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# Dominion Dental Journal

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## Original Communications

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### A PROFESSIONAL WARNING.\*

By MARK G. MCELHINNEY, D.D.S., L.D.S., Ottawa, Ont.

The professions of medicine and dentistry are divided into two great classes, legitimate practitioners and quacks. Each of these professions, as the result of long experience, has accumulated a set of rules, written and unwritten, for the guidance of its members. These rules enjoin those lines of conduct that will conduce to the best interests of the practitioners, and ensure protection and the highest class of service to the public.

Those members of a profession who observe the spirit of these rules are looked upon as legitimate practitioners. Those who disregard the rules are called quacks. Nearly all start out in the legitimate line, but bad fortune, inability to face the long and weary struggle of practice building, bad counsel or example, desire to grow rich rapidly without considering the means, and many other causes weed out a percentage and send them forth to prey upon the world as quacks. Very few quacks succeed in making a brilliant success, for it requires a superlatively clever man to fool the public for any great length of time—the remainder of these sink lower and lower until they become mere street-corner fakirs. The quack holds the same relation to the legitimate practitioner that the tinker does to the skilled engineer, the scab to the honest skilled laborer, and the tramp to the reputable citizen. The quack is a professional tramp. The quack may be, in fact frequently is,

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\* Read before the Ottawa Dental Association, January 12th, 1897.

a skilful man; there have been Napoleonic fakirs in all lines of life, but his methods are not those best calculated to ensure the best welfare of his patients.

There are several reasons why itinerant practitioners, even if skilful, cannot give as good services as regular practitioners. The itinerant has no fixed place of business, no regularly equipped surgery and laboratory. He must put up with the various inconveniences and annoyances of temporary quarters, consequently his services must vary with his circumstances. The quack, in moving from place to place, trusts to his advertising for patronage and does not gain permanent patients, hence it matters little to him what may be the result of his work, for he has no reputation to preserve or character to protect. The quack often, nay, nearly always, lays claim to skill far beyond the range of the regular dentist or physician. A moment's reflection will show that a person possessing such superior skill and powers could attain fame and fortune legitimately in any great city and must be a fool to turn peddler and give his services at half price. The quack having obtained his dupes' money, wishes quickly to be rid of them, and does not care what future trouble may ensue, hence it is positively dangerous to engage the services of such totally irresponsible persons. A case in point—several years ago a dentist came to Ottawa equipped with a brass band, a variety troupe and electric light. He sold patent medicines and extracted teeth by the thousands. Between the distracting noise of the band and the effect of a powerful drug contained in a bulb on the handle of the forceps he actually extracted a large number of teeth in a painless manner. What was the result? A large proportion of the teeth were broken in the rapidity of the operation, the victim being hustled down too quickly to discover this or make protest. A large number of good teeth were sacrificed, the extraction of which was little short of criminal. The last and most serious result was the subsequent inflammation and sloughing caused by the drug or some of its constituents. There were many cases of serious inflammation and suppuration, and in at least one case the victim was in danger of losing the whole lower jaw through caries. Such are the unlovely results of such wholesale malpractice.

The claims of these men to superior skill and special knowledge are totally unfounded. Each and every dentist in Ontario must attend the Royal College of Dental Surgeons for the full course and must pass the prescribed examinations. The opportunities for instruction are equally open to every student. Every effort is made by the professors to obtain the very latest methods and most modern appliances, and no improvement can exist for any length of time without its advent becoming a matter of discussion in the dental journals, which are widely circulated and read by professors,

students and practitioners. There are no trade secrets in dentistry. Individual variations in method are many, and of these any practitioner may choose that best fitted to his requirements, but the system of modern dentistry in all its intricacy is the common property of the dental profession. Our surgeries and laboratories are ever open to our brother practitioners, and at our meetings together we exchange and discuss our ideas and opinions, and above all, what characterizes most dentists as men of liberal and scientific spirit, is that any one who makes an improvement or discusses a new fact immediately calls his brethren together and gives them the benefit of his good fortune. Is it reasonable to believe that an itinerant tooth-puller could by any possibility possess knowledge that could remain hidden from a numerous and educated profession that singly and collectively is continually striving for higher and better attainments?

The claims of the quack are based as much upon his own ignorance as upon his knowledge of the gullibility of human nature. It was not long ago that a young man called at the writer's surgery and endeavored to sell a secret method in connection with crown and bridge work. He was surprised to find that the writer had been shown the same method by another older practitioner in this city, and that in all probability the method is in the possession of almost every member of the profession to-day. In addition, the method is one of minor importance, suited only to occasional cases and more a trick of manipulation than any real improvement in result.

The possession of the degree in dentistry is sufficient evidence of average ability, which is all that average recompense calls for. It may be held that the regular practitioner is afraid that he will lose money if the public patronize itinerant operators. There is also something in this, for the resident practitioner pays rent and taxes, and otherwise contributes to the general prosperity of the community, and the better the public supports him the better services he can render. Every professional man spends much time and money in adding to his knowledge regarding difficult points in practice, and frequently on an especially difficult case he may spend ten times as much as that case can repay. The writer is aware of more than one case where the practitioner, for the sake of the patient, for the sake of his own reputation, and for his own professional satisfaction, brought it to a successful termination at an expense not only far beyond anything received in fees, but owing to fewness of such cases beyond any possibility of future remuneration.

It has been charged that we labor only for the almighty dollar. Were it not for necessity it is probable that many of us would not be in the profession; but once in, it is a poor and mean individual

who does not develop some interest in the welfare and advancement of his chosen calling. Cheapness is the great bait held out by quackery. Mean and ignorant persons imagine that they have done a smart thing in saving a few dollars in medical fees, even if they have, by resorting to quackery, lost the life of a wife or child. It is the same in dentistry. The same people will stop at half a dollar in the price of a filling, even when it may mean the loss of a tooth which is a vital necessity to health and comfort. Even if the quack rendered equally efficient services, which cannot for a moment be admitted, it is a manifest injustice to extend to him the patronage that rightly belongs to the resident practitioners, for to them all other members of the community are more or less indirectly indebted as members of the same social arrangement.

In some of the smaller towns and villages where the population of each is not sufficient to support a resident dentist, it is necessary for one to visit them at intervals, but this practitioner always has an established headquarters and does not come under the definition of a quack. Some of the most reliable men in the profession have practices of this description. They have a clientele in each place, and are as careful of their professional reputation as any of the resident dentists of a large city. The advent of a quack always results in the regular dentists being crowded by a lot of difficult and unsatisfactory cases for which equivalent remuneration is very difficult to obtain. The cases consist of misfitting artificial teeth, uncleanly crowns, roots left in during careless extraction, inflammation from use of powerful drugs, and sometimes even fracture of the jaw from brutal manipulation, and blood-poisoning from the use of uncleaned instruments. Imagine for a moment the extraction of hundreds of teeth in an evening without even wiping the forceps, as the writer has actually seen take place. What a splendid opportunity for the wholesale dissemination of syphilis and kindred diseases. This sort of thing is criminal, and should entitle the perpetrator to a term of imprisonment that would teach him not to indulge in malpractice. The serious results that may follow the use of unclean surgical instruments are not half appreciated by the laity. Ask any physician, and he will say that since the advent of antiseptic surgery the mortality from surgical operations has decreased to an astonishing degree.

It is a fact that the existence of syphilitic virus in the first of one hundred patients operated upon consecutively with unclean forceps could entail life-long misery upon the other ninety-nine, not to speak of transmitted disease through countless generations of their posterity. The dentist who for a greatly reduced fee is compelled to handle too many victims in a given time to make a living, has not time left to attend to such a small, though important,

matter as the cleansing of instruments. He is forced to leave the debris, and perhaps deadly poison, of the last operation in the mouth of the patient next following.

There is no doubt that a restaurant keeper who took no time to wash dishes and table linen could provide meals for a few cents less, but how many customers would he get even in the slums? Yet in a matter of a thousand times more importance some people, for that few cents, will run the risk of misery and even death itself.

A great many would-be wise persons refuse to be warned that the services of the cheap-john are most expensive in the end, and like the people described in the legend of the Noachian deluge, keep right on to destruction. Be that as it may, the profession, in sounding many a note of warning, has the satisfaction of knowing that it has, as far as lay in its power, done its duty.

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### AMBIDEXTERITY.

By HERBERT LAKE, L.D.S., Mitchell, Ont.

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Ambidexterity: a term applied when the movements and sensations of the limbs on one side of the body are under equal control and command with those on the opposite side. There seems to be an unwritten and yet unalterable law to the effect that man should use one hand rather than the other as the instrument of his will. That is to say, one of his hands is the active or controlling member in all that he does.

Right-handedness means, the right hand is the guiding hand, while in work the left one assists. The union is inseparable. In all work which requires both hands the left does as much work as the right, but only as an assistant, and that involuntarily. The active hand is always nearest the work. The baseball player who bats right-handed holds the bat over his right shoulder, has his right hand next the end with which he hits the ball.

The foregoing may also be said of a left-handed person. There are ideas prevalent as to the cause of the majority of about fifty right-handed persons to one left-handed. Some writers affirm that it is a matter of training; that to the untrained child there is no distinction, and as the brain develops, the powers of imitation, together with the training of nurse and mother, bring about the result. There is much in this story. Take a child before the age of training can begin; hold before it a simple toy. Which hand will be reached out to grasp it? As often the one as the other. Further, say for argument's sake that the child is developing left-

handedness. Imprison that hand, and see if the child will not adopt the usage of the other. Naturally it will, all theories to the contrary. Set free the imprisoned hand, and what is the result? In one case which came under the writer's notice, the happy faculty of being ambidextrous.

There are many degrees and shades of right and left-handedness prevalent in adult life. There are many who are ambidextrous naturally—many to certain degrees showing the natural preference for either the one or the other hand, and yet are indifferent even to preferring the alternate use of both hands. They throw a ball right-handed, bat it left-handed, spring into a race from the left foot, but in the running jump may leap from the right foot. The lower limbs are less closely controlled by the will than the upper. Their movements are more often involuntary, though the moment they are in such a position as to change them from their natural bent the brain is at once called in for a decision. Some writers have attempted to prove that the right hand is the one intended by the economy to be the useful hand, and have gone so far as to say that left-handedness is indicative of a lower degree of intelligence. The idea is combatted by all the observations and tests one can bring to bear on the subject.

