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Dominion Dental Journal

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Original Communications

HINTS.

BY A LAZY MAN.

I claim no originality for anything I possess, excepting original "sin." But I give these hints as I've gathered them from chats with my confreres. They were new to me. They may be new to others like myself, who accept good ideas no matter where they come from.

1. DARK JOINTS.—If your set has dark joints dip a sharpened point of wood into aromatic sulphuric acid ; put a few drops into each joint, let rest a few minutes, wash with water.

2. Do not hammer plaster impression out of your impression cup. Cut off overhanging surplus ; hold the cup over a flame, the plaster will fall out.

3. To get a correct bite make patient lean his head forward ; depress his chin until it touches his breast, then bite.

4. To get good impression with wax, wax and paraffine, or the compound, take impression as usual, but not fully ; then remove and gently soften surface over a flame and re-insert, press into place, let it cool.

5. Cotton twisted on the mandrel of the lathe can be made to reach any hole or corner in polishing plates.

6. When you have grey spots in black rubber, try Dr. Barrett's plan of rubbing them with carbon bisulphide.

7. For heating rubber try Dr. Beacock's suggestion of a soapstone slab. The rubber does not stick to it. I always wash every sheet of rubber with a nail brush before cutting.

8. The wire-spring laboratory apron now on the market was first suggested by Dr. Beacock, of Brockville. I wish he would give us more of his good ideas.

9. After using clamps and ligatures and wounding the gum, massage the parts with the finger and camphor or alcohol to revive the normal function of the constricted gum.

10. Paint the model with thick lather of soap before packing. It prevents the plaster sticking to the plate.

11. If your gas-bag bursts coat a piece of vulcanized rubber with chloroform, and press it for a few moments on the break.

12. Try Dr. E. C. Kirk's plan of sterilizing instruments. Soak them for a few minutes in a warm aqueous solution of liquor ammon. fort.

Medical Department

Edited by A. H. Beers, M.D., C.M., D.D.S., L.D.S., Montreal, Que.

CLINICAL REMARKS ON AMPUTATION OF THE LOWER JAW.

I think it may be safely affirmed that since the publication of Mr. Cusack's memoir on "Amputation of the Lower Jaw," which appeared in the *Dublin Hospital Reports*, little has been added to our knowledge in reference to the technique of this operation. The line of incision, the method of bone section, and the difficulties and dangers connected with the procedure, as well as the after-treatment, are all dwelt on and described with a precision and accuracy that leave little to be desired or added to. The paper, in truth, constitutes a landmark that will always serve as a guide to the operating surgeon in dealing with such cases. One of these was an example of that comparatively rare condition termed multilocular cystic disease of the lower jaw. The late Professor Robert Adams has given a graphic description of the case, which he published in the *Dublin Hospital Gazette*, 1857, and a well-executed illustration of the tumor removed forms an attractive feature in Mr. Christopher Heath's exhaustive work on "Injuries and Diseases of the Jaws." In this work, too, will also be found an illustration of another remarkable case of the same kind, operated on by the late Dr. Edward Hutton—one I took a special interest in, as I was at the time of the operation one of Mr. Hutton's

dressers in the Richmond Hospital, and had charge and took notes of the case for him. Of this case Mr. Heath has observed that " it is the best example of the disease hitherto known as cystic sarcoma with which I am acquainted." The specimen was formerly in the museum of the Richmond Hospital, but is now in the possession of the Royal University of Ireland.

As these cases presented many features of analogy as regards appearance, history, and pathology to one that I recently operated on in the Meath Hospital, a brief record of it will probably not be deemed devoid of surgical interest.

M.B., aged 29, a domestic servant by occupation, was admitted into the Meath Hospital under my care on November 14th, 1898. She suffered from a large, and, it was stated, increasing tumor of of the greater part of the left side of the lower jaw. The patient stated that the tumor was first observed in 1893. On March 20th, 1897, she presented herself at the Dental Hospital of Ireland, complaining of pain accompanied by swelling of the lower jaw on the left side. Mr. George Moore, one of the surgeons of that institution, saw her at this time, and has kindly furnished me with the following notes of the case which he took at the time:

Four years ago (1893) she suffered from excessive pain in this region, to relieve which a local practitioner extracted the left six-year lower molar. Two years now elapsed, during which time the patient was free from discomfort, but soon afterwards (in 1895) she noticed the jaw swelling in the region of the second left lower molar. This increasing, advice was sought at a general hospital, and as a result an opening was made into what appears to have been a cystic tumor. Some fluid was evacuated, and the cavity packed on several occasions with lint. The swelling subsided, but in some months returned. The patient then sought advice at the Dental Hospital again. On examination, the wisdom tooth on the affected side was found absent, and had never been erupted nor extracted, while the twelve-year molar was present and badly decayed. Much swelling was present around the lower tooth, principally affecting the buccal aspect, and running backwards and upwards upon the ramus, the bone being evidently thinned. It was considered expedient to remove the remaining molar which, along with all other decayed teeth and roots, was extracted under ether. The molar tooth, without any evidence of fracture, came away, but it had no fangs or roots, nor did a probe passed into the socket detect any. The probe could be passed into a cavity of some size, but from which apparently no fluid escaped. The case was then sent to the Meath Hospital, and placed under my care.

On her admission, the deformity caused by so large a growth was very striking, so much so that it is a source of regret to me that a photograph of the patient was not taken previously to the

operation. The patient stated that recently there had been great activity in the growth, and she suffered much, especially at night, from pain in the ear on the affected side. The family history was on the whole good. On inspection, the tumor was seen externally extending from behind the angle of the jaw to within an inch of the symphysis menti. On the buccal aspect the growth was found very prominent, and pushing the tongue towards the right side, and to a certain extent interfering with both speech and deglutition. The growth also extended downwards below the ramus of the jaw. The integuments over the tumor were apparently healthy, and were freely movable over its surface. The external surface of the tumor was hard, but on the inside, where it projected into the mouth, some portions of it were soft and crepitating.

The case being one which clearly indicated operative interference, I recommended removal of the affected part of the bone, and the patient willingly consenting, I commenced by making a free incision an inch behind the angle of the jaw, and carried it forwards and somewhat behind the bone to a point corresponding to three-quarters of an inch to the left of the symphysis menti, and then vertically upwards towards, but not through, the red border of the lip. The transverse facial artery was severed by this incision and both proximal and distal ends secured. With a periosteal raspatory, an opening at a point where the anterior section of the bone was to be made into the mouth was accomplished, and the bone divided by means of a chain saw. This section was effectually and rapidly carried out and without any difficulty. The soft tissues were thus, partly by the scalpel and partly by a raspatory, detached. On reaching the coronoid process and portion of the bone posterior to it, I found that the disease had extended much further backwards than I had anticipated. The coronoid was expanded by the cystic growth, and the same might be said of the cervix and condyle of the bone. This portion of the bone I have never previously seen affected in this manner. Owing to the cystic development here the bone, in my efforts to remove it at the articulation, broke down, and had to be removed piecemeal. At this stage of the operation the hemorrhage was very severe, and I greatly feared some of the larger branches of the internal maxillary artery had been wounded. Happily, I succeeded in arresting the hemorrhage by ligation and pressure, and no further trouble from hemorrhage was experienced. The wound was then securely packed with iodoform gauze, and the edges brought together by a continuous silk suture.

