 treated by 800 full-time VA staff dentists and more than 60,000 private-practice dentists, at an annual cost of over $27,000,000, with 280 VA facilities involved.

The private practitioner will also be interested in knowing something about the administrative set-up of the VA. The Department of Medicine and Surgery of the VA, as it now exists, was created by an act of Congress, January 3, 1946. This act specifies "that one Assistant Chief Medical Director shall be a qualified doctor of dental surgery or dental medicine, who shall be directly responsible to the Chief Medical Director for the Operations of the Dental Service." The department is under the direction of the Chief Medical Director, William S. Middleton, M.D., and the Assistant Chief Medical Director for Dentistry, John E. Fauber, D.D.S.

The department has divided its facilities (which are in the United States, Puerto Rico, Alaska, and Hawaii) into seven administrative areas. These are supervised by offices maintained in Boston, Trenton, Atlanta, Columbus, St. Paul, St. Louis, and San Francisco. In each of these offices there is a dental representative who is assisted by four part-time dental consultants who are outstanding in the profession.

The dental program itself falls into two great divisions—dental treatment within the institutional settings of VA hospitals and VA domiciliary homes, that is, the inpatient service; and dental treatment given through VA clinics and offices of private-practice or "home town" dentists, the outpatient service.

The VA dental program, like the programs of other public agencies, is not well understood by the general public, and, again like other public health services, its goals, its activities, and its accomplishments are only vaguely grasped even by members of the health professions. One widespread myth is that VA gives medical, dental, and allied health care and treatment to any and all veterans. Since there are 20,000,000 veterans in the United States today, even Uncle Sam, still the richest man in the world, would find that tab on the heavy side.

Most of the confusion and misunderstanding is

form, cannot control a hissing *s*.

A patient sometimes takes advantage of the fact that he alone is the final judge of the mechanics of the denture. If he dislikes the way they look and finds he can't articulate or masticate as well as he did with his natural dentition, he believes the denture leaves something to be desired.

In such cases, a Chicago prosthodontist tries to determine any unusual speech patterns of his patients before he does extractions. With some, he experimented. He tape-recorded sentences read by the patient involving the function of the tongue against the teeth, the use of *s, th,* and *z*. Such sentences are, "Children should seek churches" and "In Mississippi, father lolls with an author friend and eats bushels of sassafras." Usually a patient is unaware of a speech abnormality, for that is the way he is used to hearing himself speak. The dentist could then assure the patient his speech difficulties are not necessarily due to the denture but to his normal speech habits.

Doctor T. Kubacki, head of the Department of Prosthetics, University of Illinois, points out that speech difficulties are usually reduced with immediate dentures. The patient does not have to learn to speak twice, once with no teeth and again with the dentures. After immediate dentures are fitted, the

dentist sends the patient home with instructions to practice speaking in front of a mirror until his speech sounds normal to his ear.

The recognition of problems based on dental-phonetic defects in your young patients should be of some concern in your practice. Psychologist Wendell Johnson shows that speech defective children form the largest group of handicapped children in America, yet little effort is made to help them.

When dental anomalies exist, the general dentist should be able to recognize them and refer the case to the orthodontist, prosthodontist, or speech therapist. In cleft palates the main patient complaint is speech difficulty which can be improved with the use of prosthetics and speech exercises.

The general dentist frequently will find children with open bites that cause a slurring of the sounds *s-sch-ch* and *sh*. Try testing them with words like *Mississippi, steamship, sure,* and *tense*. If the lips cannot be brought together readily, *p, b,* and *m* will be defective. One cause of this type of malocclusion is prolonged thumb-sucking.

Another case the dentist may detect is the lingually locked upper anterior class III. The child will have difficulty with the *k* and *c* sound as in the word *cat* or *cook*.

Applied speech therapy in dental-phonetic cases is a comparatively new field and represents a new approach to age-old phonetic aspects of language. You dentists are not expected to teach a patient how to say *ah* and *oh,* but you should realize a responsibility in both the cure and the prevention of speech difficulties that fall within the scope of your knowledge. You should strive to recognize speech disturbances that arise from faulty dentition. You may observe incorrect speech and report it to the parent and child. You may send postoperative and postadjustment cases to a competent speech correctionist for examination and treatment.

