

The serumal deposit is always on the root, never on the crown, of a tooth. When you can see the chalky deposit about the necks of the teeth, even though the gums be inflamed, you may be sure it is only a simple case of gingivitis, the deposits are salivary and are easily removed. This is a condition of every-day experience and easily cured; but when the deposit cannot be seen, when the gums look irritable and hypertrophied, with small quantities of pus oozing from them upon pressure, then you can conclude that there are nodular deposits present, giving rise to a pathological condition distinct and specific. I do not claim that these deposits are always present. Indeed some say they are never found in the advanced stages of pus degeneration and destruction of the peridental membrane. Again, these deposits may be found where there is no break on the gum at the gingival border, showing they are not formed from the oral fluids. Kirk, Pierce, and Barrett attest that these nodules have been found near the apex, while the gingiva was unbroken. In the majority of cases, however, they unmistakably begin at the cervical margin and work to the apex. These nodules are exceedingly irritating, and very difficult to remove. Barrett says, "that the most mischievous irritant is that which lies deepest and nearest the point of actual attachment of the pericementum and the tooth." These deposits may be found on one tooth or on several. It may appear suddenly and without any premonitory symptoms. It is sometimes found in the mouths of young people, but it is generally regarded as a disease of middle life. The wasting away of the alveolar process is undoubtedly the effect, not the cause, of the disease. In the treatment of this disease the principal thing to watch is malocclusion and malposition of the teeth, and, above all, mechanical irritation, which so often gives rise to inflammation of the peridental membrane.

Many dentists claim that teeth crowned with metal are immune from pyorrhea, that the metal acts as a sort of microbe destroyer. The late Dr. W. H. Atkinson tried this method in the advanced stages of pyorrhea, but the experiment was unsuccessful. There is good reason to believe, however, that devitalized teeth are freer from these concretions than living ones. Pulp removal, then, would be justifiable in a stubborn case. This hypothesis evidently has its origin in the belief that when the blood supply of the tooth is cut off by devitalization, an increased supply is given to the pericementum, or in other words, "an increased supply of nutrient material is diverted from the internal circulation to the external, strengthening the pericementum and fortifying it against the ravages of the disease." It is also claimed that pyorrhea rarely attacks a replanted tooth. In fact, replantation is often recommended in a case where the disease has produced malocclusion, and elongation of the teeth. It is not the purpose of this paper to give any form of constitutional treatment, which is doubtless of