The patient rallied well after the operation, and suffered little from either shock or pain. The temperature and pulse remained practically normal, and the wound healed by first intention. The

sutures were removed within a week; no trace of suppuration having ever been seen in connection with them. The local treatment of the wound consisted in frequent irrigation with a weak permanganate of potash solution. It is needless to say more than that the patient made an uninterrupted recovery, and returned home in excellent health and spirits in March, 1899. Having regard to the fact that almost the entire of half the lower jaw was removed, it must be admitted that the result was satisfactory.

The tumor is an example, and a signally well-marked one, of the comparatively rare condition, multilocular cystic disease, formerly known as cystic sarcoma. It is, as already stated, similar in its growth and structure to the remarkable examples of the disease described and illustrated in Mr. Christopher Heath's work on "Diseases of the Jaws." The case recorded above, however, differed in one respect from these—one which in no small degree added to the difficulties in the technique of the operation—and that was the extension of the disease so far posteriorly, involving as it did not only the coronoid process but also the cervix and condyle of this bone. This feature or peculiarity in the case, which added so largely to the difficulties of the operation, made it differ from any of the specimens I have read of, operated on, or seen in any pathological museum.

The diagnosis of these tumors is at times surrounded with difficulty, and if the contents be fluid or partially so, the characters of chronic abscess, dental cyst, dentigerous cyst (follicular odontome), and multilocular epithelial cyst (epithelial odontome) will have to be differentiated. In Smale and Colyer's work it is stated that the last (epithelial odontome) "may be suspected if the swelling shows a tendency to be nodular. This form of tumor is likely to be mistaken for a medullary sarcoma, and the diagnosis between the two is often very difficult; but with the former there will nearly always be an absence of a tooth or teeth from the series."[1]

There is much obscurity in connection with the origin of these bone cysts, and much difference of opinion exists among some acknowledged surgical authorities. Mr. Heath states that this origin is probably in the cancelli of the bone, and due to irritation caused by neighboring teeth, and also that the multilocular form of bone cyst seems to be more closely connected with the teeth than the single cysts.

Distension and absorption of the alveoli go on as the cysts increase in size, so that the walls at length become membranous, and the macerated bone shows great gaps in its outline.—*Heath.*

At variance with these views we have Mr. Pollock's statement that these cysts appear to be independent of either any tooth irritation or of any previous cartilaginous deposit.

The theory of tooth irritation has also an advocate in Mr.

Salter, who has observed that the cysts only arise "when the tooth or teeth associated with them are embedded in the substance of the jawbone"; but in another place we find his somewhat contradictory statement that "impaction of a tooth is not necessarily a cause of these serous collections, the former being common, the latter comparatively rare."

Mr. Coote[2] also holds the view as to the cysts being the result of irritation produced by decayed teeth; Magitot that they resulted from the fusion, and sometimes subdivision, of several dentigerous cysts, those, namely, connected with imperfectly developed teeth.

The view that they are due to an abnormal development of the enamel organ has also been advocated by Falkson,[3] and, lastly, the theories of Eve,[4] and endorsed by Malassez,[5] that these growths have *not a dental origin*, but that *they are neoplasms of a epitheliomatous nature*.

According to Ziegler[6] these "Zahncysten" may originate from cystic dilatation of a tooth socket of a developed tooth, as well as through a corresponding degeneration of buds "Sprossen" of enamel germ, or of the dentinal sac of a tooth in the course of development. In the latter case the cysts are lined with cylindrical epithelium. Orth[7] maintains that the jaw cysts originate from tooth germs, and part also are cystic fibromata.

The late Sir John Tomes has observed that "such cysts are tolerably frequently observed attached to the roots of extracted teeth. The process is probably identical with that resulting in the formation of alveolar abscess; but the process being less acute a serous cyst takes the place of a rapidly suppurating sac. As such cysts increase in size they produce absorption of the bony structures round them, and may in this way come to occupy the cavity of the antrum."[8] As regards unilocular cysts this view is, I should say, most likely the correct one.

An interesting pathological feature that is observable in the case I have drawn *attention to is the condition of the molar tooth* that was extracted by Mr. G. Moore previously to the removal of the tumors. I allude to the complete absence of the fangs and the under surface of the tooth not showing any evidence of ulceration, being smooth, cup-shaped, and polished. The cause of this partial absorption of a permanent tooth is, like the origin of the bone cysts, involved in much obscurity.

Sir J. Tomes[9] held that the cases of absorption of permanent teeth might be divided into two classes—first, "when the whole or part of the root of a permanent tooth is absorbed without reference to the growth of an adjoining tooth; and, secondly, when a portion of a permanent tooth is absorbed to make room for the eruption of a neighboring tooth. The mechanism of the absorp-

tion which takes place when one tooth impinges upon another below the level of the gum is not fully understood. When the contact takes place above the gum no harm is done, but when at a lower level absorption is set up, whether by the periosteum being irritated by being squeezed between the crown of the advancing tooth and the cementum of the other or by some other process."

In connection with this subject the following remarks by the eminent dental surgeon, Mr. Mummery, of London, will be read with interest. They occur in a letter recently addressed to Mr. Moore:

"In all such cases which I have seen the absorbed surface exhibits the lacuna of Howship, and in many portions a re-deposit of bone or cementum.

"I think there is no doubt that the factor in absorption of the roots of such teeth is the osteoclast, as a bone. I have preparations showing absorption of the roots of the teeth and the so-called absorption organ (the accumulations of osteoclasts) *in situ*.

"I mentioned your question to Tomes, and he agrees with me that the absorption of the root in these cases is exactly the same process that we see in the skull when the bone is excavated by the presence of an intracranial tumor, when the characteristic lacuna of Howship and the osteoclasts occupying them are well seen."

The points of especial interest in connection with this case are as follows:

First, it raises the question as to the origin and differences, clinical as well as pathological, between the unilocular and multilocular cystic maxilliary growths.

Secondly, the extension of the disease posteriorly to the temporo-maxillary articulation, a feature I have never seen before, and one which added in no small degree to the difficulties of the operation.

Lastly, the condition of the teeth, and the question that arises therefrom as to whether imperfect or arrested development was an etiological factor in the production of the growth, or an effect produced by the latter.—*Sir William Stokes, F.R.C.S.I., Ch. M. Univ. Dub., Surgeon-in-Ordinary to Her Majesty the Queen in Ireland; Hon rary Member of the Imperial Academy of Medicine, St. Petersburg; Professor of Surgery, Royal College of Surgeons, Ireland; in British Medical Journal, June 17th, 1899.*

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THE TEETH OF RECRUITS.