Most important, stresses Doctor Clarence D. Simon, is to combat the rather prevalent idea that children will outgrow speech difficulties. Too often the dentist says to the parents, "Oh, don't bother with that, he'll outgrow it." This is pernicious advice. Occasionally children do outgrow speech difficulties. This gives slight reason for the opinion, but statistically the chances are against outgrowing the problem. For those who have seen the constant stream of adults in speech clinics know children do not "outgrow" their speech difficulties. If you can train yourself to be aware that a problem exists and know where to refer the patient for help, you have performed a great service.

Good speech is extremely essential for social adjustment and success in this modern age. This fact plus the major role the mouth plays in speaking is what is sending patients into dental offices to seek help where dental-phonetic problems exist. Usually these cases are handled best by full cooperation between the dentist, prosthodontist, orthodontist, and speech therapist. The dentist should be equipped and willing to play his part.

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Chicago 43, Ill.

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10 things to do for profit

How to Be a Clever Conventioneer

by Maurice J. Teitelbaum, D.D.S.

Why are conventions so popular in America? Well, I have never conducted a survey on the subject but I've asked a number of dentists the question and they all agreed that they enjoyed conventions because it presented them with a good opportunity to mix business with pleasure—and could still be claimed as a tax deduction.

There is no doubt that the convention plays an important role in American business, political, industrial and professional life. When you attend the annual meetings of the American Dental Association Convention, your State society, your local dental group, or your dental fraternity, you are contributing to the two billion dollars that are spent each year for conventions in the United States.

But do you get your "money's worth" when you attend a dental convention? If you are like any one of these extreme types of conventioneers then you get very little out of the conventions you attend.

DOCTOR EAGER BEAVER: He signs up for every course offered, wants to see every exhibit, takes in every speech, reads every notice, fills up six or seven books with notes, talks with every clinician—and returns home on the verge of a nervous breakdown. He then spends two weeks in bed to recuperate and, because of the loss of time in the office, he swears off conventions forever.

DOCTOR EXPLORER: He doesn't sign up for any course. He doesn't even make hotel reservations. He likes to wait until he gets there to see what's going on. He wants to explore the situation first hand. When he gets to the convention the hotels are booked solidly and the only reservation open is an Indian one in the next county, so he settles for a motel six miles out of town or a dungeon-like room in a fifth-grade boarding house. The enrollment for most of the courses is filled, and on Wednesday, when he finally spots a course he would like to take, he learns that it was given on Tuesday. He returns home a devoted fighter for the abolishment of conventions.

DOCTOR SIGHTSEER: To him, the sole purpose of a convention is to enable the conventioneer to "see the town." He misses out on the speeches, the exhibits, and all the instructive courses. He returns home with a half dozen boxes of color slides, a well-worn map of the city streets, and a wish that the next convention be held at Glacier National Park.

DOCTOR GUZZLER: He is never seen without a couple of glasses and naturally makes a spectacle of himself. (Clever, hey?) He drinks to be sociable and then to be sociable he drinks. By the second day he drinks to drink and becomes obnoxious. He wakes up each afternoon with a hangover and the nearest he comes to the convention hall is the bar on the floor below.

To get the most professional and social benefits from a convention requires intelligent planning. Before you decide to send in your check to attend the next dental convention, here are some suggestions to help you have a more enjoyable and instructive time.

Ten Suggestions

1. Plan your program of activities at the convention well in advance. Don't leave everything to the last moment or the day of arrival. Make your hotel reservations as early as possible. If something unforeseen should turn up that makes it impossible for you to get away, you can cancel your hotel accommodations without any obligation.

2. Check very carefully the list of courses to be offered and try to gather some additional information about the clinicians. Schedule your time so that you are not rushed. It is better to take three courses with an alert, rested mind than to attend five sessions feeling worn and weary. Naturally, select those subjects that interest you most and not those that interest your friends.