We know that where there is a choice of two directions of growth or movement in plants or animals without apparent advantage either way, a preference is shown for the one over the other. For example, among the heavenly bodies the planets and their accompanying satellites follow a similar law; all accompany the earth and its moon save the moons of Uranus, which circle their primate an opposite way. The woodbine twines in its own direction, possibly from left to right, but the climbing hop-vines may reverse that and run from right to left. The grain of the rock-elm is always from left to right, but the ironwood of the northern zones grains in the opposite direction. The squirrel will turn to the right as he spirals up a tree, unless there is danger in that direction; but his cousin the chipmunk almost invariably seeks the opposite course. When the question of moral intelligence is mooted in this connection, what can be said of the coon, who turns neither to the right nor left as he shins up out of danger, his heart full of guile and his stomach full of stolen property?

Why does man use his right hand more than his left? Can the arrangement of the internal organs be made to account for it? The heart is lying obliquely in the left side. The organs of respiration differ in size and weight. The blood vessels in the upper part of the body are unsymmetrically arranged. More than one scientist has undertaken to prove this a cause for the action, though it is hard to see that, separate from the brain, any of the organs have ought to do with it. Now, the left side of the brain controls the

limbs on the right side, and *vice versa*. Does anyone venture to say that the left brain is greater in size, weighs heavier, or contains more matter than the right? Popular usage, early training and a predisposition to the right hand accounts for the majority of right-handed persons. It is a fact, however, which cannot be gainsaid, observation has established, and tests have proven, that a left-handed person is with that left hand more skillful, more accurate, more steady than is a right-handed one. It is also a fact that a left-handed person is ambidextrous to a greater extent than is a right-handed one. Popular prejudice is against the left hand, and the right is trained to dexterity. Manufacturers of instruments, of utensils, etc., do not allow for left-handedness, and as a result the unfortunates have either to work under a handicap or adapt themselves to the circumstances.

What is the benefit to a dental operator in being ambidextrous? What operations has he to perform in which he would be helped by his ability to use either hand with equal skill? The statement is ventured, and though discussable, is nevertheless made, that instead of being of use ambidexterity would be a hindrance. Time is money to the dentist, and the time lost in selecting instruments, shifting positions, etc., would not suffice to recompense for the advantage gained by the use of the opposite hand. Again, the servant may make a good master, but the master never makes a good servant. The right hand of the operator is the directing, the motive hand. The left is the assistant. A gold filling is in progress. While the right hand is placing the pellets in position and guiding the mallet, the left is adjusting the rubber-dam, managing the saliva pump, holding the mouth mirror, etc.—a deal busier than the right hand, but still occupying a minor position. Now, let us change places. The left hand directs the work, and training and practice will insure a degree of success unsuspected, but no amount of will-power, practice or determination will enable the operator to perform with the right hand the work of assistance so admirably and yet involuntarily undertaken by the left. You may make the left hand a successful director, but never will the right occupy a subservient position.

As one who has practised ambidexterity with the desire to benefit thereby, let me advise leaving it alone. The results are no reward for the time spent.

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THE most barbarous method of dentistry in the world is that practised by the Kaffirs. The Kaffir dentist places his patient on the ground, and four men hold him down. Then the operator takes a piece of sharpened ivory, steel or wood, and hacks away on the gums until the tooth is extracted.



## TWO INTERESTING CASES OF CAPPED PULPS.

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By R. E. SPARKS, M.D., D.D.S., Kingston, Ont.

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My experience of capping exposed pulps has not been of the most encouraging character. After practising it for twenty years, in all cases where there seemed to be any probability of success, I am led to wonder who extracts or treats the failures of those who report almost universal success.

I think I get a fair share of cases; and, as I said before, I cap all cases where there promises to be a probability of success. I have tried all methods that I have read of, or heard advocated. While I recognize the advantage of a tooth having a living pulp over one from which the pulp has been removed, I must confess that, from my experience, I feel much more confident of success when I have made an application to devitalize an exposed pulp than when I have capped it.

Two cases came under my notice recently, which illustrates this:

Case 1. Miss M., aged about twelve, came to have her teeth filled, on February 27th, 1890. Among other cavities was one on the anterior surface of the left lateral incisor. It was only an ordinary sized cavity, and had never given any trouble. When I removed the decay near the cutting edge, I was surprised to find I had made a slight exposure of the pulp. I capped it. It gave no trouble. On July 8th, 1891, I refilled it with cement. On March 9th, 1894, I refilled it with gold, everything being, apparently, in a satisfactory condition. Until about the new year, 1897, I would have reported this an unqualified success. At about that date the young lady came to my office complaining of severe pain in that tooth. I found the gum swollen above it; the tooth somewhat loose. The color had remained remarkably good. The characteristic opacity was present, however, upon close inspection. This, with the other symptoms, convinced me that my grand success was, as in many other cases, an utter failure. Upon opening into the pulp chamber, pus boiled out profusely. After thoroughly cleansing and a few daily antiseptic treatments, the root was packed with cotton, saturated with eucalyptol and closed up until the 16th, when it was refilled permanently, and, so far, is perfectly comfortable.

Case 2. Dr. R., aged about 65, came complaining that between his first and second molars, on the left side of the lower jaw, food would wedge, and was difficult to remove. Upon examination I found the gum receded considerably from his teeth, making large spaces between them. In the space referred to, I found a large

cavity on the posterior surface of the first molar, about the neck, opening out well to the lingual side. I removed the decay from this opening. At one point it was very sensitive. I suspected that the decay had reached the pulp, but as the tooth had caused him no pain before, I filled the cavity with cement. About two months afterwards he reported that from the time the tooth was filled it was sensitive to thermal changes; that it had become so much so that he had no comfort with his meals. It pained when he went out doors and again when he came in. I was convinced that the pulp must be devitalized. I opened through the grinding surface; a slight shock was caused when the drill opened into the pulp chamber. The main body of the pulp was removed without pain, and the opening enlarged. I found a little nerve matter not entirely dead in the root canals. I dropped a drop of the saturated solution of cocaine in carbolic acid into the pulp chamber and after a little patient working with a broach was enabled to remove the balance of the nerves. After drying the canals with cotton on broaches, followed by hot air, I swabbed them out with eucalyptol, and filled with chloropercha and gutta percha points, at the same filling. This was some months since, and the doctor reports having had no trouble whatever since the operation.

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### INCIDENTS IN OFFICE PRACTICE.

By G. V. N. REEVE, L.D.S., Oswego, N.Y.

Stratagem at times is as necessary in dentistry as in war. A patient called, when the following colloquy ensued: "Some twelve or fourteen years since you filled these front teeth with gold, and they are so nice that I will have nothing but gold in my mouth. My eye tooth is decayed, and if you think it will reach the nerve I will not have it done, but instead will have it extracted. You once killed a nerve for me, and it almost killed me."

I examined the tooth and assured her that it was not very bad, it would not reach the nerve. I commenced to excavate, and doing it carefully had it, as I supposed, ready for the filling. On close examination, however, I saw the pulp shine through the thin wall and at once abandoned the idea of filling with gold. In my palmy days, when I was ambitious, I would have considered this a grand opportunism for capping. In this case there were potent reasons for not adopting it, and in a future article I will give my experience about capping; when and why—when not and why. To tell her the real condition would have involved objections, explanations, etc. In such a case I retire for deliberation, and in this

instance came to the conclusion to ask for time. The gums had been somewhat wounded and I advised her to defer the operation and let the gums heal. Then I applied my devitalizer and covered it securely with a four per cent. cocaine. In two days I was to see her again. At the next sitting she reported no pain. On examination I found the pulp devitalized and no inflammation. Quietly and without creating any suspicion I gently removed the pulp almost to the apex, then forced pure wood creasote up and advised a temporary filling, and she could have a gold-filling later. When next in the chair I showed her the filling, which was white amalgam, and said why not leave it as it is, it does not show from the outside and it will save you several dollars, to which she gladly consented. I then told her about my destroying the nerve, removing it entire unbeknown to her, and such a blank, disappointed expression you can scarcely imagine. I have written this for the benefit of young operators.

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### A HINT ON EXTRACTING.

By E. A. RANDALL, D.D.S., Truro, N.S.

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I have often seen an operator's face and shirt front bespattered with blood, from extracting teeth, while the patient was under an anæsthetic. This is unnecessary. I use nitrous oxide as a general anæsthetic. The moment that the inhaler is taken from the face I push a small sponge into the mouth; this prevents roots, which I may drop in the mouth, from being drawn back into the trachea, and absorbs the blood which would otherwise be swallowed or blown out in the operator's face, and does not prevent breathing, as the patient breathes through the nose.

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### SOLID GOLD CROWN.

By R. E. SPARKS, M.D., D.D.S., L.D.S., Kingston, Ont.

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To make a solid gold crown, stamp cusps of thin soft platina and trim to size. Proceed to articulate. It may be dinged or bent to suit the case. Now melt it full of gold scrap of any desired grade. It will now be found that while the platina has retained the shape of the cusps its color has almost entirely disappeared. If any remain and is likely to be exposed it may be removed in the finishing process.

## TO OPEN PULP CHAMBERS OF TEETH AFFECTED WITH PERICEMENTITIS.

By R. E. SPARKS, M.D., D.D.S., Kingston, Ont.

We often have to open up teeth which are very tender to the touch. The pressure necessary to make a steel drill enter the outer layer of enamel, together with the shocks caused by the revolutions of the flat-sided drill upon the uneven surface of the tooth, causes excruciating pain. To avoid this, grind, with a small stone, a pit at the point at which you wish to enter the tooth. The drill will then run smoothly and penetrate much more easily. When desiring to open on the palatine surface of the incisors or canines, after grinding the pit, take an inverted cone bur, a little larger than the drill intended to be used, and cut into the pit the depth of its diameter. This gives a flat surface for the point of the drill to start into, and avoids the shocks before spoken of. Keep the point of the drill well lubricated with oil of turpentine or glycerine.

