

pericementum. Dr. J. N. Farrar has named it *loculosis alveolaris*, as it usually has its origin in a pocket beside the alveolus. Some use the term *gingivitis*, others *infectious alveolitis*, believing it to be of a communicable nature. Professor Pierce calls it *calcic pericementitis*, with the prefix of two clumsy adjectives: the one to designate its local or salivary origin, the other expressive of its constitutional character.

Pierce, as you all know, believes in two different pathological states—different, to use his own words, “in their etiology, their clinical history, in their symptomatology, and in their susceptibility to treatment.” Miller claims that there are three factors in its production: constitutional diathesis, local causes, and micro-organisms. Professor Barrett, who gives a clear exposition of what is really known of the disease, recognizes in it three distinct pathological degenerations. While there is a great diversity of opinion among the leaders of our profession as to the etiology of the disease, none of them underestimate the fact that it is a formidable pathological state and one of the most difficult with which the dentist has to deal. It may be worthy of mention that the advocates of the uric-acid diathesis and the devotees of the micro-organism theory, and those who still hold that it is a local disturbance, and amenable to local treatment, all invariably agree that the first step in its successful treatment is the thorough removal of all calcic deposits, whether these be of salivary or sanguinary origin. To the ordinary practitioner, therefore, it is not a matter of vital importance whether this disease is local or constitutional, whether it is an expression of the uric-acid diathesis, whether it has its origin in the fluids of the mouth, or in the blood, or whether it is associated with anemia, Bright’s disease, tuberculosis, or any other concomitant, the one great point of agreement remains conspicuous—the first step is purely mechanical, “consisting of the thorough removal of all calculus, both salivary and serumal, from the neck and roots of the teeth, washing out the pockets with some antiseptic solution that will put the mouth in a more hygienic condition.”

It may now be asked, what are the chief characteristics of this disease viewed from a clinical standpoint? In speaking of these pyorrhœal deposits I do not include the so-called green stain found in the mouths of children, nor the white deposit, both of which can readily be removed by the application of iodine, with a revolving brush or felt wheel on the engine. Barrett says that even these superficial deposits, if allowed to remain, will form micro-organisms that will disintegrate tooth structure. Salivary calculus is simply a deposit of carbonate of lime precipitated on the teeth by the action of the breath on the saliva. While calcium forms the basis of both the salivary and serumal deposits, the latter possess characteristics and constituents not found in the other.