3. Get your office in order before you leave. See that there are no appointments scheduled during your absence and that your assistant or a telephone service handles all your calls in your absence.

4. Contact out-of-town friends with whom you would like to visit and arrange time to get together with them.

5. Call local colleagues who might be attending the convention and go down as a group. If you are driving together, this will cut expenses and make the trip more pleasant.

6. Make notes of specific problems that you would like to have cleared up by a convention clinician or exhibitor. If a particular technique or the handling of a specific dental product has you puzzled, jot it down and query some authority at the convention to clarify matters.

Angles and Impressions

If there is any quality that is a must in a dental office it is perseverance. The ability to stick to the task at hand, whether it is a difficult cavity preparation or a new impression technique, is imperative for good results and developed skills. And when I think of perseverance, I think of a "character" I met some years ago, a man who really knew what it meant to persevere.

In 1952, when I was with the Army Dental Corps in Germany, I had occasion each month to travel to detachment headquarters in Stuttgart. I was stationed in the town of Heilbronn-on-the-Neckar, an inland water port of some 60,000 inhabitants that lies about equi-distant between Heidelberg on the north and Stuttgart thirty-five miles to the south. Before my car had arrived from the States, I made the monthly trip by train.

During one of these periodical excursions, as I settled myself rather uncomfortably on the shiny wooden slats that serve as benches on the local trains, I was greeted by a cheery "Good morning" from across the narrow aisle. The cordial greeting came from a squat German with a generous nose that spread impartially toward both cheeks and was underscored by heavy lips and an acromegalic jaw. A broad irradiating smile and twinkling eyes fought to overcome the homely distorted facial features. The gentleness and warmth of the smile seemed to be more than a match for his repulsive countenance, for as the time passed he became increasingly easier to look at. If he was a man burdened at all by his face, he never showed it.

I acknowledged his greeting with a nod and a smile. Apparently, this simple response was just what he was waiting for. In a moment I found myself moving closer to the window and making room for him as he seated himself next to me.

"A fine day, is it not?" he said.

"Ya," I answered.

"It is a most fine day," he repeated, speaking slowly and selecting each word with infinite care like a six-year-old mechanically reading from his first primer. "I am most happy to speak with the American soldier." His accent was thick and he had difficulty pronouncing the word "soldier." When it finally stumbled from his lips he displayed the discolored silicate fillings in his anterior teeth with a triumphant smile.

"Woher gehen Sie?" I asked.

"I go to Stuttgart. Where do you go?"

"Nach Stuttgart," I replied.

I continued to converse with him in German while he spoke in English. Despite the assistance of a small book on English grammar that he took from his pocket and an English-German dictionary I extracted from my Ike jacket, we slaughtered both languages unmercifully. Occasionally we lapsed into our native tongues, but generally we traveled on foreign soil. We plodded through the mass of decapitated words and crippled phrases valiantly, and managed to make the small talk stand up.

As I recall, his name was Rudolph Steinmuller. He lived in Flein, a tiny village bordering Heilbronn, and operated a tram in Stuttgart. His English was self-taught and to improve his speaking knowledge of the language he sought every opportunity to converse with American soldiers. The study of English was his hobby. He read the little grammar book nightly, tackling the subject with the unbounded enthusiasm a fanatic golfer has for his game. When I complimented him upon a choice phrase, the completion of a grammatically perfect sentence, or the correct use of an idiom, he beamed with delight. He had approached the green from a difficult lie and parred the hole.

The minutes passed quickly and when we pulled out of Ludwigsburg he laid the grammar book on the seat between us, fumbled in his pants pocket, and pulled out a battered bulging black wallet.

"Listen how I can read," he said. Three quarters of an hour of verbal parrying and thrusts had not blunted his enthusiasm. He fingered the cards in his billfold and with a grand gesture extracted a dirty folded piece of yellowish paper. With loving care he opened the paper, straightened it out on his knee, and then, after clearing his throat, started to read slowly, mouthing each word meticulously. It was a letter, written in English, from an uncle in Melbourne, Australia. There was news about the family, the forthcoming marriage of a cousin, and questions about conditions in Germany. When he finished reading, without hesitating over a single word, he looked up at me, his face radiating supreme satisfaction.

