MOMENTUM

News & Viewpoints for Eastman Dental Center Alumni & Friends

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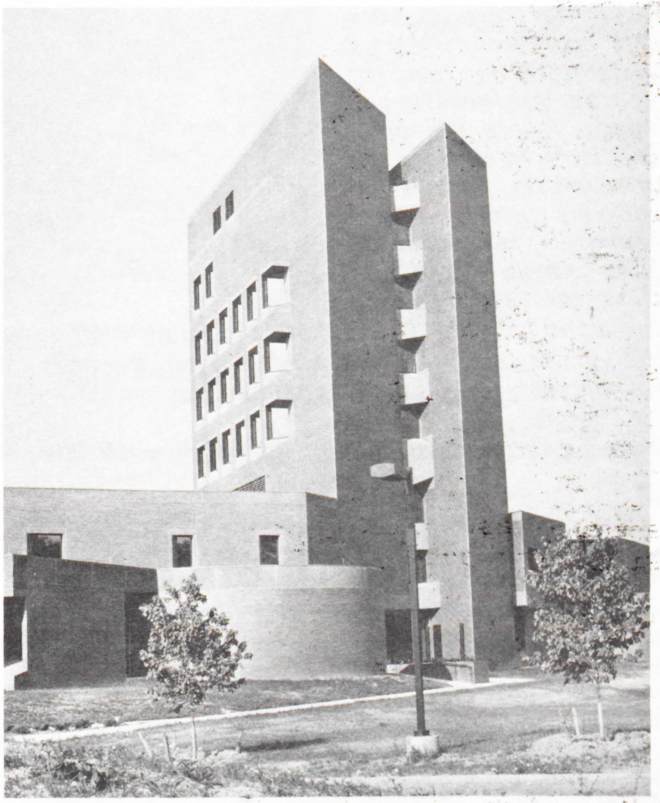
William D. McHugh, D.D.S., Director
Jo Helfer, Editor

From The Director's Chair

Eastman Dental Center is now located at 625 Elmwood Avenue, Rochester, New York! The move from the Main Street building took place in May 1978 and, thanks to the excellent efforts of our staff, proceeded smoothly and without major problems. Our new facilities are proving very functional and pleasant and, once the various problems associated with the electrical and ventilating systems have been overcome, should serve us very well for many years.

The formal dedication of the new building is scheduled for Thursday, October 26, 1978, when Elliot Richardson, former U.S. Secretary of Health, Education and Welfare and currently Ambassador at Large to the U.S. State Department, will be the principal speaker. Alumni reunions, workshops and symposia are also being arranged and we hope that all of our alumni and friends will have an opportunity to visit our new home on one or more of these occasions.



Commencement

Thirty-seven residents received certificates marking completion of their studies at EDC at a ceremony in our new auditorium on Friday, June 16.

Dr. John W. Hein, Director of Boston's Forsyth Dental Center, was guest speaker. Dr. Hein, who received a D.M.D. from Tufts College Dental School, was awarded a Ph.D. in Pharmacology by the University of Rochester School of Medicine and Dentistry in 1952. Upon receiving that degree, he was named Chairman of the Department of Dentistry and Dental Research at UR, a position he held until 1955. From then until he became Forsyth's Director in 1962, he was first Dental Director of Colgate Palmolive Company and then Dean of Tufts Dental School.

Excerpts from Dr. Hein's address follow.

Opportunities for Leadership for our Dental Centers

I am very pleased to be honored with the privilege of being the first graduation speaker in this splendid new home of the Eastman Dental Center. It is just a few days short of thirty-two years ago that I arrived in Rochester to begin my research training. At that time Eastman was about to become reinvigorated under the spirited leadership of Basil Bibby. And now I am fortunate to be on hand once again at a moment when Eastman has prepared itself to challenge new horizons. I use the word fortunate most deliberately because institutions have the precious quality of being an immortal element in the affairs of mortal men and as such they possess the capacity to maintain a continuity of purpose far beyond any single lifetime.