COLONEL DALBIAC'S question addressed to the Under-Secretary of War as to "the number of recruits rejected during the past year on account of bad teeth, who were in every other respect fully up to the required standard," and the answer that the number under the heading "loss or decay of many teeth" was "1,767," require some analysis to bring out the true statistical significance of the figures. The report of the Inspector-General of Recruiting for 1898 shows that 66,501 recruits for the regular forces were medically inspected, so that 1 in 38 (nearly) were rejected on account of bad teeth. The total number rejected was 23,287, which gives about 75 per 1,000 on account of bad teeth. The total rejections, however, are divided in the report into two classes; (1) various ailments; (2) want of physical development, the former including all those rejected for purely medical reasons, the latter for those under military standards. Those under standard numbered 9,318, and those rejected for various ailments, 13,696; the first should be set aside, because, coming under the early part of the examination, they would be summarily rejected without reference to teeth; of the second, the proportion rejected on account of teeth works out at about 127 per 1,000. But none of these figures really show the actual numbers with bad teeth, which are no doubt very considerably more, because in the examination of recruits the first point is standard measurements, which, if seriously defective, causes the summary rejection of the recruit without reference to teeth. As, however, the examination of teeth is usually about the last part of the medical inspection, those rejected for defective dentition, may be held to be fairly fit in other respects. The question of teeth in recruits is a difficult one, but is fairly met by a recent revised regulation giving examining medical officers a wide discretion. It is really astonishing how many fine muscular men there are of the recruits' age with poor and defective teeth. On the other hand, numbers of weedy men have fair teeth. It is not so much a question of the total number of teeth lost or decayed, but whether (including the wisdom teeth, probably in young recruits still unset) there are left sufficient opposing molars for effective mastication. Beyond that it is neither desirable nor practicable to lay down hard-and-fast rules.—*British Medical Journal, May 6th, 1899.*

POWDERED SILVER NITRATE IN ANTRAL EMPYEMA.

FEIN (*Archiv. f. Laryngologie*, Bd. ix, Hft. 1) uses powdered nitrate of silver in cases of old-standing suppuration in the antrum. The powder is ejected in a fine cloud from a special form of powder blower, and so covers the whole surface with a thin layer of the

drug. The writer has found it useful in checking the discharge and in improving other symptoms in chronic cases. No bad effects are caused excepting a slight burning sensation after the application.—*British Medical Journal, June 17th.*

Proceedings of Dental Societies

CIRCULAR LETTER OF THE FOREIGN RELATIONS COMMITTEE OF THE NATIONAL ASSOCIATION OF DENTAL FACULTIES OF AMERICA.

To all who feel any concern in American educational matters, or in American professional affairs, the annual meetings to be held at Niagara this summer must prove of the greatest possible interest. It is probable that grave questions, more profoundly affecting the welfare of dentistry, will be discussed, and it is hoped settled at that time, than have ever been raised in American dental meetings. The far-reaching subjects that loudly demand consideration concern not America alone, but Europe as well. If dentistry is ever to become a profession in fact as well as in name; if it is ever to occupy the position to which advanced men believe it to be entitled, the professional status and tone in both continents must be brought somewhere near the same level. The future welfare of mankind demands there should be some common understanding of professional affairs.

The first dental school was established in America, and for many years the only institutions for professional training were confined to this country. The dental doctor's degree is even now peculiar to American dental schools. For many years, through their excellent practical training, they made American dentistry a synonym for the highest practical efficiency. Then for a time our schools lost ground, and their fair fame became tarnished through the misconduct of some of them, and the criminal laxness of the laws in certain of the states, which permitted the incorporation of fraudulent colleges that sold their doubtful honors abroad and at home, or granted them *in absentia.* It was not until the organization of the National Association of Dental Faculties that any concerted and determined effort to restore the tone of American dental colleges was made, or any practical attempt to bring them to a higher plane, and to force the fraudulent institutions out of existence.

As the natural consequence of the loose methods and legislation of the past, the reputation of the schools that were doing

faithful work and maintaining a high standard suffered from the faults of those which were in the habit of receiving unqualified students from abroad, and whose curriculum of study was altogether insufficient. To those not intimately acquainted with American educational matters there were no means of distinguishing between the good and the bad colleges. All were, by unthinking and uninformed people, charged with the irregularities of the few, and the consequence has been that the reputation of our educational institutions in general has suffered.

Nor was there any complete understanding among the colleges which did desire to maintain a proper standard. Each of our nearly fifty separate states is autonomous so far as education is concerned, that being one of the matters left to domestic regulation by the general government. There can be no compulsory harmony of action, for each college is, in a measure, a law unto itself, within the limits of state regulation. So long as there was no harmonious concert of procedure, the result of a common agreement and understanding between the different schools, whose sole source of income was from the students in attendance, the strife for matriculants and patronage almost necessarily led to a depression of the standard, and too often to irregular graduations.

In the absence of a common law regulating the course of study, some general agreement became a necessity for the maintenance of a proper educational status. To accomplish this the National Association of Dental Faculties was formed. At the date of its organization the general tone had been so much depressed that it was impossible to establish such a standard for matriculation and graduation as was desirable, but only such colleges were admitted as had the proper facilities for complete instruction, and were conducted by a corps of competent teachers. All other schools were excluded, and their tickets certifying to attendance upon lectures, with their diplomas, were refused recognition by the colleges belonging to the Association. Stringent rules governing attendance, instruction and graduation were adopted, and schools violating them were severely disciplined. The course of study was extended to three full years, and the semesters gradually lengthened until they included from seven to nine months of each year. The curriculum was expanded, until it comprised all the branches of study which the growth of modern professional practice has made necessary. As a consequence, it is believed that each and every one of the colleges embraced in the membership of the National Association of Dental Faculties is now giving thorough professional instruction, and is receiving no students who cannot present the evidence of a fair preliminary education. This has been the work of years, for it was impracticable and unwise to make the transition too abrupt. There is much yet to be accomplished, but

the association can point with pride to past achievements, and urge them as a guarantee for its future action.

Two years ago, at the instigation of some of our American graduates abroad, the National Association appointed a standing committee, to be called the Committee of Foreign Relations, whose duty it should be to take into consideration the condition of the American dental degree in Europe, and to institute such measures as would prevent the reception of unqualified foreign students by our schools, and to endeavor to give a better understanding of American educational affairs in Europe. It was given authority to appoint European Boards for the purpose of furthering the objects committed to its care, and it was also charged with the attempt to suppress fraudulent and unrecognized American colleges, plenary powers to use association's funds, and even to levy assessments, being bestowed upon it. These extraordinary prerogatives betokened the intense interest which the representatives of the colleges felt in the work. The committee so appointed has labored anxiously and uninterruptedly. It has named the nucleus of a European organization, which it is hoped will be of great benefit to dental educational interests. It has carried on a suit against the most flagrant irregular institution, and has secured a decree condemning it. Before this could be made effective, it became apparent that the repeal of some of the vicious legislation under which incorporation of fraudulent colleges was possible must be secured, and accordingly, in the State of Illinois, bills to accomplish this were introduced, and against strenuous opposition were pushed through the legislature and have become laws. It is believed that if the committee is sustained by the united voice of the profession its future labors will be more easy, and the entire suppression of all fraudulent schools will be accomplished.