"Good?" he asked, his eyes sparkling.

"Sehr gute," I said, "very good indeed." And then I noticed the date at the bottom of the page. From the onset I had marveled at this uneducated man's passion for the English language—now I was thrilled at his devotion and perseverance.

The letter was dated June 28, 1928.

M. J. T.
P.O. Box 350
Albany, N. Y.

by Kay Lipke

When A Wife Becomes A Patient

Sooner or later there comes a situation dreaded by many a dental wife. No matter how much she may procrastinate and pretend that all is well, she at last faces the grim fact that she must make a professional call upon her dentist. Ah me, that is the day!

The appointment may be with her own husband or, if he happens to specialize in another phase of dentistry, she takes her dental problems to some long suffering friend of the family who has taken on his fellow dentist's family as part of the burdens of practicing his profession.

Either way, the situation is apt to be difficult for everyone. Because she knows so well how busy the men are these days, the wife of a dentist very often postpones her own dentistry until painful twinges remind her that there is trouble ahead. By that time she is ashamed to face her dentist, knowing only too well what he will have to say on the subject.

One dental wife we know told us (between bites of a simply lush strawberry concoction heavy with whipped cream and loaded with sugar) that she had been very sharply criticized that morning by her husband for neglecting her teeth and allowing dental caries to move in and take possession.

"He told me that I should be ashamed of myself for neglecting my teeth like that," she confessed. "I came away from the office resolving never to touch sweets again and here I go eating all this rich stuff. Please don't tell him."

Another dental wife told me a similar grim tale. "I lost track of the time since I last had my teeth cleaned," she confessed. "I thought my husband would remind me, but he was too busy looking after other people to check on me. When finally I went down to his office, he took a look at my mouth and was simply furious.

"He cleaned my teeth without saying a word, but when I was ready to leave, he looked me in the eye and said, 'If you neglect your teeth like that again, you'd better find another dentist.' Was I crushed! I'll never let more than six months go by again without showing up at his office, I can tell you. I've learned my lesson."

With my ears ringing with these alarming statements, I hurried to make a dental appointment myself. In this case the dentist was not my husband, who was grateful at that moment (and so was I) that he did not practice general dentistry. A skilful

and patient dental friend of the family had been endeavoring to keep my teeth in order for a good many years, and it was to him that I went now.

However, my dental husband took the X-rays in advance and frowned at the result. "You're in for some trouble," he warned. "There are two bad cavities and your teeth need cleaning." Thereupon he washed his hands of me with a sigh of relief and went back to his own patients, while I crept quietly out to keep my own dental appointment.

Being a pleasant and suave gentleman, my dentist did not blurt out what he thought of the condition of my mouth. He merely looked at me with mild reproach and said, "I see you still like sweets as well as ever," and then went to work. And work it was.

An hour and a half later my mouth felt much better, and I was filled with fervent resolves as to future diet, for my dentist had spent some time talking to me about food and its effect upon the teeth.

"Instead of sugar on your cereal, sprinkle a few raisins," he told me. "Keep fresh fruit on hand and eat an orange or an apple instead of cookies or candy when you are hungry between meals. If you don't change your eating habits, I'm afraid one of these days you will find yourself outfitted with a pretty little full set of dentures." The last was said with a bland and charming smile to mask the threat, but I could tell he meant every word he said.

Certainly we women who are married to dentists should pay attention to the basic rules governing good diet and the proper care of the teeth. Nature may not have equipped us with sets of pearl-like teeth to qualify us as walking advertisements for our husbands' profession, but we can at least abide by the rules and show our husbands that we believe in the fine dental health program which they work for so earnestly.

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7. At the convention write down the names and the addresses of men you might like to contact some time in the future, either for professional advice or for a social get-together.

