fitted. Any abnormality or inharmony in the position, size or relation of the teeth of the lower arch will be reproduced or exaggerated in the upper. Further, we will have a reaction from the upper arch, and the lower trying to accommodate itself to the irregularities of the upper, so the forces which govern normal occlusion perverted become the forces of malocclusion. And if we do not place each and every tooth in its normal and destined position, we cannot expect it to remain there or be maintained permanently.

The causes of malocclusion are many, and those things which interfere with nature's plan of the denture we divide into three great classes:

1. Congenital causes—Hare lip, abnormal frenum labii, supernumerary teeth, missing teeth, large tongue.

2. Constitutional causes—Adenoids, lack of development, eruptive fevers, rickets.

3. Local causes—Premature loss or decay of deciduous teeth, prolonged retention of deciduous teeth, premature loss or decay of permanent teeth, tardy eruption of permanent teeth, habits of the lip, tongue, thumb, etc., alveolar abscess, accidents, and fractures. Constitutional causes are of the most importance to the physician, and of all the factors in producing malocclusion the most potent is nasal obstruction, of any kind, but especially that produced by adenoids.

The symptoms of mouth breathing in the child are very plainly marked. It causes atrophy of the nose and jaws. It creates a derangement in function of the muscles of the lips, cheeks and tongue.

In normal breathing the air is warmed, moistened and strained of its impurities. It aids in the maintenance of health in the tissues over which the air passes during inspiration and expiration. It in no way interferes with the delicate balance of pressure between the tongue on the inside and the lips on the outside. It allows the mouth to close and the teeth to lock normally. This balance of pressure is a very important factor. If, however, mouth-breathing becomes established, this beautiful balance of pressure is destroyed. The patient becomes pale, anaemic, the nose short with small wings, the upper lip short and curled upward, the mouth open, the teeth and gums exposed, dry and inflamed, with protruding and elongated upper incisors, narrowed or contracted upper arch, high vault. The lower anterior teeth are lengthened and frequently come in contact with the roof of the mouth when the jaws are closed. The tongue rests now on the floor of the mouth, it no longer maintains the form