## IS A BUSINESS EDUCATION NOT NECESSARY TO THE PROFESSIONAL AS WELL AS TO THE COMMERCIAL MAN?\*

By J. G. GARDNER, L.D.S., D.D.S., Montreal, Que.

If I were asked this question I would immediately answer Yes, but the professional man need not have such an extreme business education as the man engaged in commercial pursuits. Before entering into the reasons why he should have this education, I will give my reasons for choosing this as the subject of my paper.

One evening on entering the café for dinner I noticed seated at one of the tables one of our medical specialists; he motioned me to a seat beside him and told me during the course of our conversation that he had rather a perplexing subject submitted to him for his judgment. The question was this:

He had a nephew whom it was decided should have a medical education, but it was decided that he should first receive a preliminary training, and it was what this preliminary training should consist of that was the perplexing question. The parents thought that an arts course would be best, and as this medical man is a graduate in arts his opinion was asked.

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\* Read before Montreal Dental Club.

He told me that if anything happened which would prevent him following his profession he did not think his arts course would prove of much assistance in securing him a position where would be much remuneration.

While admitting that the arts course was a good thing, enabling him to follow his medical studies with greater ease than if he had not pursued this preliminary course, yet he was inclined to advise going still further by giving the boy a business education in some first-class commercial house or even to go so far as to have him learn a trade and then take the arts course, and lastly the medical course.

He asked me if I would give him my opinion, which I did, and which I advised should consist of a business education, the arts course, and then the medical course, and now I will give my reason for advising this course. 1st. The business education. When we consider the incomes of the members of the dental profession and how little they can show for it, either in the amount at their credit at the bank or as property holders, it should strike us that there is something wrong, and if we decide that such is the case can it not be remedied?

I am satisfied that if the profession (*i.e.*, the members of) received a business education they (not all, perhaps,) would be able at the end of a few years' practice to sign their names to a cheque for an amount in the four figures at least. And is it not becoming more necessary every year that we should make provision for the future when we consider the number of our patients who are constantly reminding us that Dr. So-and-so is too old, is not progressing with the times, has to wear double glasses as he is losing his eyesight, and such other foolish comments, which, though we know are not true or perhaps not detrimental though true? Yet it is the public upon which he depends for his income, and when they form these opinions it is a case of forced retirement which stares him in the face and nothing we could say or do could prevent it. When we consider that members of our profession who are not over fifty years of age are spoken of as too old it points out to us what we may expect, and we should govern ourselves accordingly.

But how govern ourselves accordingly, you will ask, and to this I will reply, We will take the average age at graduation at twenty-five, a pretty high average, but it will suffice for an example, the great majority of our young dentists would have no difficulty in saving at the very least two hundred dollars a year were they only to practise economy; if they were to save this sum each year until their fiftieth year (of age) they would have a capital of \$9,587.58, allowing interest at five per cent. per annum and compounding it. This rate I do not think I have placed too high, as I myself receive seven per cent. interest and a bonus of one per cent. on certain securities I hold.

Take a man who has saved this small sum annually out of his income and who has placed it at five per cent., in his fiftieth year (of age) he will be receiving interest on the capital amounting to \$447.03, not a bad help by any means. When we look around us and see men such as Atkinson, Devinelle, and others too numerous to mention who have enjoyed such large practices and such enormous incomes and yet who had so little of this world's wealth in their old days, it should open our eyes to the necessity of imparting to the rising generation a good business as well as a good professional education.

But the question arises, all are not able to give their sons a business as well as a professional education. This might be overcome to some extent at least by the giving in our colleges by a professional man with a business training a series of lectures on how to conduct a practice on business principles (not a dental parlor one, however).

Gentlemen, ours is a trying profession in more ways than one, as you are all aware, and we should not wait for the public's gentle hint that we had better retire as we are too old, but rather we should endeavor to place ourselves in such a position that one can retire gracefully and enjoy our old days in pleasure, peace and comfort.

Do not for a moment think that I would advise retirement to a man who had only managed to save \$200 per annum, but as a portion of the public deem him too old at fifty to attend to them, he must content himself with a much smaller income from his practice than he enjoyed in his younger and, will we say, palmier days, therefore this little income of about \$447 per year would help swell his income from his practice so that he would not feel the decrease so keenly as he would if he had not managed to save this amount each year.

But there are a large number, and I may say the majority, who are able (if they but make up their minds to do so) to save \$500, and some over \$1,000 or \$2,000 per year, without stinting themselves to any extent.

Those who can save \$500 per annum under the same conditions as those saving \$200 per annum will, at the expiry of the same time, have a capital of \$23,885.18, and a yearly income from that capital amounting to \$1,113.58, so you see that a man, even if he has no business training, but is economical, and uses what business ability nature endowed him with, can manage to accumulate a little fortune.

Of course, with a business education he would be in a position to place his capital to better advantage and thereby increase it to a greater extent.

A professional man, and those of the dental profession more

particularly, should keep a set of books so that they can tell at a glance what amount of work they have done, how much they have collected, what they have lost in bad debts, what it has cost them for instruments, materials, and any other incidental expenses connected with their office or laboratory; they would then know their net income to the cent and not have to guess at it as so many do who do not keep account of their earnings, but simply put any money that comes in into their pocket, and it goes out as easily, and then they wonder where all their money goes to. Would it not give more satisfaction (for the few minutes it would take each day to post the books) to know exactly where the money had gone, and this can only be done by keeping a set of books.

It has been said, and truly, that a dentist cannot make a fortune out of his practice, but we must remember that we have not invested the capital that business men who make fortunes have; we hear of men making fortunes in the commercial world who have no capital, we also hear of men who pick up large nuggets of gold, they are rare—one is about as rare as the other.

Gentlemen, it takes money to make money, and if we have money (capital) we can make money, but if we have a business education as well, we can probably make more.

We are not the worst off of the different professions and callings in life, as we at least have the opportunity, if we avail ourselves of it, of becoming, not millionaires, but independent men, which is by far the happier existence.

My earnest wish, in closing this part of my subject, is that we may all become the latter, and give those who are to follow us a *business education*.

Although what is to follow may be foreign to the subject, still I feel that the paper would not be complete did I not touch lightly on the remaining parts of the course I advise.

2nd. An arts course. Why, you say, is an arts course necessary to a professional man? In reply I would say that it better fits him for the medical, dental, or other education which is to follow; he learns more rapidly, with more ease, and has many more advantages over his less favored brother student. But it is in his later life, when he gets into practice, that he has the greatest advantage, as he can converse more freely and on more varied subjects than the great majority of those who have been less favored; he also takes more pleasure in reading and covers a wider field, not contenting himself with reading only a few of the journals published in the interests of the profession of which he is a member.

3rd. The professional education. Should it be the desire to enter the dental profession, the system we have adopted is probably the best in the world, as by it he receives both an office and college training.

## ORAL SURGERY: THEORY AND RESULTS.\*

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By G. LENOX CURTIS, M.D.

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Theories in surgery, as in finance or government, when founded on insufficient data, are apt to be exploded when an attempt is made to demonstrate their real worth by practical test. For it is undeniable that results are the true criteria of the value of work. A theory which will not at all times bear this test falls.

While general surgery and many of its special branches have been brought to a high degree of perfection, where theory and result accord beautifully, there are departments of the great work of no less importance than the fields, now cultivated by the medical profession, which are utterly neglected in the teachings of the medical institutions and in the practice of medical men. The physician considers it beneath his dignity to investigate the mouth as an indicator or cause of disease further than to look at the tongue. He will not refer to the teeth lest he may be classed with the "dentists." Yet the mouth, which is the gateway to the alimentary tract, the portal through which passes the food which nourishes the body, would seem to demand his first and closest consideration.

The completeness of the lack of knowledge on the part of the average physician and surgeon, concerning diseases attendant upon or following affections of the teeth, of the effects, near and remote, which such affections may cause in the organism, is appalling. Many times their patients suffer untold agony or endure prolonged illness because of the doctor's ignorance upon these subjects, which should be among the fundamentals. For which, if not all, of this the medical institutions of learning are responsible. In the curricula of many of these the teeth, in spite of all the attention that is given to them and their diseases, let alone their anatomical and nervous relations to the remainder of the economy, might well be foreign bodies. In view of all this, it may not be an unprofitable investment of the time to devote twenty minutes to the discussion of a few reports from a plain record of facts.

Mr. A., aged twenty-eight years (who, up to July 1st, 1894, had been in good health, well nourished, and above the average in physical development), in the latter part of March experienced trouble in the eruption of the right inferior wisdom-tooth.

Examination by his dentist revealed inflammation of the gums surrounding an impacted wisdom-tooth, but not sufficiently developed to lead him to do anything for relief of patient. The first

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\* Read before Canadian Medical Association.



and second molars were in position. Dismissed with advice if trouble continued to call again. Soreness increased until May, when the gum over the tooth was lanced and painted with tincture of iodine. This was several times repeated until June 1st, when an abscess was formed. This also was lanced and treated in like manner until July 1st, when the suffering of the patient caused the dentist to advise the extraction of the tooth, and the address of a professional extractor, whose knowledge of surgery was evidently based on theory, was given. Under nitrous oxide an attempt was made to extract the tooth, which resulted in the removal of the alveolar process on the lingual surface. When the patient recovered consciousness he was assured that the tooth had been fully extracted, and was shown a piece of bone of considerable size that had been taken out. He experienced excessive pain and discomfort from the operation, and there was great soreness, due to the lacerated tissue. Complaining of this, the extractor said it was of no importance, he would be all right in a day or two, not even prescribing a disinfectant mouth wash. Patient noticed considerable excitement on the part of the dentist and his assistant, and recalled hearing, while in a semi-conscious condition, the associate express surprise, which led him to believe that the operation was out of the usual run. For several days the patient was confined to his room, and unable to lie down because of the severe soreness of a bruised back. His jaws became rigid and closed, necessitating the use of a fluid diet. Face was badly swollen and pain increased hourly. On the second day following the operation pus began to flow from the mouth, and the swelling was so pronounced that he again consulted the extractor, who laid the trouble to cold and malaria, and considered the operation a perfect success.