8. Don't spend every moment at dentistry—leave time for fun and relaxation. However, know your limits and get to bed at a reasonable hour if you have to attend early morning sessions. Don't exhaust yourself.

9. A gathering of men at a dental convention serves as a stimulant to learning. However, don't leave your enthusiasm at the convention. Return to your office with renewed vigor and fired with ambition.

10. Don't miss the exhibits. The companies presenting the dental exhibits help to pay for the convention. They also afford you the opportunity to learn about the newest dental products at first hand.

A convention is a great place for renewing old acquaintances, making new friends, adding to your store of dental knowledge, and just plain fun. Be a clever conventioneer, get the most out of your next dental convention by investing a little time in planning. You'll receive a bonus in added knowledge and enjoyment.

446 Clinton Place
Newark 8, N. J.

INTERNATIONAL DENTISTS

Scientist and teacher, Doctor Herman Becks, University of California Dental College.

DOCTORS AND DENTISTS

"Doctors and dentists"—an expression I have heard;
Is to me one that is ignorantly absurd.
"Doctor" means teacher—and this should be known,
So why call an M.D. a doctor just alone?

Now I do not claim to be a Percival Prim
And there is no one person I wish to trim,
But what gets my goat is for an M.D. to shout
That "the doctor is in, but the dentist is out"!

A veterinarian is a doctor the same as an M.D.;
A chiropractor, a chiropodist has that title you see.
A teacher of philosophy is a doctor also,
An osteopath and a minister are in the same row.

Now my wife she smiles when I romp and rave;
She says what I'll gain is an early grave;
But why in the world can a man be so dumb
As to show such distinction and remain so mum!

"Physicians and dentists" is quite proper to say.
Now you editors, you listen—one more word if I may;
Stop printing such wording as I read all the time,
As "Doctors are Wanted"—but please mention which kind.

"I'm going to be a doctor" I hear kids exclaim,
And I admire their ambition for its a profession of fame.
But I am tempted to yell out loud with this rot:
"What kind of a doctor—horse, toe, or what!"

Aubrey F. Suit, D.D.S.

Mural in the Institute of Dentistry, University of Santo Domingo, in the Dominican Republic.

Part 10

Treatment in Oral Cancer

in a series

by Joseph Murray, D.D.S.

Modern research indicates that chemotherapy (treatment with chemical compounds, like colchicine and nitrogen mustard) and hormonal therapy (use of male and female sex hormones) may be instrumental in curing certain types of cancer in the near future, but the fact remains that a malignant growth in general, and oral carcinoma in particular, can be treated effectively today only by surgery or radiation or a combination of these two therapeutic measures.

Usually the cancer victim prefers radiation to surgery, based on the fallacy that the former method is not painful, will not produce deformity, and does not entail anesthesia and the complications of surgical interference.

In the past a good deal of controversy existed as to the method of choice. Even at the present time both forms of treatment are considered competitive. Yet, as Doctor Hayes Martin advises, "The choice should obviously be based upon the following single consideration: which method when employed initially will give the best chance of permanent cure?"

Should both forms of therapy have equal curative value, then the treatment that produces the better cosmetic and functional result and the least morbidity would be indicated.

At times the family physician or dentist will be asked to give an opinion, especially if a difference in choice of method exists. He should bear in mind that the patient's welfare would best be served by a therapist who is skilled both in surgery and in radiology, for cancer is uncompromising. Should incomplete surgery or inadequate radiation therapy be performed, then the neoplasm would continue to spread until heroic measures of any kind are futile. For, it must be remembered, that a cancerous growth is never subsequently found suitable for operative cure as it was in the beginning, and frequently irradiation is responsible for serious complications if surgery is attempted afterwards.

In the opinion of Doctor S. G. Castigliano, the primary or local oral lesion is best treated by irradiation. He has come to this conclusion after having observed the results of many years of experience with his own efforts and after having weighed the outcome of cases treated by clinicians before him.

As for the question of metastasis, this noted oncologist feels that surgery alone, although the dominant

which result from malacic diseases of bone.