We believe there will be none to dispute the assertion that in the teaching of practical dentistry the dental schools of America have not been excelled by those of any other country. The trouble has been that, for lack of general legislative regulation, the standard of preliminary study has been too low. It is utterly impracticable to raise this to the proper point at one time. Until there shall be a public sentiment created that will sustain effective enactments, it is idle to attempt drastic measures. Such action would only divide the profession and exclude schools which, if the proper time can be given, must of themselves raise their standard to the right level. A regulation that is but a dead letter is far worse than none at all, for it brings law into disrepute. It is utterly hopeless to look for harmony of action through separate state enactments. There must first be an agreement among the representatives of the profession, and then unanimity of action on the part of those of all the states. The attempts at repressive or

compulsory action through the different state legislatures, as a primary measure, must inevitably result, as it has already done, in a yet greater diversity of laws, and more intense antagonism of professional feeling between different sections. It cannot but end in dividing the profession into two adverse and discordant parties, and the perpetuation of the fraudulent colleges, which it will be impossible to suppress except by unanimity of action. The violent and arbitrary laws already enacted, which encourage and foster bitter animosities, tend to defeat that harmony which alone can bring satisfactory results. If a part of our colleges, existing in the more recently settled and less educationally advanced portions of our common country, are refused recognition and fraternization because they are unable, from lack of time in which to adapt themselves to the changed requirements, to comply with those of a greatly advanced standard, they will thereby be forced into an unprofessional attitude, and will thus perpetuate the existence of irregular American dental schools, to the continued reproach and disgrace of our professional name. We believe it to be far better to advance gradually, but as fast as existing conditions will permit. Hence we deprecate drastic measures, or arbitrary and despotic action. No man or set of men can, by independent movements, dominate a profession of the dimensions to which dentistry has grown. A proper professional feeling must be a thing for time to bring about. Confidence is said to be a plant of slow growth, and this is eminently true in professional matters.

The wonderful progress made within a few years, under the administration of the National Association of Dental Faculties, leads us to hope that if it is permitted to pursue its own course it will, in a comparatively short time, bring all our colleges up to a point of perfection unattainable by any other means than this mutual agreement and harmony of action. The past is a guarantee for the future, and so long as such rapid progress is being made, it is worse than folly to attempt any violent measures that can be only problematical in their results.

There will be a series of meetings held at Niagara this summer that can but exercise an overwhelming influence for good or evil on our whole professional future. It is earnestly desired that all who take any interest in our educational affairs will be present at one or more of these meetings. Especially is it important that there be a full consultation between representatives of the colleges and their representative graduates resident in Europe. It is hoped that as many of them as possible will be in attendance, and that so far as is practicable every member of the European Advisory Board will make the pilgrimage to Niagara in July. Nor need the attendance of dentists from abroad be restricted to those thus appointed. The members of the association will gladly welcome

and seek the counsels of any reputable dentist resident in a foreign country.

The meeting of the Foreign Relations Committee will be held at Niagara, commencing on the morning of July 26th. The assembling of the parent body, the National Association of Dental Faculties, will doubtless be called for July 28th, while the National Dental Association, the meeting of the representative men of the profession at large, will convene August 1st. It is desired that foreign representatives in as great numbers as possible will be at Niagara for all these meetings, for while the sessions of the college men have not heretofore been open to strangers, ample opportunity will be given for expression of the views of, and consultations with, our foreign brethren, and it is within their power to confer lasting benefits upon their profession by making their American confreres fully acquainted with the status of professional affairs abroad.

Respectfully submitted,

W. C. BARRETT,
S. H. GUILFORD,
J. D. PATTERSON,
T. W. BROPHY,
H. W. MORGAN,
} *Committee on Foreign Relations.*

BUFFALO, N.Y., May 20th, 1899.

The following is a list of the Dental Colleges of America which at the present time are members of the National Association of Dental Faculties, whose diplomas and tickets alone are recognized and received by the members of the association :

Alabama—Birmingham Dental College, Birmingham.

California—University of California, Dental Department, San Francisco ; Dental Department College Physicians and Surgeons, San Francisco.

Colorado—University of Denver, Dental Department, Denver; Colorado College of Dental Surgery, Denver.

District of Columbia—Columbian University, Dental Department, Washington ; Howard University, Dental Department, Washington ; National University, Dental Department, Washington.

Georgia—Atlanta Dental College, Atlanta ; Southern Medical College, Dental Department, Atlanta.

Illinois—Chicago College of Dental Surgery, Chicago ; Northwestern University Dental School, Chicago.

Indiana—Indiana Dental College, Indianapolis.

Iowa—State University of Iowa, Dental Department, Iowa City.

Kentucky—Louisville College of Dentistry, Louisville.

Maryland—Baltimore College of Dental Surgery, Baltimore; Baltimore Medical College, Dental Department, Baltimore; University of Maryland, Dental Department, Baltimore.

Massachusetts—Boston Dental College, Boston; Harvard University, Dental Department, Boston.

Michigan—University of Michigan, Dental Department, Ann Arbor; Detroit College of Medicine, Dental Department, Detroit.

Minnesota—University of Minnesota, College of Dentistry, Minneapolis.

Missouri—Kansas City Dental College, Kansas City; Western Dental College, Kansas City; Dental Department Marion-Sims College of Medicine, St. Louis; Missouri Dental College, St. Louis.

Nebraska—University of Omaha, Dental Department, Omaha.

New York—University of Buffalo, Dental Department, Buffalo; New York College of Dentistry, New York; New York Dental School, New York.

Ohio—Cincinnati College of Dental Surgery, Cincinnati; Ohio College of Dental Surgery, Cincinnati; Western Reserve University, Dental Department, Cleveland; Ohio Medical University, Dental Department, Columbus.

Pennsylvania—Pennsylvania College of Dental Surgery, Philadelphia; Philadelphia Dental College, Philadelphia; University of Pennsylvania, Dental Department, Philadelphia; Pittsburg Dental College, Pittsburg.

Tennessee—Tennessee Medical College, Dental Department, Knoxville; School of Dentistry, Central Tennessee College, Knoxville; University of Tennessee, Dental Department, Nashville; Vanderbilt University, Dental Department, Nashville.

Virginia—University College of Medicine, Dental Department, Richmond.

Washington—Tacoma College of Dental Surgery, Tacoma.

Wisconsin—Milwaukee Medical College, Dental Department, Milwaukee.

Canada—Royal College Dental Surgeons of Ontario, Toronto.

The following appointments to membership in the European Advisory Board have been made. The vacancies will be filled at the meeting of the Foreign Relations Committee to be held at Niagara, commencing July 26th.

Great Britain—Wm. Mitchell.

Holland and Belgium—J. E. Grevers.

Denmark, Norway and Sweden—Elof Förberg.

Russia, Germany, Austria and Hungary.

Italy and Greece—Albert T. Webb.

France—J. H. Spaulding.

Spain and Portugal.

Switzerland and Turkey—L. C. Bryan.

THE NEW BRUNSWICK DENTAL SOCIETY.

The tenth annual meeting of the New Brunswick Dental Society will be held at St. Stephen, N.B., August 24th, 1899. A cordial invitation is extended to members of the profession. Reduced railroad rates.

C. F. GORHAM, *Sec. Treas.*

Selections

FACTS ABOUT THE DISGRACEFUL ISSUING OF DEGREES AND LICENSES IN THE STATE OF ILLINOIS.

BY PAUL STEINBERG, M.D.S., D.D.S., CHICAGO, ILL.

[This gives our readers a birds-eye view of this matter in the United States. The editor of the *Items* is to be congratulated for his effective work.]

The protest raised by the American Dental Society of Europe against illegal institutions in the states of Illinois and Wisconsin, which have flooded this and European countries with their bogus diplomas, has been recognized not only by the American Association of Dental Faculties, who created the Foreign Relations Committee at its last annual meeting in Omaha, for the sole purpose of suppressing such institutions, but also by every honorable D.D.S. of this country!

Now, as war has been declared on "Fake Diploma Mills," in order to facilitate this work it is my earnest belief that every dentist, knowing of unlawful actions by colleges, should be forthcoming with them and not be afraid of having the truth published!