After a week of intense suffering and extreme weakness for want of food, he consulted his family physician, who was unable to relieve his suffering, and advised him to see a general surgeon, who in turn told him he was a subject for the dentist, and that he knew nothing of such diseases. Another surgeon, placing his finger along the inside of the cheek back to the upper wisdom-tooth, which had been fractured during the attempt to extract the wisdom-tooth, said that the whole trouble was there, and again he was referred to the dentist, who ridiculed and dismissed him as before. There was excruciating pain in the region of the right tonsil, which was relieved on opening of abscess. A physician was then called, who admitted his inability to treat the case, and turned him over to a young man with a recent hospital experience, in whose hands he got his first relief.

Pus had burrowed through and formed a large cheek abscess. The patient was now very weak and debilitated, with constant

discharge of pus from the mouth. An opening was made through the face in the region of the malar bone, which was syringed daily. Under this treatment the patient improved and the swelling subsided, leaving an opening below and back of the angle of the inferior maxillæ, which was caused by the pus. Through the poison in his system the patient was in so precarious a condition that a consultation was held, and he was advised to go to New York for treatment. With his physician he appeared in my office on December 7th.

Examination revealed a large indurated mass just below the jaw on the right side. Very offensive pus was discharging from the opening before referred to. The introduction of a probe revealed extensive destruction of tissue below the jaw and extending back to the tonsil, where a hardened substance about an inch in size was outlined. Had not the history of the extraction been so definite, I would have been led to believe that a tooth was lodged there; but we concluded it was a fragment of the alveolar process covered with fibrous tissue, which his physician had been trying to dissolve with medicine given internally. The patient was able to separate his teeth one-quarter of an inch, which allowed me to examine the wound where the tooth had been extracted. Pus was exuding freely from this wound of the same offensive character that predominated. Passing a probe into the wound I found that the alveolar process had been fractured, and that a large opening led to the hardened mass external to the tonsil. The patient was in constant pain, confined largely to the right side of the face, very anæmic and nervous, and health completely broken. An immediate operation was advised. Under an anæsthetic the wound where the tooth had been was enlarged, rough bone due to the fracture of alveolar process and suppurating tissue leading to the hardened mass was curetted, allowing more complete examination for the cause of the trouble, when a steel probe readily detected enamel. I passed an instrument around and behind the tonsil, and gradually dislodged and removed a wisdom-tooth, upon sight of which his physician said, "It would take me a long time to dissolve that with any agent known to medicine."

The abscess under the jaw, which involved the entire cellular tissue, was thoroughly curetted, leaving a depression about two by three inches in size with exceedingly thin skin. Packed with gauze and allowed the wound to granulate from bottom. No pus from wound near the tonsil after the operation, but some in outside wound until it was curetted.

Patient began at once to improve on antipyemic treatment and nourishing diet. Several days after the operation he complained of severe pain extending along the right side of the face. Examin-

ation of the superior third molar revealed an exposed pulp, following the extraction of which there has been no return. In three weeks the patient was dismissed, and with no deformity from the operation and no return of trouble.

It seems reasonable to me that when the dentist attempted to extract the tooth, instead of grasping it he bore down upon its masticating surface with the point of the forceps, forcing the tooth through the alveolar process, which was fractured, and crowded the tooth behind the tonsil, where it was found embedded. I am told by the patient that since the extractor learned of the removal of the tooth he stated that he thought the patient had swallowed it, and did not dare to acknowledge the facts, preferring to cover up the wrong-doing by saying he had extracted the tooth and it had been lost among others in the cuspidor.

Mr. B., aged fifty-five years, suffered from neuralgia, which the dentist thought was due to abscess of the inferior left central incisor, and inferior left molar, which were pulpless. These teeth had been under treatment for some time, but resisted all efforts to be cured. On examination the upper arch was found edentulous, the patient wearing artificial teeth. Examination of diseased inferior incisor revealed a canal thoroughly opened, and a fistulous opening through the gum at the end of the root, through which a probe showed extensive absorption of the bone. The left lateral and cuspid teeth were found to contain decomposed pulps, and a probe could be passed from the fistula back to the bicuspid below the ends of the roots. The molars were also abscessed, with a fistulous opening through the gum on the lingual surface. The posterior canal was opened through the apex, and the anterior buccal canal was partially entered and plugged with bamboo. Inferior wisdom tooth lost. On November 27th, 1894, the central incisor canals were cleansed, sterilized, and filled to the apex with chloropercha.

The canal in the lateral incisor was opened freely and drilled nearly to the apex, but I was unable to get nearer than a fraction of one-sixteenth of an inch from the apex. Sterilized and filled with chloropercha. Patient was referred to dentist for removal of gold crown from cuspid root, which was abscessed, and to report on Saturday. On that day examination revealed the removal of crown; the canal of the cuspid was more fully opened into and dressed with creosote.

On December 1st, canal of cuspid was more fully opened and a probe passed beyond the apex. Canals sterilized and filled with chloropercha, some of which oozed out through the apical foramen. Cocaine was injected into the gum and alveolotomy performed. Chloropercha oozed out through the wound. Cavity in alveolar process around cuspid and incisors burred and curetted. Debris

washed out and wound sterilized. December 3rd, the gums over the cuspid found considerably swollen. Wound opened with probe and tincture of iodine injected. December 5th, gums found less swollen and less inflamed. External application of iodine. Anterior buccal canal of molar opened to apex; also posterior canal more freely opened to apex. Search for lingual canals, from which the abscess started, resulted more favorably after drilling considerable dentine away in the floor of the pulp-chamber. Canals found to be small and almost closed by deposit of secondary dentine, but larger upon opening into them. Both were opened to the apex so that a delicate probe passed beyond. All four canals were flooded with carbolic acid; ropes of cotton were packed in and sealed for the purpose of disinfection. Two hours' time was occupied in opening these canals. The following day the canals were packed with iodoform. No unusual disturbance around tooth. December 7th, all signs of inflammation had subsided and the teeth were entirely comfortable. The canals were dried and filled with chloropercha, which was forced through the apical foramen of the distal canals, and oozed through the fistula in the gum. The floor of the pulp-chamber was carefully lined with gutta-percha and the cavity filled with cotton. Case referred to dentist for filling. Under cocaine alveotomy was performed abscess and debris burred and curetted; wound washed out with electrozone. Wound dressed daily for several days with disinfectant and tincture of iodine. Patient complained all the time of severe neuralgic pain in the left side of face, more especially when tired or at night. I directed the dentist's attention to second left inferior molar, which was very sensitive, owing to abrasion and its having been ground down so as to make the teeth on the plate above occlude properly. Advised to look for irritation of pulp. This advice was not considered good to the extent of investigation. December 19th, after an exceedingly restless and painful night, patient consulted family physician, who bitterly censured the advice and operations of the dentist and of myself, and demanded that he immediately go to a professional extractor and have the teeth drawn, leaving the posterior molar untouched. It was no easy task for me to dissuade the patient from acting on the physician's advice. Again I repeated the necessity of care of back molar; I also opened through the gum and curetted around the anterior buccal root of the first molar with a view to blood-letting and to relieve light congestion around tooth, and also in the pulp of back molar. The pain continued, and the dentist reluctantly saw the wisdom of opening into the second molar, which revealed four pulp-stones about the size of a pin's head as the cause of the trouble, on the removal of which, along with the entire pulp, all pain disappeared and the patient was rendered

comfortable. Since this treatment patient has enjoyed best of health.

Mr. D., aged thirty-four. December 18th, 1894. For ten years or more had dull pain in upper right half of face, sometimes extending to side of head, with soreness in upper jaw below malar bone. About seven years prior he had the first superior molar extracted, since when he noticed an opening through the gum in the neighborhood of the affected tooth, through which pus discharged. All these years he at times had very heavy dull feeling in the right side of the face, in the nose, and under the eye, which would leave the eyeballs sore and tender. A pain sometimes ran down the right arm and side of the chest, resembling that of rheumatism. For one year he had continual sharp pain in the left side of the face and in the eye, which on any quick movement of head or an attempt to read rendered him dizzy so he would stagger. When apparently free from pain a quick turn of the head would cause it to reappear. Neither physician nor dentist could point out the cause of the trouble, but advised the extraction of the second bicuspid on the affected side, where the pain centered, and an attempt to do so resulted in the fracture of the root, when, in order to get the pieces, nearly the entire alveolar process surrounding it was cut away. The wound was a long time in healing, and the neuralgic pains continued just the same. One of the surgeons whom he consulted gave him a placebo, from which I inferred, as did the patient, that the surgeon took his case to be one of hypochondriasis.

He appeared at my office with the history given above. Examination of the right side revealed a fistulous opening posterior to the second bicuspid, which would be exceedingly difficult for inexperienced eyes to detect, as there was no inflammation or hypertrophy surrounding it. A delicate probe was readily passed through it and into the antrum. The removal of the probe was followed by a straw-colored fluid, leading me to the belief that bone disease existed. I found that all the alveolar process anterior to the second molar roots and first bicuspid, save sufficient to hold that tooth in position, had been destroyed. The destruction extending to the lower border of the malar bone and floor of antrum. Within that area it was completely gone. The hard palate opposite the extracted tooth was necrosed for half an inch and a sequestrum about one-quarter of an inch in width, held and supported by a narrow neck, was forming at the line of demarcation. The second bicuspid contained a putrescent pulp, which when opened was exceedingly offensive. I concluded cause sufficient for disturbance on the right side of the face had been detected. The symptoms on the left side were then looked into. The left half of the upper lip was swollen and inflamed, especially

so at night, bothering him in talking and eating. A notable condition in the expression of that half of the face was the want of normal fullness showing a long-continued irritation of the nerves which supplied the muscles, which had resulted in their being atrophied, save those of the upper lip; even a change in the size and expression of the eye was visible. During the examination he had many paroxysms of pain. The inferior left wisdom-tooth had been extracted. The teeth in upper jaw excepting the first molar had a normal appearance. The wisdom-tooth was elongated from lack of occlusion, and the gum around the same was slightly inflamed. Percussion of the teeth produced normal notes save in the first molar, in which the discord was very faintly heard, there was no soreness of tooth, but a change in the expression of the eye led to the belief of pulp-stones occupying it. There was also faint discoloration. The mesial buccal root was slightly denuded of gum tissue, due to extraction of the bicuspid and the injury to the gum. The cementum of the denuded root was not sensitive to any of the usual tests made, and I decided to open through the side of this root with a small drill to ascertain its vitality. The canal was entered with no visible signs of a pulp. No odor present to indicate that it was dead. I passed a flexible bristle to the apex of the root without resistance. A drop of blood was drawn from beyond the apex. A large opening was then drilled through the masticating surface of the tooth, and the pulp chamber was fully exposed and found to contain three large pulp-stones. One covered the canal of the palatal root, and upon its removal the entire pulp of that root came away attached and completely ossified except a sixty-fourth of an inch at the apex. Its removal was followed by a gush of blood.