These changes are characteristic and are easily recognized in roentgenograms and casts. The extent of alveolar bone recession can be accurately gauged in mm. from the papilla of the maxillary rugae as a point of beginning to the plane of occlusion as a termination point; and again from the papilla to the median line of the mandibular ridge crest to reestablish the correct height of the interalveolar crestline space dimension.

The once normal vertical dimension of the interalveolar crestline space and the elevation of the plane of occlusion can now be described as extant.

The elevation of the plane of occlusion must be recaptured in advance of the interalveolar crestline space which is to contain both dimensions—for which the nomenclature committee seeks a newer appellation as yet undetermined. Finding these correct dimensions is a task separate and apart from the manufacture of an articulator. It must be done by the operator at the chair using pre-extraction casts and precision instruments.

There are at least thirty malacic diseases of bone that induce atrophic changes in the alveolar processes of both jaws.

Some of these changes affect the elevation of the plane of occlusion. They invariably affect both ridge crests which absorb in opposite directions *from* each other *and* the plane of occlusion, thus increasing the height of the interalveolar crestline space.

Inversely, pathological changes decrease the height of the interalveolar crestline space and affect the integrity of the plane of occlusion by causing it to deviate from its normal position—a deviation that is described as extant. Diminishing heights of the space are typical, as are changes in the location of the elevation of the plane of occlusion in this category and are caused by encroachments upon the plane of occlusion from opposite directions by the opposing ridge crests. Diminution of these space heights are termed extant.

They are induced by staggered extractions, hypertrophied tuberosities, abraded teeth, drifting teeth, and exfoliations.

Recapturing the extant heights of the planes of occlusion and the interalveolar crestline spaces is done by use of auxiliary pre-extraction casts with mm. precision.

The elevation of the plane of occlusion is recorded first by measuring the length of the maxillary incisor in situ on the cast, from cervix to its incisal edge in the median line.

In the edentulous state this dimension is transferred to the maxillary occlusal rim in mm. by placing one beak of the outside caliper in the fossa

of the base plate formed by the incisive papilla. The other beak is placed on the labial surface of the occlusal rim and the dimension in mm. is marked. With this mark as a guide, the occlusal rim is heated and paralleled anteroposteriorly with the tragus-ala line previously drawn with a tissue pencil on the face from the lower border of the external auditory meatus to the ala of the nose, thence laterally with an imaginary line drawn through the pupils of the eyes.

The arbitrary occlusal plane thus established is carefully equalized and notched to receive its mandibular counterpart which is heated and closed against the maxillary occlusal plane to the predetermined dimension taken from the papilla to mandibular ridgecrest in the median line.

The papilla of the maxillary rugae thus becomes the anatomical landmark used as a point of beginning from which to gauge elevations of the occlusal plane and heights of the interalveolar crestline space.

It should be apparent that the maxillary plane of occlusion is recaptured with the maxillary occlusal rim as an initial step to be followed by the recapture of the interalveolar crestline space as a second distinct and concluding step. The maxillary and mandibular planes of occlusion are thus integrated with the temporomandibular articulation to act as reciprocal dependents one upon the other during mastication. When the occlusal rims are assembled with millimetric precision the inter-occlusal or so-called free space is automatically restored. Centric occlusion is likewise reestablished in its correct vertical and horizontal position.

The coined word "vertocclusion" can be used (if acceptable) to describe the dimensional union of both occlusal planes in preference to the less euphemistic and inexact term "the height of the bite."

516 Sutter Street
San Francisco 2, Calif.

A vital essay on an important theme

VERTOCCLUSION

by Frank H. McKevitt, D.D.S.

The term "the height of the bite" is not at all descriptive or euphemistic. Because of its long and continuous use in dental literature it has become an habitual prosthodontic expression. Doctors Norman G. Bennett and Alfred Gysi and their predecessors have perpetuated its use.

Ineffectual attempts have been made to change this term to "the vertical" and also to the lost dimension which figuratively describes it.