I have heard of such diploma sale and the unlawful issuing of the State licenses in this State, since I came to Chicago, which was more than seven years ago. Repeatedly I tried to interest members of the Board, but the evidence was not strong enough, as it was more or less hearsay; but I never stopped till I had collected data, which I consider strong evidence against the corrupt actions of the parties concerned.

Fraudulent Diploma.—The first is the fraudulent obtaining of the title of D.D.S. by Fritz W. Huxmann, licensed October 21st, 1881, Dean of the German-American Dental College. Dr. W. Kuster, of this city, who was connected with this college in its earlier days, assures me that he, as well as the other members of the Faculty, was induced by the Dean, Fritz Huxmann, to fill out some blanks, which were to be given as duplicate diplomas to some students, who desired to have it attested by a notary public and the German Consul of this city, for the sole reason to make this worthless parchment appear somewhat bigger in the eyes of the German public. Instead of using all these duplicates, "Huxmann" filled one of them out with his name. Ever since he holds the title of D.D.S., besides Professor, Dean, etc.

Fraudulent License.—The second case is that of the fraudulent obtaining of a license from this State by a gentleman named Samuel Schlesinger (now practising in partnership in Vienna, Austria), with the aid of Dr. Huxmann, who, at the time this took place was the Secretary of the State Board of Dental Examiners. Schlesinger was examined in Huxmann's private room, on the sixteenth floor of the Schiller Building, and not as the law prescribes, together with the rest of the candidates. The interpreter was appointed by Dr. Huxmann, the latter gentleman's own assistant (whose name by request I will not mention as yet, but who promised at any time, should the Board take action, to repeat his accusations). The latter had not only to translate the papers as well as he was able to, but had also to help answer the questions received. By the interpreter's own statement, he is himself only very little conversant with the English language. The candidate was allowed to use Dr. Huxmann's library. The interpreting gentleman, by order of Dr. Huxmann, demanded of the candidate $60 for this service, the half of which he was forced to deliver to Huxmann. By the candidate's statement, as the interpreter tells me, his license to practice was bought at the price of about $300. This took place in 1893.

Fraudulent Diplomas.—Another diploma case is that of Zahntechnicker Grün of Thorn, in Germany. He took only *one course* at the G.A.D.C. Part of his time was spent with relatives in Leadville and New York, so that the time spent at his studies could hardly amount to even one full course; nevertheless he was allowed to come up for graduation. "He failed." Dr. Huxmann then informed him that on the payment of $50 he could try again right away. Mr. Grün paid the money; he then was given the questions, which were worked out with the help of another dentist at home, and on the strength of this more than questionable examination, was given his diploma and the title of D.D.S. Mr. Rolle, Zahnartz of Wiburg, Finland, was another candidate who

failed, but when he paid the sum of $25 or $30 he was allowed to try again, and then received his diploma.

The German A. D. College *Honoris causa* degree was granted to Mr. Max Bejuch, chief editor of the *Zahnartzlichen Rundschau*, Berlin (Huxmann's advertising medium), and his friend Mr. Laury; also to Zahnartz, Zeuner of Kasan in Russia, and lately to a gentleman in Zurick, Paul de Terre. The gentleman who has given me most of these facts was for many years closely connected with this college, holding a professorship. I hold his signature that above statements are true.

Dr. Huxmann hardly ever failed to have licenses issued for graduates and undergraduates. He recently prepared a candidate of about twenty-four years of age for the Board examination: the candidate was no more than six months in this country; was Zahntechnicker in Germany, and had only attended the German-American College for just that time. If required, I will give the name of this gentleman and nine more such candidates who passed the Board at the time under similar circumstances in 1898. Dr. Huxmann seemed for years to manage to be good friends with the different secretaries of the State Board. I trust that the mystery surrounding these and many more cases will be successfully lifted.

Fraudulent Licenses.—While Huxmann was the Secretary of the Board he had back licenses issued to every graduate of his college; and so it happened that a barber, Philip Orth, who had taken two courses at the Huxmann College, I think in 1890, being more than sixty years of age, had his license issued, and so half of his barber shop was arranged as a dental parlor. He announced himself to the public as Dr. Philip Orth (I believe this gentleman has since given up his double business). At these last State Board examinations, I believe in March, the following gentlemen of Huxmann's school passed the board; Zahnartz Eugen Pfeiffer, Emil Doerring and Oscar Stahl, all of whom were given the questions in German by the *indispensable* Dr. Huxmann, who was again interpreter for his own college students, which service brings $25 apiece. I do not wish to injure the candidates, but this wholesale issuing of licenses under above conditions ought to be stopped by all means. The sole purpose of these gentlemen in obtaining the State Board license, as they never practise in this country, lies in the fact that they like to have something more than this German college diploma to show upon their return to the old country, to prove that they are full-fledged American dentists. There is Th. Lübeck, of Ausbach, in Bavaria, who attaches the letters L.D.S. to his name because he received license with the help of Dr. Huxmann from the Illinois State Board, therefore he is a Licentiate of Dental Surgery.

During the past few years all Huxmann's students must pass the State Board first, before they are given the diploma as a Doctor of Dental Surgery by the G.A.D.C.; but does this give a greater value to that diploma, if the State Board examination lays entirely in the hands of Dr. Huxmann? There has hardly ever been a member on the Board, aside from Dr. Huxmann, that understood the German language sufficiently to conduct an examination therein.

The G.A.D.C. had nothing to lose in presenting its candidates first to the Board before granting the diploma. Thereby it only secured recognition of the State Board of Illinois, as has not been the case heretofore; in fact, its reputability has repeatedly been questioned by former State boards. Inquiry made by the German Government regarding the reputability of that college was formerly answered by her consul in this city thus: "College is regularly chartered by the State Board of Illinois, its diploma being recognized by the State Board of Dental Examiners," and never a word is mentioned that this school does not belong to the National Association of Dental Faculties.

There exists also in this city the Cosmopolitan Post-Graduate School of Dentistry, its Dean, Dr. C. Weil, 704 Belmont Avenue, who issued diplomas after a course of six weeks, bearing the title of D.D.S. Dr. C. Weil is a former German-American Dental College professor, just as the famous Dr. Albert, of Milwaukee, Wis., is a Huxmannian scholar. Another such school is that of Dr. Malock's, who will give diplomas in anything you desire—D.D.S., M.D., Ph.G., Midwifery, etc., Milwaukee Avenue, city. This was quite sufficient for most of the European governments (as they cannot comprehend the corruption of some of our American colleges) so allow the holder of such diplomas to affix the title of Doctor Chir. Dent., American Dentist, etc., to their names without further molestation; at least there is no differentiation made between a fake or a well-earned American diploma in Europe! The German Government since 1897 does not allow any American graduate to call himself a Doctor of Dental Surgery, except by special permit.

The following questions I have presented to the different *members of the Illinois State Board of Dental Examiners:*

1. Are you in favor of granting licenses to foreigners, who never intend to practise in this country, but simply wish to have the State license in order to present themselves as full-fledged American dentists abroad?—some going so far as to attach the L.D.S. to their names.

2. Should not the interpreter be a gentleman who is in no way interested in the candidate?

3. Are you aware that Drs. Huxmann and Weil make it their

business to present candidates to the Board, and never fail to have them passed? I know of many such cases—one particular—a Mr. Linzemann, Zahntechniker of Mulhausen, who being but two weeks in this country, passed the Board with the aid of Dr. Weil, who was interested in this gentleman, and by this time no doubt is also a D.D.S.