The cure was like magic. The patient's general expression changed instantly, as if he had been freed from captivity, and he exclaimed: "Why, what have you done? The pain has gone; I can turn my head quickly without causing pain." Believing this statement to be true, and to immediately make further test, I said, "Perhaps it is only mental relief," upon which he remarked, "Mental or not, there certainly is a change, and I am free from pain"; and this condition has proved to be lasting, as well as true. All three canals were opened to the apex, filled with wax, and left for the dentist to finish. The patient reported having had the first night of uninterrupted sleep in over a year, with no pain. He also had been able to read without vertigo, and he very much enjoyed the ability to move his head quickly without anticipation of suffering. Not finding indications of pulp-stone in the wisdom-tooth, and it being no practical value to the patient, because of the loss of the antagonizing tooth, I extracted it with the view of examining the pulp, and thus prove tests of diagnosing pulp-

stones, and was gratified on opening the tooth to find a normal pulp. This is contrary to theory by surgeons who claim that pulp-stones only appear in teeth that have lost their antagonist, Thorough cleansing, sterilizing, and filling of the canals of the bicuspids in the right side followed. Examination of the antrum did not reveal a purulent condition, only a chronic inflammation. The discharge of pus was from the necrosis of the palatal plate. The operation consisted of burring away the sequestrum, abscess sac, and granulating tissue, curetting and removing same, and douching both the alveolar cavity and antrum with peroxide and bichloride solutions, and repeating the bichloride twice daily for forty-eight hours. Ten days later the report from the patient was very favorable, no inconvenience whatever having been experienced. This is one of many cases with such satisfactory results.

Another typical case bearing on the subject in hand is reported to me by my friend, Dr. Ives.

A lad, twelve years of age, was brought to him November, 1894, for dental operation. Examination of the mouth showed an overcrowded arch, resulting in irregularity of the teeth, which were very poorly calcified, and contained many sensitive cavities. In the inferior first molars were extensive amalgam fillings and several disintegrating spots. The pulps of the superior first molars were dead, and in reply to an inquiry as to why the lad wore glasses, his mother said, "By order of his physician, under whose care he has been for a long while for treatment of 'St. Vitus' dance of the eyes.'" The boy's eyes, lids and brows were rapidly and constantly twitching, to the great discomfort of himself and those about him, and he was nervous and irritable. Dr. Ives's experience enabled him to quickly see the relation between the boy's trouble and the condition of his teeth, and he directed that he be taken to Dr. Hasbrouck for the extraction of the four sixth-year molars, with the assurance that the extraction would cure his "St. Vitus' dance." This was done, and at the expiration of ten days the boy returned, without glasses, and all signs of irregular movements about the eyes had disappeared. The boy was then taken to the physician, a well known oculist of good repute, with a statement of what had been done, but he repudiated the idea that the change was owing to the extraction of the teeth. "It was impossible," he said, and claimed that the cure was entirely due to his own treatment.

These cases point to the idea previously expressed of the lack of appreciation among members of the medical profession generally, of the important *role* which the condition of the mouth and teeth, more especially the latter, plays in disease. They can be duplicated by the dozen, but hundreds, alas, of the sufferers from the protean effects of unsuspected dental disease never find relief

because of the ignorance of their physicians. There are many cases, again, when the dentist discovers the cause of the trouble with the patient's general health, but he is overruled by the physician, whose authority and knowledge are supposed by the patient to be supreme.

Few, perhaps, have better opportunities than I to see the evils which flow from the physician's ignorance upon the subject of the teeth. The physician, in formulating his theories for the explanation of obscure troubles, entirely ignores this factor. He has never been taught to appreciate the teeth as a possible element in any disorder, except toothache, or perhaps a neuralgia of the face. The medical schools are no aid to him, the text-books give no inkling of the truth. The teeth are the province of the dentist, and the dentist is too often looked upon with contempt by his medical confreres as being a one-sided, semi-educated man, when really this very one-sidedness has made him a master in oral and facial diseases. Upon these points the dentist does not vainly theorize. He gets results, and these results are his recommendations to the medical profession.

It seems to me that in this day of enlightenment upon the teeth among dentists, it is almost criminal in the medical institutions of learning to send their graduates out with less than half the knowledge which should be given them. If this be so with regard to the colleges, what shall we say of the man, who practising the most beneficent profession in the world, fails to acquaint himself with a subject so important to the sound pursuit of medicine? Is he not lacking in his duty to himself and to his patients? With so important a factor, in many cases entirely omitted, can he do more than vainly experiment upon his patients, blindly groping for what he has not eyes to see?

I have no objection to experiments with patients, with a view to further enlightenment, provided it is done honestly and with all the possible known elements estimated at their true value. But when experiment is necessary because the physician or surgeon lacks common practical knowledge which he can easily avail himself of, I cannot uphold it. Such a course must necessarily be merely mercenary. A theory formed by such a man must be wrong, his practice cannot help being mischievous, his results, so far as good is concerned, will be nil. He is simply a "guesser," and while he is guessing his patient's life may be slipping away.

It behooves us, then, to endeavor by every manly means to free ourselves from every environing circumstance which tends to cramp our efforts to relieve human suffering. What we are after are results, not theory. As we can learn industry from the little busy bee or patience and perseverance from the spider, so we may even learn from the dentists the relations of the condition of the teeth



to apparently unrelated lesions. Certainly we should neglect no source of information which would strengthen or enlarge our means of fighting disease. So, and so only, shall we be able to confer upon our patients the highest benefits within the limits of our profession.

New York ; 30 West Fifty-ninth Street.

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## Translations.

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### FROM FRENCH WRITERS.

By J. H. BOURDON, L.D.S., D.D.S., Montreal, Que.

At the meeting of the Odontological Society of Great Britain, Mons. P. Hv. Poinot sent a communication referring to investigations he had made in the electric annealing of gold. Mons. Poinot presented to the Congress of Bordeaux last year an essay on the molecular modifications that occur in the constitution of metals in general by electric currents of sufficient intensity ; and in the paper to which we allude, he discusses the point of gold as a filling. He makes use of a 110-volts apparatus, with an intensity from 80 to 100 amperes. Such currents will volatilize gold foils, for the amperage must be in direct ratio to the section of the metal amenable to electric treatment. He does not exceed, in consequence, two and a half amperes ; uses No. 3 foils, supplied him by S. S. White Company. Every sheet is cut in two parts, and rolled into a rope, or folded into tape ; then each piece is cut into two equal parts, and each extremity of every string so formed is placed on two flat posts (*bornes electriques*), one fixed, the other being movable, in order to apply to the variable length of the strip. Through this gold passes an electric current, giving progressively from 0 to 2.5 amperes—the operation lasts half a minute. The gold is then cut into pieces required. It can be used at once, or kept for use ; must be kept very clean and very close, and passed lightly above an alcohol flame before using. It keeps the whole softness and malleability of soft gold ; every morsel is spread out with facility, without any tendency to shrink. It is pliant under pressure ; does not curl ; does not harden at its surface, as cohesive gold commonly does, but possesses to a superlative degree the cohesive properties. It realizes fully the ideal sought for in vain until now—the easy adaptation of soft gold united to the resistance of cohesive gold.

## Abstracts.

Edited by G. S. MARTIN, D.D.S., L.D.S., Toronto Junction.

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BICARBONATE of soda will arrest the toothache from a live pulp.—*Dental Review*.

I AM fully convinced that the average dentist does not use temporary fillings nearly as often as he should—that far too many cavities are opened up, prepared and filled at once.—*Dr. Garrett Newkirk, in Dental Review*.

A COUNTER IRRITANT.—Wet a square of paper fibre with vinegar, cover it with red pepper, not too copiously, and apply to the gum. A small piece of rubber dam may be placed between the cheek and the paper to protect.—*Dr. Harlan*.

SILICO-FLUORIDE OF MERCURY.—This salt has been recommended as being twice as energetic as corrosive sublimate as an antiseptic. It is far less poisonous than the latter salt, hence it deserves notice. It is used in aqueous solutions, 1 to 1,000.—*Pharmaceutical Era*.

A PRACTICAL HINT.—An easy and rational method of securing good joints in gum sectional work, is to provide yourself with a sheet of white rubber, from which cut a piece for each joint about half-inch by three-quarters; lay it so as to thoroughly cover the space. Pack your dark rubber so that it cannot become displaced and a clean and perfect joint is the result.

TOOTHACHE DROPS.—Equal parts of carbolic acid crystallized, camphor, chloral hydrate, menthol and glycerine. Pulverize separately the camphor and chloral, mix, and when liquefied add menthol, previously triturated; and lastly, the carbolic acid and glycerine liquefied together by heat. In packing the tooth cavity with this, none of the fluid should be allowed to ooze over the gums.—*Western Druggist*.

I KNOW there are many who favor immediate root-filling, but in my estimation, the parts surrounding these affected teeth should be placed in a healthy condition, to produce healthy action, and that requires thorough treatment. When one studies closely the pathology of devitalized teeth, particularly of troubles arising from putrescent pulps, he cannot fail to discover that the whole tooth and adjacent parts are poisoned by the effete matter passing off from the dead pulp.—*Dr. J. H. Woolley, Chicago, in Dental Review*.