I am certain that each of you, who are graduating this year, will find in the years ahead that the Eastman Dental

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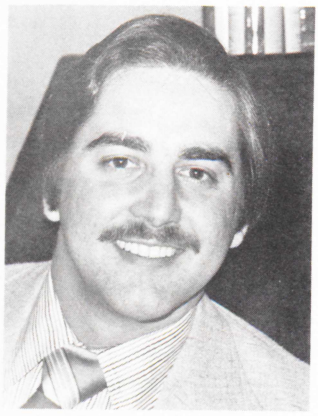
Recent Thesis



Jaime de Jesus, who received his Certificate in Ortho in 1976, is currently associate professor of orthodontics and coordinator for all undergraduate research at the University of Puerto Rico's School of Dentistry. In addition, he practices in partnership with his father. . .also Jaime. . .and also an EDC Ortho graduate, class of 1959. Dr. de Jesus and his wife, Dianne, are expecting their first child in July and "are very excited about the baby." He enjoys boating, diving and photography.

Craniomaxillary Growth Changes in Cleft Lip and Palate

by Jaime de Jesus-Vinas

This study was sparked by a need for additional information pertaining to the craniomaxillary growth process in unilateral cleft lip and palate during the second decade of life. The nature and degree of growth coordination in the maxillary to cranial base segment as well as the possible range of nasopharyngeal space adjustment between these two areas are of specific interest.

Data focusing on the craniomaxillary complex was gathered in an attempt to differentiate hereditary from acquired influences in cleft palate growth. The longitudinal analysis of skeletal relationships could permit distinguishing between those morphologic characteristics most related to cleft lip and palate from those related to skeletal development. The extent to which extra-maxillary structures were involved in the cleft anomaly was also of specific interest.

Thirty repaired complete unilateral cleft lip and palate males were followed during the second decade of life utilizing lateral cephalometric roentgenograms. Data were collected starting at nine years of age, in two year intervals, up to early adulthood. The subjects were subdivided along skeletal guidelines identifying maxillary protrusion, retrusion and an average relationship. A control group of thirty non-cleft males of similar age and skeletal characteristics was obtained for comparison. The variables studied were designed to analyze the maxilla, cranial base, sphenoid bone and nasopharynx both in dimension and in form. The collected data were then subjected to an Analysis of Variance for the statistical testing of the cleft and skeletal attributes.

The following conclusions were drawn:

1. Total and anterior maxillary development are related to the skeletal relationship present even in repaired cleft individuals.

2. The posterior maxillary area is highly susceptible to the cleft anomaly exhibiting reduced vertical and hortizontal dimensions.

3. The overall cranial base dimensions and form are unaffected by the presence of a cleft palate.

4. The pharyngeal form of the cranial base is flatter in maxillary retrusions and more convex in maxillary protrusions.

5. The sphenoid bone is related to the skeletal relationship, exhibiting an increased antero-superior length in cases with maxillary retrusion and reduced length in maxillary protrusions.

6. The sphenoid bone uprighted slightly with age. This change is masked during the growth process to a large extent.

7. The nasopharynx grew larger with age but the cleft group showed consistently smaller dimension for height and length and airway space.

8. The nasopharyngeal form became narrower in both groups with time.

The cleft lip and palate population was found to be different from controls within a well defined area. The posterior maxilla was shorter and more cephalad than normal. It was closer to the cranial floor and foramen Magnum as well. The bony nasopharyngeal height and width dimensions were reduced and the airway smaller. The posterior maxillanasopharynx region appears to be pivotal in the postnatal cleft growth process. Form and function meet in this area important to almost all the sensory functions and many motor functions of the head. The cleft palate anomaly should thus be viewed as a complex interplay of the hard and soft tissues.

Seven months before he received his Perio Certificate in June 1977, Michael E. Kantor won second place in the prestigious Orban Award Competition at the annual meeting of the American Academy of Periodontology.

After spending a year in Boston in private practice and as a part-time clinical instructor in the Department of Periodontology at Tufts, Dr. Kantor is moving to Minneapolis. He will be an assistant professor in the Department of Periodontology at the University of Minnesota and practice in the area.

The Influence of Periodontal Inflammation...

by Michael E. Kantor

To clarify the relationship between trauma and inflammation in peridontal disease, a study was designed to investigate the potential for regeneration in the peridontium following the removal of both inflammation and trauma in the squirrel monkey. If marginal inflammation has some inhibitory potential upon bone regeneration, it would also be of interest to determine whether bone loss due to periodontitis alone would be reversible after removal of the factors responsible for the inflammation.

When the agents responsible for the inflammation in the connective tissue of the marginal periodontium and the jiggling trauma were removed, there was no coronal

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Recent Theses...