4. Could it be possible that such candidates can pass the Board, were the interpreter independently appointed and not self-appointed, as are those who make it their most profitable business to prepare foreign candidates for the Illinois State Board in wholesale; they advertise to that effect in German dental journals, announcing that it is still possible to pass the Illinois Board under the most favorable conditions, but only during the next two more terms!

5. Do you know that these gentlemen receive $25 per candidate for interpreting? As I understand (March, 1898) there were ten such candidates—making it a very profitable business for Dr. Huxmann, besides his charging the candidates $50 and more for preparatory course, which specially consists of nothing more than handing the questions and answers to the candidates in advance, with the understanding that they are to keep secret the term of their preparation, also to sign a contract to take the final course at $100 at his college after receiving the State Board license.

6. Are your examination papers open for inspection? If so, will you kindly appoint a time that I might see and inspect the papers of all foreign candidates who were admitted to the Board by Drs. Huxmann and Weil?

7. Is the German-American Dental College recognized by the Illinois State Board? If not, why can all Huxmann's students pass the Board without difficulty—must this not either prove the recognition of the college or the corruptness with which the State Board examinations are carried on?

8. How long will this State allow colleges to exist, like the Cosmopolitan Post-Graduate School of Dr. C. Weil, which confers diplomas after a course of six weeks, and the German-American Dental College, which does the same thing in six months, and in but very few instances one year?

9. Can you give me a complete list of such foreigners who have passed the State Board, and those who have failed—(in case there are any of the latter class)?

10. Have you been aware of the fact that Dr. Smyser tried to withhold licenses of such students on the ground that they first ought to learn something, and that they must finish in Dr. Huxmann's college before they could receive and make use of their license?

Dr. Smyser was not so successful with every candidate. A

gentleman who has informed me of those facts was not quite so green as Dr. S. supposed him to be, and upon Dr. Smyser's request, by *letter*, to take the final $100 course, he flatly refused the invitation, and demanded his State Board license, which finally was given him to keep him quiet.

COPY OF DR. SMYSER'S LETTER SENT TO DR. XX.

March 28th, 1898.

DEAR SIR,—Your examination papers submitted to the meeting of the State Board of Dent. Ex., March 12th, 1898, will entitle you to the license to practise dentistry in the State of Illinois as soon as you pass the final examination in the German-American Dental College.

DR. L. A. SMYSER,
Secretary of the State Board.

LETTER FROM DR. H. W. PITNER.

FAIRFIELD, ILL., May 29th, 1899.

PAUL STEINBERG, D.D.S., Chicago, Ill.:

DEAR DOCTOR,—Your remarkable letter at hand, and in reply will say this is not the first letter of similar import, but as yours seems to be open and manly, it shall receive my notice.

You make some very damaging assertions, which I hope are not sustained by the facts, yet as an honest man I cannot let such specific charges against a Board, of which I am a member, pass by unnoticed. Now, my dear Doctor, if you have any grievances, I will listen to what you have to say. You, or any reputable dentist in Illinois, are at liberty to examine any or all of my papers. I have saved them all. I fear no investigation of my official acts. I have not looked over the papers of the last examination. *No one saw them* until the morning of the examination. I would be pleased to have you come to Fairfield, and bring with you some other prominent dentist, and make the investigation you desire. If your charges are correct, I want to know it. I want you to send or bring German journals with ads. in them.

I am not in touch with the Secretary of the Board. As that gentleman ignores my letters, I never know who passes the Board, or who does not. The Secretary has not, as yet, made a report to the Board. I think he absorbs all the money collected, as I have not received one dollar for my services up to the present moment, and have given all time and expenses out of my own pocket, and I think it is the same way with the other members except the Secretary. I have understood he has been trying to raise revenue by

assessment of the profession, and am trying to find the truth of the report. I have given the Board notice that there will be a lively time at our next meeting. I want all these ugly rumors cleared up, and would appreciate any help I might receive from my professional brethren.

I was not appointed on the Board for revenue, and I knew there was no pay attached, and I will never lend my name or person to any unmanly or dishonest practice or scheming. I alone made the agreement with Dr. Huxmann. He was to translate in the presence of the Board, and was to deposit $25 for a fee for independent verification by a *disinterested German scholar* who was competent. I thought he would do as he agreed, for I told him I would stand no foolishness or trifling; and further, I told him he could have no say in the matter of *verifying the translation*, and that *if we found any attempt* upon his part of *assisting* the *student* by a false translation, he could never again bring a foreigner before the Board who did not stand his examination in plain English.

I have been noticing for some time that the German students were very similar in their answers, and unusually bright in their replies, much more so than our American boys, but I did not suspect such damnable trickery as you attribute to Dr. Smyser, for he told me he had a bright German scholar, a *friend of his*, who verified for the Board, and I supposed him all right.

If you can prove your charges, in the name of God come down here with your proofs, and I will turn heaven or raise hell to have the guilty banished from the Board.

I only hope your suspicions are groundless. I do not want to think of any member of the Board as anything but a gentleman good and true, with the good of our profession at heart.

Respectfully yours,

H. W. PITNER.

LETTER FROM DR. KUESTER.

As I have been informed, F. W. Huxmann, of this city, is in possession of a diploma conferring the degree of Doctor of Dental Surgery upon himself, and my name having been used as a professor signing the same, I wish to make it known that if it be true that F. W. Huxmann is in possession of such a diploma, I herewith declare the same *void*, as I never signed a diploma conferring the degree of D.D.S. upon the aforesaid party. I will admit, however, that I did deliver lectures at the German-American Dental College at this time when it is said this diploma was issued.

I also know that students have obtained in this particular college, without standing as many courses as the State law of

Illinois prescribes, diplomas conferring the degree of D.D.S., which, in my opinion, is an injustice and does by no means reflect credit upon the American dentist abroad. Respectfully,

WM. KUESTER, D.D.S.

Chicago, Ill., June 1st, 1899.

ADVERTISEMENT FROM

Zahnarztliche Rundschau, Berlin.

Staatsexamen in Amerika betreffend!

Bekannil finden nur noch 2 Prüfungen vor der staatl. Prüfungsbehörde fur

Zahnarzte

im

St[illegible]te Illinois

nach den seitherigen Bestimmungen statt. Es findent diesen Sommer ein

Vorbereitungskursus

hierzu statt, und bittet man Interessenten. sich unter Rgd Heb 9748" an die Expedition ds. Bl. zu wenden.

(15728)

TRANSLATION.

Concerning State Examination in America.

Only two more examinations will be held before the Illinois State Dental Examining Board in accordance with the old statutes.

A preparatory course will be given this summer. Persons interested please address Rgd Heb 9748 of this paper.

LETTER FROM DOCTOR PFENNIG.

I herewith state that the following facts have been given to me by Otto Cohn, D.D.S., of the six weeks' Post-Graduate School of Dr. Weil, and Licentiate of the Illinois State Board of Dental Examiners, March 28th.

Said Otto Cohn took a preparatory course with Dr. Huxmann for the State Board examination, for which he had to pay $50.