Modern dental graduates with degrees of A. B., M. A., and D. D. S. frown upon, and will not accept without protest, the older terminology, and not without reason, for its language is ambiguous and not precisely descriptive.

The purpose of this paper is to attempt to clarify some of the technical intricacies of the subject under discussion in order that unequivocal terminology may be derived, one which involves the recapture and integration of the correct plane of occlusion and the correct height of the interalveolar crestline space when disease has destroyed the normal condition.

Before deviations from the normal can be recognized, acquaintance with the norm must be had. The norm is established by the eruption of the mandibular and maxillary first molars. The elevation of the plane of occlusion is established concurrently with it and the temporomandibular articulation for functional and reciprocal dependence of the three units one upon the other. The elevation of the plane of occlusion and the interalveolar crestline space vary from patient to patient, therefore no averaged dimensional height can be struck.

When disease occurs, changes take place in the vertical height of the interalveolar crestline space and in the elevation of the plane of occlusion.

The changes can be recorded under two separate categories, one of which describes increases and the other decreases in the heights of the vertical dimensions of the interalveolar crestline space. A third extraneous factor results from human errors while the dimension is being reestablished prosthodontially at the chair.

Alveolar bone is a highly specialized tissue. When it has served its purpose it is readily absorbed. It is also absorbed while teeth are present and in good positions in the mouth because of atrophic changes

agent in the treatment of such cases, fails too often. And irradiation alone is too conservative to be effective. Therefore, in metastatic involvement Doctor Castigliano advocates, in properly selected cases, a technique utilizing preoperative precision irradiation to the nodes, followed by radical surgery, as the method of choice. On occasion, extensive surgery is the only means of salvaging a patient who has undergone poorly planned or executed radiation therapy.

In general, the reactions to this therapeutic measure are both systematic and local.

Frequently there is loss of appetite, nausea, vomiting, diarrhea, loss of weight, headache, and dizziness. Leukopenia, a decrease in the number of white blood cells, is occasionally present, confining the patient to bed. What is more, if not recognized, this condition can end fatally.

Some common local reactions are blistering of the the skin (vesiculation) and inflammation of the mucous membrane, together with different degrees of pain. These reactions will vary in intensity, with dosage, number of treatments, and tissue tolerance of the patient.

The effects of radiation therapy on the dental structures often are toothache, alveolar process and tooth destruction, and osteomyelitis of the jaw bones, especially of the mandible, commonly known as osteonecrosis or osteoradionecrosis.

This phenomenon will be discussed more fully in an article to follow.

Regarding the role of surgery, besides its employment as a major factor in the eradication of the malignant lesion, it is used to remove precancerous growths, teeth, and sequestra; to control pain and hemorrhage; and to eliminate nonradiation-sensitive neoplasms, like mixed tumor, adenocarcinoma, ameloblastoma, and sarcoma.

Since surgical excision and radiation therapy often cause scarring or loss of normal tissues, plastic and reparative surgery is frequently utilized in mouth cancer. And it is not uncommon for the specially trained dentist to replace with a prosthetic appliance, parts or the whole of such structures as the hard and soft palates, gums, maxillae or mandible removed by surgery; or to replace with an artificial replica an organ like the eye, ear, or nose when reparative or plastic surgery is impracticable or impossible.

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HARVEST TIME REFLECTIONS

When autumn comes
And students go
In wan pursuit of knowledge,
A friend asks me
To recommend
His son for dental college.
I tell my spouse
A dental wife
Is wise if she perceives
A dentist has
More pressing work
Than raking Autumn leaves.
My office girl
Has autumn fruit
And gourds upon our file
Above the bills
As yet unpaid;
I pause—reflect a while.
There's gold upon
The produce from
The land the farmer tills,
I wish that I
Could harvest too
The gold in "them thar" bills!

Nancy Talbert

Rebating Relatives

Should you

or should you not?

by Rolland B. Moore, D.D.S.

Last month a dental friend from the West Coast visited me for a few days. We were sitting in my reception room one morning when a lady came in and said, "This is the day you were to put my new bridge in. Is it ready, Rolland?" I told her it was, and I cemented the bridge in.