COCAINE solution decomposes in forty-eight hours. You need to prepare it fresh when you use it. If it is more than forty-eight hours old it will not give good results.—*Dr. Meeker, in International Dental.*

ALL broaches before using should be made thoroughly aseptic, and they should never be passed from one root to another without using the same precaution to free them from septic matter.—*Dr. J. H. Woolley in Dental Review.*

THE dentist who constructs artificial teeth has in his keeping the making or marring of the whole human face. If he is not an anatomist, and if at the same time he has not artistic ideas, and if he does not, as carefully as the sculptor, study the face which he is endeavoring to idealize, he is unworthy a place among artistic dentists.—*Dr. W. C. Barrett in Cosmos.*

BROKEN INSTRUMENT REMOVED FROM ROOT CANAL. (By Dr. B. H. Catching, Atlanta, Ga.)—The head of a Gates-Glidden drill was broken off in the root canal of a superior lateral incisor, about half way up. To remove it the canal was much enlarged to the broken piece. A four-sided, sharp-pointed drill was made from the broken instrument. A small hole was drilled by the side of the obstruction. Into the hole a Donaldson canal cleaner, repeatedly dipped in 75 per cent. sulphuric acid, was worked back and forth, with lateral pressure, which removed tooth substance from around the broken piece. A forcible discharge of water from a hypodermic syringe into the canal brought the piece out.—*Dental Review.*

BLEACHING TEETH BY MEANS OF SODIUM PEROXIDE APPLIED CATAPHORICALLY.\* (By Henry Barnes, M.D., Cleveland, O.)—The case presenting was a right superior central incisor badly discolored. The root canal had been filled about two-thirds of its length. The process of bleaching was carried on as follows: A quantity of sodium peroxide, in powdered form, was placed within the pulp cavity and the unfilled portion of the root-canal. The positive electrode was then applied and the contents of the cavity moistened with water. In this case the voltage was carried as high as eighty, indicated on the dial, and the current was continued for from ten to fifteen minutes altogether. The cavity was next filled with a 10 per cent. solution of hydrochloric acid, to neutralize the sodium peroxide, then rinsed with bicarbonate of soda solution to neutralize the acid. The cavity was then lined with paraffined white wax, and filled with cement. The result was very satisfactory.—*The Ohio Dental Journal.*

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\* Clinic given at the Ohio State Dental Society, Columbus, December, 1896.

AMMONOL.—Dr. Watkins, at the First District Dental Society, State of New York, reported in December *Cosmos*, described ammonol, one of the coal tar products, as the most satisfactory preparation he had used for pericementitis. In cases where a tooth has been filled for some time and becomes sore and elongated, ammonol given in 5 to 15 or 20 gr. doses will entirely remove soreness in a short time.

CATAPHORESIS.—In a short time the most of us will be using cataphoresis to obtund sensitive dentine. Making a fresh solution each operation certainly has a great deal to do with its ultimate success. In a case where the dentine is unusually sensitive, it is possible that a certain amount of the pain might be avoided by heating the cotton with the solution before placing it in the cavity.—*Dr. H. D. Boyes, in Pacific Stomatological Gazette.*

MANY of our best dentists of to-day, and those who are continually experimenting, have but little to say, some because of inability to express themselves satisfactorily. Many a man has excellent ideas who is unable to put them in writing or present them to a society. Some prefer to keep them to themselves that they may have a slight advantage over their neighboring dentist. Such a man is untrue to his profession, untrue to his people, and belittles himself in the sight of God. It is every professional man's duty to do what he can to advance his chosen profession, and thus benefit the community at large.—*Dr. C. J. Soule, Rockford, Ill., in Dental Review.*

I HAVE no sympathy for the young man who says he cannot contribute a short paper, or talk to his local society meeting, because he has nothing of real interest to say. If we only opened our mouths when we had something of great value to put forth, what a very quiet world this would be—even during a presidential campaign. As a bit of mental discipline it would be an excellent idea for the young dentists to form a habit of writing up (in their moments of enforced leisure) any cases of interest that may occur in their practice, not simply with the chastened hieroglyphics of the case book, but with an eye towards a slight literary style and finish and scientific edge strength; not necessarily for publication either, but as an evidence of good faith and interest in their profession, outside the bread-and-butter aspect.—*Charles McMannus, D.D.S., in International Dental Journal.*

THAT OLD CREASOTE ODOR.—Several times lately we have removed cotton dressings from cavities in teeth and pulp chambers more or less saturated with creasote, in most cases covered with more cotton soaked in sandarac varnish. On what basis a root or

cavity dressing should be covered with such a mass of micro-organism pesthouses we are not able to determine. Creasote, to begin with, is not a disinfectant, being simply an oleaginous antiseptic. It is not a destroyer of bacteria in the sense that a dentist should use it. It is not a deodorant or chemical disinfectant. It simply masks the smell of mephitic gases. It is very useful as a preserver of telegraph poles and fence posts. It is sparingly soluble in water, and is not an anæsthetic. It will arrest pus formation alone; when iodine is dissolved in it, it is the iodine that does the work. As for a sandarac dressing, the alcohol in which the gum is dissolved is not a germicide, nor is the gum. Why use it? The more or less porous meshes of the cotton after the separation of the gum by evaporation of the alcohol, is a fruitful source of infection. Users of such dressing, as a rule, are not careful in applying them. They seldom or never use the rubber dam in making such dressings to roots, and never adjust it when removing them. Contaminated saliva entering an aseptic root is just as bad for it as the food debris, etc., was in the beginning. If you must use creasote, use it on shingles or for preserving wood in some form, but never in the mouth.—*Editorial, the Dental Review.*

**DENTALPHOBIA.**—Writing under this heading, Dr. W. H. Robinson, Alameda, Cal., in the December *Stomatological Gazette*, discusses that kind of pain experienced by some of our patients which arises entirely from dread of the dental chair. In these cases the patient has such a horror of dental operations that to touch a tooth with an instrument causes him to jump and declare he has been hurt dreadfully. The mind apparently does not distinguish between the sensations of touch and feeling, and the only anæsthetic available is to relieve the mind of the fear and dread that induces this condition, by making it capable of distinguishing between these sensations. Cure the pain dread that fear induces, and the actual pain the dentist causes will be but little trouble to the patient. As fully one-half the suffering in the dental chair is caused, not from dental instruments, nor from lesions made by them, it will be seen how worthless are all obtundents except as their application suggests and induces mental conditions that overcome this dread. Be candid with your patients; do all you can by gentleness and sympathy to gain their confidence and relieve their dentalphobia. Use all rational drug obtundents, and when these fail join in the patients' whims, put their language in the superlative, intensify it to the highest degree; tell them it hurts awfully, fearfully, worse than having their picture taken. To your surprise you will find this better than that old chestnut, "It won't hurt."

## Medical Department.

Edited by A. H. BERRS, M.D., C.M., D.D.S., L.D.S., Cookshire, Que.

TUBERCULOSIS OF THE ALVEOLAR PROCESS. Carl Zandy (*Arch. f. klin. Chir.*, LII, No. 1, p. 178).—While this is considered to be a rare condition the author was able to collect thirty-seven cases from the literature of the last twenty-five years. He also gives the history of a patient observed at the clinic of Bonn. The teeth are of the greatest importance in the etiology of this condition. Carious teeth are the seat of entrance for tubercle bacilli. Wounds of the alveolar process, especially those caused by extraction, are of grave importance. Whether the bacilli come from a phthisical lung or from the outer world, they need no better soil for development than the alveolar cavity left after extraction. There is no seat of predilection in this disease, and any part of the alveolar process may be affected. As a rule, other parts of the buccal mucosa are involved at the same time. It is very likely that the pulmonary lesion which is found at the autopsy is secondary to the alveolar disease. Syphilis is no bar to a tubercular involvement of the alveolar process. The disease seems to develop between the ages of fifteen and fifty. Males are more frequently affected than females. Usually the gum will swell and become loose, soft and bleed very rapidly. This will soon be followed by ulceration, with pale, sluggish granulations. Following this the teeth will get loose and fall out and the bone may become necrotic. Pain is not very marked, but salivation is very profuse and the mouth has a very foul odor. A differential diagnosis is to be made from syphilis and carcinoma. The diagnosis will be facilitated by the presence of tuberculosis of the larynx or lungs. The best therapeutic measure is through curetting and removal of all suspicious tissues. This can be followed by applications of equal parts of lactic acid and distilled water to all recurring foci.—*Amer. Med. Surg. Bull.*, August 15th, 1896.

MOLDING OF THE SUPERIOR MAXILLA IN ADENOID VEGETATIONS.—According to *Rev. Hebdom. de Laryng., d'Ortol., et de Rhin.*, Korner, in 1891, drew attention to the particular change of form which takes place in the upper jaw, at two different periods. When adenoids obstruct the nares during the first dentition, elevation of the palatine vault is produced, along with a sudden retardation of development in the whole upper jaw; the transverse diameter is shortened, and the longitudinal lengthened. After the second dentition, the following changes are added to the above: The bony palate becomes still more elevated; the alveolar borders approximate still closer, and the maxilla seems to be compressed

laterally, producing an angle at the median line; the two middle incisors turn their lingual surfaces toward each other, and a transverse section of the maxilla assumes an oval form. In nasal obstructions, of other origin, the secondary changes of the maxilla are not like these—the angle of the median line and the V-position of the middle incisors being exclusively found with adenoid vegetations. These changes are denied to rickets, because those due to rickets are found in parts of the body in full development. This occurs in the cranium in the first years of life, whereas the molding of the superior maxilla from adenoids occurs most often after the second dentition. Besides, rachitic anomalies occur only on the *lower* jaw, while nasal obstruction changes due to adenoids are limited to the *upper*. Finally, Rosenberg, in 1895, pointed out the frequent absence or decadence of the *lateral* incisors in these cases. Reyntjes has seen a case of elevated palate without adenoids. Bloch found elevated palate related to modification of the lateral cavities; but, along with Sikkell, maintains that the median line angularity presents only with adenoids.—*Surgical Department, Amer. Med.-Surg. Bull., March 10th, 1897.*