On the evening before the Board's examination took place, he, as well as nine more candidates, were given the questions and answers by Huxmann, under the promise to keep it secret and to take one course at Huxmann's college at $100. The candidates had to pay off $25 to Dr. Huxmann. They all passed the Board and received the license, but not until a sharp demand was made to the Secretary, Dr. Smyser, who refused them repeatedly on the ground that they first had to take another course in the Huxmann College. Mr. Otto Cohn had not done so, but instead took a post-graduate course with Dr. Haskell, on which ground he received the D.D.S. diploma from Dr. Weil's "Cosmopolitan Post-Graduate School."

These are the facts as represented to me by Mr. Otto Cohn himself.

As this gentleman was in my employ as helper in the laboratory, I had the opportunity to notice his lack of any theoretical knowledge and operative skill, and if it were not for the facts, as given by himself, it would have been a miracle to me how he could have passed the State Board examination.

E. Pfennig, D.D.S.

Chicago, Ill., June 1st, 1899.

Statement Signed by Dr. Schnitker.

Schlesinger had established a dental office in Wells Street, near Goethe, and practised there under his own name without having a license. Induced by a communication directed to Schlesinger by Huxmann, then the Secretary of the State Board of Dental Examiners, a "Zahnarzt," Dittman, on a certain day called on Huxmann, on the sixteenth floor of Schiller Building to confer with him about Schlesinger.

The result of the conference was that Schlesinger, at the next examination of the State Board, was allowed to compose his written examination, not with the candidates, and in the presence of the members of the State Board, but alone, in the private room of Dr. Huxmann, with the help of a so-called translator, who was not even under oath.

There also were in this room dental books belonging to Huxmann, which Schlesinger, of course, consulted. Moreover, most of the answers were dictated to him by the translator, who did not even know English. For this work the translator received $60 from Schlesinger, half of which he had to deliver up to Huxmann. According to Schlesinger's own statement, the examination cost him a few hundred dollars.

Mr. Grün, of Thorn (Germany), was in America for one term, part of which he spent with relatives in Leadville, and in New York (with a brother or married sister), so that he was by no

means a full term in Chicago. After the examination, Huxmann informed him that he (Grün) had failed, but that for $50 he could immediately pass another examination. Grün consented and paid $50, after which he received his new papers from Huxmann, who told him that he could work them out at home. Grün did so with the help of another Zahnarzt, and received his diploma from the German-American Dental College.

Rolle, Zahnarzt, of Wiborg, Trinland, also failed in his examination with Huxmann, but, after payment of $25 or $30 was allowed to immediately pass another examination, after which he received his diploma.

Diplomas *honoris causa* were received by Laury, Berlin, and Zenner, Zahnarzt of Kasan, Russia.

(Signed) HERMAN SCHNITKER,

Chicago, Ill., June 1st, 1899. 111 North Avenue, Chicago, Ill.

The following letter was sent to Dr. Smyser:

NEW YORK, June 7th, 1899.

DR. J. H. SMYSER, Chicago, Ill.:

DEAR DOCTOR,—I have received a communication from Dr. Paul Steinberg, in which he intimates that Dr. Huxmann, of the German-American College, is allowed by the Board of Examiners to act as interpreter for the students of his college when coming before the Board of Examiners, and upon his report of their examinations these men are given licenses to practice; that these men then go to Europe and advertise themselves as L.D.S., on the strength of having a license from the State of Illinois, by which means they seem to have the right to an extra degree.

Moreover, he charges that, in at least one case, a student was examined prior to graduation, and that you notified him that he would receive a license from the State Board of Examiners after completing his term at the German-American College. All of which would seem to indicate that this German-American College, which has the repute of being an irregular school, has more than the usual influence with the State Board of Examiners.

I am, of course, loath to publish matter of this kind if there is any chance of doing injustice, but, at the same time, I feel it my duty to inquire into the case, in order to determine whether or not such irregularities could exist in a State Board of Examiners. I therefore feel that the proper course is to appeal to you direct for your version of the affair.

Will you kindly let me hear from you immediately, and oblige,

Very truly yours, R. OTTOLENGUI.

Dr. Smyser's Reply.

Chicago, Ill., June 12th, 1899.

R. Ottolengui, M.D.S., New York:

Dear Doctor,—In reply to your letter of 7th inst., I will say that the letter is a base fabrication. This man Steinberg is an enemy of Dr. Huxmann, who conducts the German-American Dental College, and presume to this is due this letter. The State Board of Illinois has nothing whatever to do with the above-named institution, and students from that school are examined the same as any other students. Dr. Huxmann has done some of the translating in the presence of the Board, as it is extremely difficult to get any one who is competent to do this work. Dr. Huxmann, up to last March, has done this work for the Board since 1881. Unscrupulous men, who do not know the facts in the case, like this man Steinberg, write as he has done, to do the Board an injury, and I will ask you to kindly send me an exact copy of his letter, as I think it is no more than right that such as he should be punished. J. H. Smyser, *Secretary.*

OPEN-FACE CROWN VS. CONTOUR FILLING, OR RICHMOND CROWN FOR INCISORS.*

By H. T. King, D.D.S., Fremont, Neb.

To illustrate my subject, we will imagine a central incisor. The mesio-occlusal angle gone; the disto-occlusal angle so undermined that no good operator would think of filling it without removing it. White decay, the kind formerly described as occurring in soft teeth, has penetrated in all directions, and we may or may not have pulp complications. The enamel of the labial face of this tooth, when not already broken away, seems perfect, but without a good support of healthy dentine.

Now we have the tooth, what is to be done with it?

The incompetent operator, or the one who seeks an easy way to gain a living by the practice of dentistry, will tell the patient that the teeth are too soft to hold gold fillings, and will either extract or plaster up with cement, thereby gaining a small fee, but without doing the patient any permanent good. The worst feature of that kind of practice, however, is that the faith of that particular person, and possibly many of the friends, in the ability

*Read before the Nebraska State Dental Society.

of dentists to save teeth, is weakened, if not entirely destroyed. How often we hear something like this: " Dr. So and So (and he is a good dentist, too) told my sister that her teeth were too soft for gold, and my teeth look just as soft."

The expert operator, who must also be an enthusiast, will take the tooth, and by liberal cutting, get fairly good enamel walls, will cut a groove through the occlusal surface, shorten the lingual plate of enamel, and by thus connecting the two cavities, make a large contour filling that will be secure, as fillings go. This is an operation that is very tedious and trying, both to patient and operator, and you have, when done, for the cutting edges, a soft gold, or at least a platinized gold, either of which, if brought to a thin incisal end will soon show signs of batter and wear. This kind of an operation is not to be condemned, but for suitable teeth, highly recommended. There is a point, however, to the most expert gold builder, and reached all too soon by the average operator, when the filling of such a tooth will not be thought advisable, and it will be cut off and the root crowned. It is just at this border land between reconstruction and destruction, that the method that I shall advocate comes in.

Those of you who were not in the practice of dentistry twenty years ago can hardly realize the advance made by developing the modern methods of crowning roots and badly broken down teeth; but that too many teeth are being cut off, or crowned with shell crowns, I think no observant person will deny. Teeth with scarcely more than a compound cavity, and those that the average operator ought to be able to successfully fill, are being crowned with all gold shell crowns, and other teeth, if further front, are constantly being cut off, and Logan, or other crowns, stuck in their place.