After she paid her fee and left, my friend said, "She seemed to be an old friend."

I replied, "She's more than a friend; she's my Aunt Anna."

Surprised, he asked, "And you didn't give her a rebate on that work?"

I shook my head. "Of course not. She would not have expected it. After all, her husband has a lot more money than I have."

My friend sighed. "It's a lot different with me. Even second cousins expect me to cut my fees for them. If I didn't they would be angry. Don't you reduce your fees for your relatives?" I said I did but only for my immediate family—brothers, sister, and their children. I noticed he was wearing a fine suit and, thinking I'd change the subject, I told him I liked his taste in clothing.

"It ought to be a good suit," he said. "It cost enough." Then he added that he had bought it from a cousin.

"Did he give you a special price?" I asked.

"I should say not! He charged me what he would have charged anyone else. And I have been doing his dental work for years at a 50 per cent discount too!"

I suggested: "You do this from now on: Whenever you buy anything from him, put down exactly half of his selling price and thank him for the discount. If he objects, tell him he has had his dental bills halved by you."

"Curing" a Relative

I had trouble with some of my own relatives when I first began my practice. They seemed to think I was fair game. I got fed up with it. My wife and I talked it over. Later Henry, a relative, came to the office. He had two hours' work done. Then he got out of the dental chair, thanked me, put on his hat, and left.

The next morning my wife went into his meat market and selected a fine beef roast. It was wrapped up, the charge was penciled on the wrapping paper, and the bundle was handed to her. She thanked him, smiled, and walked out of the market without paying. Henry looked puzzled. Then he called after her, "I get it now, Anna." Since then, he asks me how much his dental fees are—and he pays.

There is no reason why relatives—other than one's own immediate family—and friends shouldn't pay for dental treatment. After all, you would not expect them to give you merchandise off their store shelves or personal services without charge, or at a discount, if they are in business. You have nothing to sell but your time and services. They are the same as money. Presumably your cousins would not come to you regularly and ask you to give them money. Yet that is what happens when they do not pay the full cost of your time and services.

Charging Other Dentists

Many dentists do not charge other dentists for work they do for them. I believe it is a mistake not to make some charge, say 50 per cent. None of us feel easy if we have gone to another dentist and take up part of his working day without adequately reimbursing him for time he could have made profiable for himself. Then there is another aspect to consider.

I had a lower molar that began to ache. I went to a dentist I knew. Probably because I was another dentist, he felt he didn't have to "bother." He shot the anesthetic in, laid down his needle, grabbed his forceps, and then, without waiting even ten seconds to give the novocaine time to anesthetize, he extracted. Frankly, I never suffered such pain in my life. I thought I would faint. Had he waited ten minutes, I should have felt no pain. When I recovered, I asked how much I owed him.

"DON'T PLAN ON BUYING A NEW CAR THIS YEAR."

He grandly waved aside my question as though he had done me a great favor.

"Not a cent, doctor. No indeed," he said. I asked what he would have charged anyone else. He told me. I insisted on paying the fee. I told him I was not a pauper yet, and added it was the most painful extraction I had ever experienced. I told him some other things, too—even though he was a devout church member.

To get back to my California friend: He said he had always cut his fees in half for physicians and nurses. I said I did also, and for clergymen as well. I told him the following story.

A clergyman came to me for dental work. What followed is something I shall always remember. After I had finished, he asked my fee. I figured it up, then cut it in half.

He said, "Look here now. I can and expect to pay just as much as anyone else. You need your money, it comes harder, and it does not go as far as mine. You have a family to support and office expenses. Here is the full amount of your bill." He laid the money on my desk. "I insist, doctor. Please." He thanked me and walked out.

I have heard this question of rebates and no fees discussed among dental groups. But I prefer to pay my way with a dentist who works on me. I don't want dental care for nothing or at a discount. And I see no reason to give relatives and friends rebates, which are the equivalent of cash handouts. You and I, doctor, have a living to make, the same as they have. It is not fair to us or our families to play the role of "fall guys."

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