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gain of connective tissue attachment, but a significant regeneration of alveolar bone occurred. Removal of the traumatic influence alone in the presence of an existing marginal periodontal inflammation did **not** result in any alveolar bone regeneration. It must be concluded that the presence of an existing marginal inflammation in the supracrestal connective tissue inhibited the potential for alveolar bone regeneration.

The speed of bone regeneration was remarkable. Two weeks after resolving the inflammation and stopping the jiggling, new bone appearing to be structurally the same as woven bone, accounted for one-half of the total coronal interproximal bone.

There is an apparent potential for bone regeneration when periodontal destruction results from a combination of inflammatory and traumatic factors. There now appears to be a biologic basis for therapy when periodontal destruction results from a combination of these factors.

Following the removal of factors responsible for periodontal destruction, there is also a potential for alveolar bone regeneration without any evidence of new connective tissue attachment. Since the greatest increase in bone occurred when inflammation and trauma were present and subsequently removed, it may be concluded that when both these factors are present, there is more regenerative potential than when these factors occur separately **or** that this may be due to the greater destruction as compared to when only a single factor caused the bone loss.

It would seem prudent to eliminate these factors early in periodontal therapy when periodontitis and trauma are present either alone or in combination. Therefore, the periodontium's own innate potential for healing is realized, so that alveolar bone regeneration can occur giving a more favorable osseous architecture before any definitive surgical procedures are planned. This investigation provides some evidence of a biological basis for initial preparation (i.e., removal of plaque-retentive factors and occlusal trauma) in the management of periodontal disease.

To conclude:

1. After the removal of both inflammatory and traumatic factors, there was significant bone regeneration. This verified the hypothesis that existing marginal inflammation has the potential to inhibit bone regeneration.

2. When alveolar bone loss resulted from an experimental marginal inflammation alone, bone regeneration occurred after the marginal inflammation had been resolved.

3. Although bone regeneration occurred in situations 1 and 2, the resultant amount of bone was not the same. It is unclear whether this was due to the magnitude of the initial bone destruction or the nature of the etiologic factors.

Commencement...

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Center will exert a continuing and significant influence on your careers.

Let us return to the origins of our institutions and observe our common ancestry. Forsyth arose out of the ashes of controversy and conflict. A dentist named Ervin A. Johnson, who was a member of the faculty of Tufts Dental School, became interested in the special problems of providing dental care for children. In vain he tried to convince Tufts and then Harvard Dental School to undertake the development of programs of dentistry for children. Both institutions turned a deaf ear to his proposals. This irritated Dr. Johnson. In fact, it made him so angry that he would talk to his patients about his problems. One of his patients was an industrialist named James Bennett Forsyth, whose numerous patents had made him and his family wealthy. After one of Dr. Johnson's diatribes, Mr. Forsyth asked Dr. Johnson what he would do if he had a lot of money. The answer was quick and clear. He'd build an independent institution devoted to the oral health of children and make sure that it could never directly or indirectly come under the control of any other institution. Nothing more was said on the matter by Mr. Forsyth but when he died his will contained the provision to build and endow the Forsyth Dental Infirmary for Children which would devote its energies to patient care, postdoctoral education and research. The will expressly forbids the institution from becoming involved in undergraduate dental education and it must always remain independent. In 1910 a charter was obtained and in 1914 the building was completed. In the interim, organized dentistry and the dental schools of Tufts and Harvard raised great hue and cry over the imagined dangers presented by the creation of this novel institution within their midst. Surely an institution giving free dental care to indigent children, conducting a postdoctoral program in an unknown specialty and doing dental research was indeed a fearsome abomination which should be destroyed before it spread like a plaque.

Fortunately, there was another self-made wealthy industrialist who was not intimidated by the power of the dental establishment. We at Forsyth know him by the name of Mr. Smith because that was the name he used on the day he visited Forsyth shortly after it had opened. His real name, of course, was George Eastman. The Rochester Dental Dispensary was born.

Both of our institutions are the products of the philanthropic urges of two inventive, self-reliant, independent thinking, highly successful representatives of the free enterprise capitalistic system. Do these roots impose any special obligations on our two institutions? To me the answer is an emphatic yes! As the only two institutions of our kind in the entire world of dentistry and owing our existence to two very special people, who backed their philosophies with endowment dollars, we surely are obligated to march to their drummer and obliged as well to let others hear the beat by way of innovative, imaginative and fiercely independent programs.