ZONA FOLLOWING EXTRACTION OF TEETH.—The patient, aged twenty-five to thirty, consulted me on July 30th, 1896, for an eruption on her body and right arm. She gave the following history: On July 20th six teeth were extracted under gas, namely, the four lower incisors, the right lower canine and a left molar. On July 26th she felt uncomfortable about the right side of the back, the inner side of the right arm, the right axilla, and the right mamma. This was succeeded by tingling pain, which every day increased in severity, and was accompanied by occasional shooting under the right arm. *The Eruption.*—Zoster, with the following distribution. In front: Two clusters of vesicles just above the right mamma; one of these in the nipple line, the other between that line and the axilla. Behind: Three clusters near the middle line and two near the axilla. Right axilla: A number of vesicles; in some of the groups coalescence had occurred; several of the vesicles were rather larger than usual. Inner side of right arm: a few groups of vesicles. When seen again on August 3rd there were fresh clusters of vesicles lower down on the inner and upper flexor surface of the arm. Fresh groups had also appeared on the back; the vesicles of the older ones had coalesced. The patient complained that the pain had been very severe, and this was borne out by her appearance. From this date recovery was rapid. An interesting feature of the case was the fact that about a year before, twelve teeth were removed under ether, when the patient suffered very much from shock, loss of blood, and, in her opinion, the effects of the anæsthetic. Comparing my rough sketches of the distribution

with Dr. H. Head's diagrams in the last edition of "Quain's Anatomy," Vol. III., part ii., p. 346, etc., I find that the eruption approximately corresponded in front to  $D_4$ ; behind to  $D_3$ ,  $D_1$ , and  $D_5$ ; and on the arm to  $D_3$ .—*George Pernet, L.R.C.P.Lond., M.R.C.S.Eng., in British Medical Journal, January 30th, 1897.*

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## Selections.

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### THE CARE OF THE TEETH.

By F. H. FUNSTON, M.D.

No meal should ever be partaken of without immediately thereafter rinsing and washing the mouth with clean, clear water, if nothing else, and obviously the addition of some pleasant antiseptic, like eucalyptol, is preferable. So, too, this act should be succeeded by a thorough scrubbing of the teeth with a moderately stiff brush, passed both laterally and perpendicularly over front and back surfaces alike; not even the most microscopic quantity of food should be allowed to remain in the interstices of the teeth or about the gums. Such a measure, if carefully carried out with the aid of a strictly antiseptic dentifrice, will prove not only a means of warding off offensive breath and the many maladies common to the gums and teeth, but will speedily eradicate tartar and retracted gums.

During the last half-century dentifrices have multiplied by thousands, each presenting its own peculiar claim. Some are really valuable; others are harmless; not a few are dangerous. In the latter connection, too great stress cannot be laid upon the fact that any article intended to be utilized for the toilet of the teeth, and which presents an acid or markedly alkaline reaction, is to be regarded with suspicion; it may be added that a number in the market are neither more or less than dilute solutions of spirit of salt (muriatic acid), which is almost rapid in its action upon enamel, and moreover promotes decay and tends to produce offensive exhalations. Others are little more than pleasantly flavored soap; but if the latter ingredient is good and pure it cannot be considered objectionable. Tooth powders, too, which sometimes accompany fluid dentifrices, must also be looked upon with suspicion, as they not infrequently contain ingredients that may prove detrimental. And it may here be remarked that those applications for the teeth which are warranted to immediately whiten are always dangerous, inasmuch as they rely upon strong chemicals for their action.

A recent improvement in this line is eucalyptol tooth paste, which,



as its name indicates, depends in large measure for its value upon euthymol, a preparation that has long been employed by surgeons wherever perfect antiseptics was desired, and has moreover deservedly gained universal popularity because of its freedom from danger except to germ life.

To the mind of the writer this preparation warrants specific mention inasmuch as it offers the ideal of a dentifrice in that it is at the same time a powerful antiseptic, reasonably detergent, modest in price, pleasant in odor, and exceptionally grateful to mouth and gums, while last, but not least, its use affords a positive protection against foul breath and other conditions peculiar to the mouth that lead to retraction and softening of the gums, staining of enamel, formation of tartar, and decay; it is likewise a reasonably certain guarantee against a number of diseases which gain entrance to the human organism through germs in the mouth and digestive organs.—*Popular Science News*.

### THE TRADE IN CRUDE RUBBER.

This remarkable substance is obtained from the milky juice of certain trees and different varieties of climbers. South America is the principal source of supply—Brazil, of the many states producing it, leading in quantity and quality, and having in its great forests sufficient to meet twice the wants of the world. The best is Para (fine, medium and *sernamby*), from the great basin of the Amazon, where more than eighty thousand *seringueiros* (gatherers) are engaged in the dry season in collecting gum. White Para, "virgin sheets," a new variety in three grades, comes from Matto Grosso. Since its importance first began to be felt, this gum has exerted an increasing influence upon the spread of civilization, especially along the Amazon and Orinoco and their tributaries and the great streams which pour out from the interior of the Dark Continent. Para, formerly an insignificant village, has grown to be a city of a hundred thousand inhabitants, with modern features, and Manaus, up the river, is fast following it. India rubber is the mainstay of the northern Brazilian states, Bolivia and Eastern Peru. Brazil has a great advantage in its immense waterway; ocean-going steamers run twelve hundred miles up the Amazon, whereas every African river except the Congo has a bar at its mouth and cataracts not far distant from the coast line. It is, besides ivory, about the only commodity produced in the interior of a tropical country that will bear the expense of transportation, often on the heads of natives along tangled man-paths, to the seaboard. So in many places it has been the basis of first commerce.—From "*India Rubber and Gutta-percha*," by Clarke Dooley, in *Appleton's Popular Science Monthly for March*.

## A FERTILE CAUSE OF DEFECTIVE TEETH.

By DR. WILLIAM H. RICHARDS,  
President of the Southern Dental Association, Knoxville, Tenn.

Dentists and physicians, in my judgment, do not recommend or prescribe as often as they should the use of suitable preparations for the care of children's teeth. If a proper and agreeable preparation be kept constantly in the nursery the little people would soon take a pleasure in its use, merely for its pleasant after-effects. Thus, through the apparent *play* with the detergent, they are paving the way to sound teeth and healthy gums, besides keeping the secretions of the oral cavity free from unhealthy contamination before entering the body.

I have been trying for a long time various preparations of the kind, with a view to settling upon something which I could recommend to my patients without inviting reflections upon my judgment. With this end in view I critically examined the Euthymol tooth paste manufactured by Parke, Davis & Co., and I feel safe in saying that I can direct the use of this preparation without expecting anything but good results.

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## Proceedings of Dental Societies.

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### ONTARIO DENTAL SOCIETY.

The Ontario Dental Society will meet in Toronto, in the beginning of July. A good programme is being prepared, and one of the best meetings ever held by the Society is expected. Lay your plans so that a trip to Toronto will be possible in July. You will be reminded of this again.

G. S. MARTIN, *Sec'y.*

Toronto Junction.

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### MANITOBA DENTAL ASSOCIATION.

The general meeting of the Manitoba Dental Association, which is held every three years, took place in Winnipeg on Tuesday, January 12th.

The meeting was very largely attended, and a lively interest was taken throughout by all those in attendance.

The retiring Secretary, Dr. S. W. McInnis, read a long and carefully prepared report stating that on account of delayed trains he

had been unable to give his report at the last general meeting, so that he now gave an account of six years' term of office.

During the past six years nine names have been added to the list of registered licentiates in the Province, and sixteen to the list of registered students.

The standard of matriculation has been raised until it is now the same as that in medicine or law, and the term of indentureship has been extended to four years.

The Treasurer and Registrar also gave satisfactory reports.

The next business, that of electing officers for the ensuing term, resulted as follows: President, S. W. McInnis, L.D.S., D.D.S., Brandon; Secretary, G. F. Bush, L.D.S., Winnipeg; Treasurer, G. J. Clint, L.D.S., Winnipeg; Registrar, R. H. Robertson, L.D.S., D.D.S., Portage la Prairie; J. L. Benson, L.D.S., D.D.S., Winnipeg.

The first step towards the formation of a dental society was taken by Drs. McInnis and Bush, the former demonstrating the use of cataphoresis, and Dr. Bush giving an article on bridge work.

J. P. Raleigh, who applied for application as under Section 13 of the Manitoba Dental Act, was admitted, and of the students who came up for final examination, one only, viz., C. A. Powers, of Brandon, reached the required standard.

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### VERMONT STATE DENTAL SOCIETY.

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The twenty-first annual meeting of the Vermont State Dental Society attracted fully one hundred dentists, many of them from without the State. Rev. J. Edward Wright offered prayer at the opening meeting Wednesday evening, and the address of welcome was delivered by Dr. C. W. Steele, of Barre. Dr. F. P. Mather, of Chester, the President, then read his annual address, which was followed by a discussion of some of the points regarding the best method of increasing the effectiveness of the Society. Papers were also read Wednesday evening by Dr. George F. Cheney, of St. Johnsbury; Dr. N. W. Gilbert, of Northfield, and Dr. W. R. Marsh, of Brandon. Prof. J. Foster Flagg, of Philadelphia, delivered the address Thursday morning, and in the afternoon several experiments were given illustrating the latest discoveries in painless dentistry. The annual banquet was held at the Pavilion Thursday evening. Dr. K. L. Cleaves acted as toast-master, and music was furnished by the Montpelier orchestra. At a business meet held Friday morning the following officers were elected for the year ensuing: President, C. S. Campbell, of St. Albans; First

Vice-President, J. A. Robinson, of Morrisville; Second Vice-President, K. L. Cleaves, of Montpelier; Recording-Secretary, Thomas Mound, of Rutland; Corresponding-Secretary, Grace L. Bosworth, of Rutland; Treasurer, W. H. Munsell, of Wells River; Executive Committee, H. Terrell, of Rutland; J. E. Taggart, of Burlington; C. W. Steele, of Barre; State Prosecutor, G. W. Hoffman, of White River Junction.

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## Reviews.