Does the private sector of dental education have a future? **Certainly.** The disappearance of private schools is not peculiar to dental education. It is part of an international trend coincident with the disappearance of all manner of private institutions and philanthropic organizations. It is my belief that without private institutions to provide breeding grounds for champions of the private sector, any field of endeavor will eventually lose this option of operation. If this happens to dentistry, would it be a bad thing for the oral health of the American public? For myself I have strong attraction for a competitive system based on the idea of providing incentive to the individual by offering rewards for the exertion of imagination and initiative and the taking of

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Commencement...

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risk. But the fact that this is my philosophy is of far less consequence than the fact that it unquestionably was the philosophy of the men who founded our institutions. I believe this imposes upon us the obligation of being staunch advocates of all private sector approaches to the solution of oral health problems. Furthermore, since we are two of the very few institutions in dentistry which enjoy the benefits of a reasonable endowment, the responsibility to meet this obligation falls especially heavy upon us. Indeed, it is not at all unrealistic to project that Eastman and Forsyth might well become the last bastions of private endeavor in dental education and dental research, the last examples of the private sector alternative in respect to these endeavors, and the last breeding ground for teachers, researchers and practitioners who are champions of the private sector alternative.

Eastman and Forsyth have not only a symbolic role to play. Their role must also include an aggressive defense of the private sector and everyone associated with our institutions and especially our graduates must be aware of this mission.

It is often found that the best defense is an offense. This is especially true when one is outnumbered and endeavoring to turn situations around. That is certainly an apt description of the private sector of dentistry and I believe our institutions must assume a more activist role relying heavily on the most precious possession given to us by our founders. Freedom. Freedom to be innovative. Freedom to have the courage to try and fail and try again. Freedom to challenge the mainstream of consensus. Freedom to be different. Freedom to do or not do just about any project related to the field of oral health. It still startles me everytime I recall that no other institutions in the entire world of dentistry possess the degree of freedom enjoyed by our Centers. Indeed, when the need arises we can pay the price of challenging Boards of Dental Examiners, Commmissions on Accreditation, the vested interests of specialty groups, organized dentistry, industrial interests or governmental bodies because the existence of each of our institutions is independent of the continuation of any of our specific activities.

During the past two years I have been especially proud of the leadership which your institution has taken in promoting non-hospital based general dentistry programs. If Eastman had not had the courage to challenge the U.S. government, the Council on Dental Education and the Council on Hospital Dentistry, the future of training programs for primary care dentistry would have been dim. For what it was worth, Forsyth was close behind in your protective shadow all the way. We at Forsyth also compliment you on your courage in undertaking the building program which has resulted in this magnificent new home for the Eastman Dental Center. We all know that it was not the most opportune time to undertake a major construction project and we therefore admire your courage in squarely facing the fact that bold measures were necessary to bring facilities into line with your institution's aspiration to be a continuing symbol of excellence for the private sector of dentistry. All of us at Forsyth sincerely hope that your new facilities will be as great a stimulus to Eastman's advancement as our new facilities were for our institution.

The very fact that you have undertaken a fund-raising program to accomplish your project is also very much a part of meeting your responsibilities as a free and private institution. I do not need to ask in order to know that fund raising has been difficult, frustrating and discouraging. Back in 1965 when I began our fund drive I learned the shocking truth that dentistry had been its own worst enemy in seeking philanthropic assistance. Whereas medicine has been an aggressive searcher for gifts and grants for over a hundred years, I found that dentistry had never even asked. Private philanthropy and private institutions are symbiotic and we in private dental institutions have not recognized our responsibility to keep this symbiosis alive and well. In failing to meet this responsibility we have played a part in allowing philanthropy to become disoriented toward its vital function as the main source of sustenance for the nonprofit private sector. Examine the record of the major foundations and you will find that most are making grants to public institutions. Examine what is done with the funds raised in the private sector by the American Fund for Dental Health and you will find no commitment to the private sector of dental education. Recall for a moment how many times you have read news items about major gifts from private individuals to public universities and colleges. Go to any meeting of the American Association of Dental Schools and you will hear the deans of state supported dental schools excitedly discussing their fund drives aimed at the private sector and, if you should be so audacious as to challenge them on grounds of territorial prerogatives, you will be told there are no private dental schools. Admittedly Eastman's current fund drive is only one voice against the many but the very fact that it now exists is of great significance. I am hopeful that having gotten out of your shell and tasted the blood of philanthropy you are now addicted and will join with Forsyth in a counterattack to rechannel philanthropy toward the private sector of dental education and research.

As graduates from the postdoctoral programs of the Eastman Dental Center, you now enjoy the privilege of sharing in and becoming a part of the heritage of this institution. If you have not been excessively preoccupied with your role as students, you will be well aware that your education and training depended to a substantial degree upon the endowment income of the institution. I do not mention this fact to chide your philanthropic instincts. I mention it only to emphasize that you have shared in the resources which make this institution free and in so doing you, yourself, share in this freedom. This is no mean gift because I remind you that, if I were to say this at any of the state supported dental schools in this country or around the world, it would be untrue.

Mr. Solzhenitsyn had some harsh words to say at the Harvard commencement this year concerning our loss of courage as a society. I personally am in agreement with him on this point. However, the courage of a society is the sum of many parts and, therefore, we must each evaluate his criticism in relation to our own special area of concern. When I do this, I find Eastman and Forsyth standing against his criticism. I hope that each of you are of the same opinion because, if you are, we have the essential resources to do our part in correcting the situation. In the final analysis this will be the greatest challenge that our dental centers and our graduates can answer.

I wish each of you great happiness and much success in your future careers. I also wish that you will have the great pleasure of seeking out, facing up to and resolving significant challenges to the profession of dentistry.

Alumni News

Dr. Elmar Montag, '57, in a delightful letter from Munster, Germany, says: ". . . The building boom is like an infection all over the world. Munster is just building a new Dental University, and as I can see from your information, Rochester EDC is starting a fabulous project. Congratulations! I enjoyed working at the old EDC very much and I like to be in touch with you even after 21 years. That is the reason why I try to help a little bit on the Campaign . . . We hope to come over some day ourselves and take a look at (the new Dental Center). Our son is trying to become a Dentist too. He even might have the same opportunity to work at the EDC as I had . . ."

Dr. Michael McCann, '59, sends the good news that he has been promoted to the rank of Clinical Professor at the UCLA School of Dentistry.

Dr. Barrie Gillings, '61, writes from Sydney, Australia: "I submitted the plaque tunnel as an entry in the J and J International Preventive Dentistry Awards Competition, and received for it an honourable mention . . . The other matter which might be of interest is my development of an intraradicular denture retention system based on cobalt/rare earth magnets. Retention per unit is about 350 grams. I have now treated ten patients this way, with excellent results. Allen Brewer might like to try some. I would be happy to supply the magnets at cost, and hope to have an instruction leaflet and some photographs of clinical results available in the next few weeks . . .The new premises look wonderful. I hope I can get an opportunity to see them on my sabbatical in the latter half of 1978."

Dr. Ziaeddin Sheykholeslam, Pedo '72, is now Associate Dean for Research & Postdoctoral Programs at the Dental School of the College of Medicine and Dentistry of New Jersey.

General Residency Study

EDC's Department of General Dentistry has just completed successfully a series of "Workshops To Assist The Development Of Residency Programs In The General Practice Of Dentistry." The project was funded by HEW with a one-year $133,000 contract. One hundred and forty people, representing 37 states and Puerto Rico, attended the three regional workshops.

The western workshop was held in Los Angeles in April; the southeastern workshop in Augusta in May; and the northeastern one at the new EDC in June. Kudos came from many:

"...it was the most well-organized and informational meeting we have attended. Especially noteworthy was the attitude and level of expertise demonstrated by all members of your staff with whom we come in contact."

"I write...to compliment you on the effectiveness of your team, especially the productivity demonstrated by Dr. Stanley Handelman. As a result of his planning and organization, I found the Workshop efficiently productive and an excellent forum for discussion of common problems."

Staff is now evaluating the Workshop and writing a project development manual.

Capital Campaign

The Capital Campaign has raised more than $2,464,000 and is at seventy percent of its $3,500,000 goal.

Alumni contributions now amount to $47,950. Many have designated that their pledges go to the Department to which they were attached. Particularly delightful are notes from alumni reminiscing about their days at the Center.

We hope that those of you who are planning to make a pledge will do so shortly. A brochure listing all contributors to the Capital Campaign will be published for EDC's October 26 Dedication.

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