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*A Practical Treatise on Artificial Crown and Bridge Work.*—By GEORGE EVANS, Lecturer on Crown and Bridge Work in the Baltimore College of Dental Surgery. Fifth edition. Revised. 625 illustrations. Pp. 336. Philadelphia: The S. S. White Dental Manufacturing Co. 1896. Price \$3.00 net.

Nothing has been a greater drawback to the correct practice of crown and bridge work, than the temerity of impostors on the one hand, and the distrust of ethical men on the other. The former pretended to achieve results of a permanent character, which time proved to be failures, and which exposed their ignorance of the first principles of diagnosis, as well as their disregard of moral law. The latter hesitated to follow any lead of the advertising fraternity, and instinctively suspected the value of anything which that fraternity so loudly extolled. The truth lay midway. The quacks quacked, and their imitators cooed. The journals discussed the questions *pro* and *con*, and the decision must be declared, that the very first requirement for the correct practice of crown and bridge work, is personal honesty and common sense. Indeed it is the very first requirement for dental practice. The author of the above work is an expert of the first water, and one who does not find it necessary to use or hire out his name, to trumpet a reputation. As a master of the art, his opinions are reliable. The preparatory treatment of teeth and roots for crown work is fully discussed. We cordially commend these five chapters to our purely "practical" men. There is up to date, nothing known worth knowing in relation to artificial crown work which the author has not touched upon, and while he succeeds in defending the hygienic objections to collar crowns theoretically, we believe that practically these objections are too often unanswerable. Predisposing, structural, local and constitutional objections are numerous. The collar or ferruled crown is a physiological intrusion. The chapters on bridge work are very thorough. Whatever may be said in defence of some of the suggestions offered by various writers, they are

utterly indefensible on conservative and even hygienic principles, especially with the knowledge we possess to-day of the bacteriology of the mouth. Dr. Evans frankly admits this and offers the very best advice an honest writer can give. The common practice of sacrificing sound cuspid crowns to obtain foundations for posts, ought to be condemned as malpractice. It is a professional felony. There is no other work in existence which is more useful to the practitioner who practises crown and bridge work. While not in any way depreciating the merits of the work, we deplore the barbarous taste, or rather want of the theory and philosophy of taste, which prevails so widely in our profession on this continent, and which is doing so much to disfigure the human mouth. If the height of art is to conceal art, we cannot but be ashamed of the libels on the science of æsthetics, which so many of our dentists are making in their practice. This does not in any way detract from the value of the standard work by Dr. Evans. He has eliminated obsolete methods, has reduced unimportant ideas to briefer terms in the description, and has incorporated not only many new methods and suggestions, but he has given very plain and critical advice, by which faddists could profit, and the best of practitioners instructed.

*California State Dental Association.* Twenty-sixth annual session, Santa Cruz, 1896.

Professionally, these proceedings are full of interest. Politically, the golden color of its cover seems to hoop it up for the golden standard, which, we are glad to say, has buried its silver rival—we hope, forever.

*Appleton's Popular Science Monthly.*—Continuing his series on the Racial Geography of Europe in *Appleton's Popular Science Monthly* for March, Prof. William Z. Ripley discusses "The Shape of the Head as a Racial Trait," showing with the aid of maps how the "long-headed" and "short-headed" peoples are distributed.

*Transactions of the American Dental Association.*—Twenty-sixth annual session, August 4th, 1896, Saratoga Springs. Publication Committee, Drs. George H. Cushing, E. T. Darby, A. W. Harlan. Philadelphia: S. S. White Co. An exceptionally interesting volume.

*Transactions of the American Dental Society of Europe.*—Nineteenth annual meeting, Geneva, Switzerland, August, 1894. Dental Digest Co., Chicago.

# Dominion Dental Journal

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## TRUCE WITH TREASON?

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The fastidiousness of a few of our friends is, to say the least, amazing. We expect the hate of the quacks, and the hostility of those who adopt quack methods, but to be at variance with those who are neither, is "the unkindest cut of all." If we took the friendly advice of some of the latter, we should fraternize with the tramps of the profession, we should keep open house for them, welcome them to our meetings, treat their mischief making with meek forbearance, approach their efforts to drag dentistry through the mud of their own mean instincts, with the gentleness of a sucking dove. We should give Judas the kiss of peace and be obsequious to Cain. Perhaps, too, we should favor them for professorships in our colleges, and seats on our Boards, and beg them to do us the honor of giving us a code of ethics of their own conception. This sort of squeamish policy may suit the fancy of the pusillanimous and the indifferent, but it will not inspire either respect or courage in the face of organized mischief. When men carry their malice into the Legislature and undo much of the good that has been won by the persistent work of thirty years; when the departmental stores are willing to encourage unprofessional connections; when the law-breakers aspire to become our law-makers, and the

camp of advertising cheap quacks, such as disgrace us in the Toronto and Montreal papers, revel in their shame, fastidiousness expects us to apologize for our existence and hoist a flag of truce. Not if we know it!

We shall continue to do all in our power to put quacks and those who imitate their methods in their proper place, as the tramps and *canaille* of the profession, whether they are professionally qualified or not. To-day, in Canada, we have an overwhelming majority of respectable and publicly respected dentists. We are recognized as a profession in every Province, having an equal rank with medicine and law. That was won by the sacrifice and earnestness of respectable men. Are we to lose it because of the low instincts of the small band of the disreputable? Are we to let the uprooting of the work of thirty years go on, and if we fight at all, are we to fight with the scabbard instead of the sword? The pigeon-hearted people ought to go to bed and hide their heads under their pillows. If they are afraid of wounding the tender susceptibilities of the cheap-jacks who are busy kicking them, they should retire into a monastery, and pray for the millennium. At least they should wear sackcloth and ashes and reverently beg the quack advertisers of Toronto and Montreal to share with them a modicum of their humbug and hypocrisy. Conciliation with quackery is akin to truce with treason.

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#### EDITORIAL NOTES.

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SOME of our friends think that our method of dealing with quacks and quack imitators is too pugnacious. On the other hand, we think that their opinion, as well as whatever "method" they have, if they have any, is too pacific. Men who deliberately malign their better-educated and more skilful confreres, and who make lying to their patients an art; who even glory in the shame of seeing their names in printed falsehoods, are entitled to all the contempt they deserve. In the history of the profession it is well, too, that the stain they have brought upon it should be duly credited where it belongs. Do not imagine you hurt their "sensibilities" by treating them as professional tramps and outlaws. They glory in their disgrace.

Do the young men who forget or ignore their duty as ethical practitioners ever stop to think that the stain they attach to their professional character, will stick as well to their personal and social reputation? To make a few dollars more is poor compensation for the loss of self-respect

SOMEONE aptly said, that men who are gentlemen do not need a code of ethics. It is quite true. It is also true that saints do not need the Ten Commandments ; the dead do not need air ; men who are well do not need the doctor. When we have in our profession no one who is not actuated by the conduct one gentleman shows to another, we shall not need a code of ethics. If our associations are to be kept free from the approach of the professional jockeys and sharpers, a code of ethics is the only safeguard.

THE sooner that the reputable members of the profession in the Provinces abandon the idea that when they are asked by the Boards to interest themselves in legislative protection, they are bestowing upon the officials a personal favor, the sooner we will succeed in preventing such amendments to the Acts of Incorporation as were passed at the last meeting of the Quebec Legislature. Every respectable dentist should do something to place the best interests of the profession before the representative of his district.

THE many friends of Dr. Ralyea, of Oswego, one of the fathers of the profession in Ontario, will learn with regret of the death last month of Mrs. Ralyea, within three years of their golden wedding.

A DENTIST who glories in his professional shame is morally insane.

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## Post-Card Dots.

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Do you think there are openings for dentists in the gold-mining districts?

Certainly we do. There are lots of the population there cutting their wisdom teeth.

Do you think "exposure" and "ridicule" of quackery will stop quackery?

We would reply by asking questions. You have perhaps tried the plan of letting things drift. Has it stopped quackery? Or you may have moralized to the quacks. Did that stop them? Or you are so mad that you think you will imitate them. Will that stop them? Quacks do not need the respect or friendship of the dentists. They want the business of the public, and the less they have to do with the dentists the more they can humbug the public.



## Personal.

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"Is Dr. Relyea still living?" an old friend wrote us. "Living?" Well, rather, and as he writes, walks and works as actively as he did when he lived in Belleville twenty years ago, he is very alive, and as he wrote us, "It is better to be young at eighty than old at forty." There is a moral in that remark for young men in our ranks.

DR. S. J. ANDRES did good and faithful service for the Dental College of the Province of Quebec, but has been obliged to retire from the position of Honorary Superintendent. Dr. L. J. B. Lablanc replaces him. Dr. Andres was presented by the students with a handsome walking cane, and an address. He will always have the affection of the boys, and the warmest good wishes of his confreres.

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COATING CASTS FOR VULCANITE WORK.—A plan has recently been suggested for this, but as it was invested with a certain amount of ambiguity, we have been at some trouble to find out what was meant, and how to make the preparation, for the benefit of our readers. Procure a quarter of an ounce of "collodion," add to this three-quarters of an ounce of sulphuric ether, so as to thin the collodion down, and pour into the bottle containing these a package of "silver gloss." Silver gloss is a preparation of tin and zinc, and may be obtained of all dealers in paints, oils, putty and other materials for house painting. Though called silver gloss, it contains no silver. It comes put up in papers of an ounce or more, in the form of an impalpable powder. It unites, to a certain extent, with the collodion, when shaken, and is applied to the face of the plaster cast, as well as to the reverse of the investment in a case flaked for vulcanite work, with a camel's hair pencil, leaving a very even and thin film over these which effectually prevents the adhesion of the vulcanite to the plaster, permitting the case to come from the flask clean. The silver gloss may be had at a slight expense enough to last for a year or more with ordinary use. It should be kept in a well-corked bottle, and the pencil cleaned after use. Should particles of it adhere to the plate it can be entirely eaten off by immersion in a bath of nitric acid and water—one-quarter acid, three-quarters water; but this we have not found necessary, as it comes from the flask clean.—*Dent. Office and Lab.*

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