To return to my subject: How would I restore the tooth a little too far gone to fill, and the loss of structure does not necessitate a crown? In my title I have designated this as an open-face crown; it is hardly that, for as shell crowns are usually made, as little gold and as much cement as possible is used, while in this case, as much gold as is necessary to make contour, and as little cement as possible is used. It is hardly an inlay, either, although the inlay principle is used in making it. I proceed as follows:

First trim away all enamel which is frail, but leave much more of the labial plate than would be admissible for a foil filling. With disks, remove all the enamel from the proximal portion of the cervix on both sides, giving a flat, highly polished surface. Remove a portion, at least, of enamel from lingual aspect. Shorten tooth a very little, beveling from both sides. Cut out decay, and if this leaves the cavities so deep or irregular that impression cannot be taken, fill the deep parts with gutta-percha. The work can all be nicely done in the mouth, but I find that time is saved and

the patient relieved by taking a plaster impression and making a fusible metal cast. A perfect reproduction of the tooth in metal can be quickly obtained by slipping into the proximal space on either side, a piece of cardboard just thick enough to fit, letting it press the gum back a little from the interproximal space.

If I wish a pin or dowel to extend into the pulp canal or deep portion of cavity for anchorage, a piece of round, wood toothpick is put in place, and comes away with cardboard in impression. When the impression is filled with Melotte's metal, I have a more or less perfect model, to which my gold is approximately fitted.

Take a generous piece of 24k. gold, 32 to 36 gauge, and by pressing, burnishing, and trimming over all the lingual and proximating surfaces of tooth, the gold on the proximal sides cut off just even with cutting edge, that covering the lingual side extending so as to fold over and fit to the shortened occlusal surface.

My way is to first fit to one proximal surface, forcing gold into more depressed portion, with a piece of erasing rubber under instrument. Slip from model and flow enough 22k. solder to stiffen it. Replace on model, drive piece of soft wood between adjoining tooth and gold that I have melted on, thus holding firmly in place while I burnish and fit to the whole lingual surface; remove and flow on gold. Replace, fasten in place, and fit gold to other cavity and proximal surface. The gold being thin and pure, all this can be quickly done.

The solder is to be laid on in small pieces, a little at a time, and heat enough given to barely melt it, for until it is fitted to tooth in mouth, no solder is to be allowed to flow onto the part that is to be fitted over end of tooth and edges of labial plate of enamel. This is important, for upon the close adaption of gold to tooth at exposed point depends the good appearance of the finished work, and, in a great measure, its durability as well. I have an idea that the best way to add piece by piece of solder is by the use of the mouth blowpipe. Possibly that is because I enjoy the use of that instrument, and have become somewhat of an expert from having done all my crown and bridge-work in that way. Others may get as good results from a mechanical blowpipe and bellows, but I have no use for them, except to melt a large batch of gold.

Our piece of work is now fitted to the model and made rigid enough to handle without fear of bending. We remove from model to tooth in the mouth and burnish to the enamel. Remove very carefully, paint the inside with whiting or finely ground asbestos and invest; sufficient gold is then added to make necessary contour. You are all workers in gold and have your own way of doing this, so I need not dwell upon it. A perfect polish out of the mouth is to be given to all parts except the labial face; a rough polish will do there, as this part is to receive its final polish in the mouth after cement has hardened.

If the work has been neatly done, cement will not show, and you have, to all appearance, a contour gold filling with less gold showing, however, than if built up and with an occlusal surface made of hard gold, that may with safety be brought to as thin a cutting edge as desired.

I have said nothing of anchorage, and some may be asking the question, "Will it stay?" The tooth having gold on all sides except labial, no ordinary force can dislodge it when applied in any direction, unless down or in—the two directions not necessary to particularly guard on the upper jaw. As a rule, I depend upon the fitting of gold into the two proximal cavities and turning over the beveled occlusal edge, or if not necessary to turn the end and have gold show, fit into groove cut through occlusal surface. This is but slight anchorage, but sufficient to prevent the crown from tipping in, unless it first comes down a little.

The method I present for the restoration to form and usefulness of badly decayed incisor teeth is not universal in its application, but in the last six years I have found many places where it seemed to me the best method, and it has given great satisfaction both to myself and patient. I have used it oftenest on frail lateral incisors of the upper jaw, but in a few cases have found it just the thing for lower incisors so badly gone that I have doubted my ability to restore with gold fillings, and did not consider them good subjects for porcelain crowns. Have also had some pleasing results from applying the principle to bicuspids, when I have found the buccal enamel and cusp in good condition, yet the tooth demanding a crown of some kind. You can give such a tooth the appearance of having a contour filling, with but little more work than making a shell crown, and the finished work will be much less conspicuous. For a bicuspid, a good strong pin should extend from gold on occlusal surface well into pulp canal, as strong anchorage is demanded. I do not know as I have made myself very clear as to why I object to Richmond crown. I do not object to the Richmond any more than any other, but take the position that a crown should be the very last resort. I do not think the Richmond crown the "thing of beauty and joy forever" that some esteem it.

If you do succeed in banding the root so that it will be protected without infringing upon the dental ligament or making a large show of gold, in matching the color and shape of adjoining teeth and in retaining the shade after passing through the fire, you have a presentable case; but permanency is not secured, and your tooth will not be a match in color when ten years have been added to life of patient. The natural teeth will darken with age, and the artificial remain the same. I will grant, for argument, that your Richmond crown will last for fifteen years. I have no fear but

what I designate as an open-face crown will last for ten years, and at the end of that time the tooth will be in just as good condition for cutting off and crowning as now.

I submit this with the thought that the method may be new to some of you, and that if it will, as I claim, add ten years to the usefulness of some teeth, it is worthy of your consideration.—*Chicago Dental Review.*

IMMEDIATE REGULATION.*

By A. F. James, D.D.S., Oak Park, Ill.

Every member of the profession present to-night will agree with me in the argument that in the practice of dentistry it is necessary for the practitioner to give the greater portion of his time to the perfection of little details; giving his attention to this little thing and to that little thing, all of which are important, even absolutely necessary.

It has been my observation during the few years in which I have been in the practice of dentistry that the greatest mistakes and the largest number of failures result from the neglect of little things—not taking the time to finish fillings perfectly, or attempting to insert fillings without sufficient separation, or neglecting to trim enamel margins carefully; the inserting of gold fillings with the pulp in an inflamed condition, or not properly protecting the pulp. These and many other things which you could mention as well as I. But one more I must speak of, and that is, not thoroughly instructing our patients how to take care of the teeth, or more plainly speaking, how to keep their teeth *clean.*

In cases of orthodontia no doubt the majority of you have felt, as I have, the need of some method by which the painful and long drawn-out process of bringing the teeth into their proper position might be abridged. A partial solution of this problem, I believe, lies in immediate regulation by surgical procedure. Certainly, all cases are not amenable to this treatment, but in many instances a single malposed tooth standing inside the arch can be brought into perfect alignment by this method at a great saving of time and patience to both operator and patient.

It is needless to dwell upon the trials attending even a single case of regulating with appliances.

In selecting the cases for immediate regulation the operator

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*Read before the Chicago Dental Society.

must be governed by the age of the patient, by the space that exists, or that can be gained before operating, and by the change of position or angle to which the tooth can be moved without changing the position of the apical end of the root. These limitations, you will observe, confine us to the anterior teeth. Taking, for example, a malposed superior lateral incisor standing inside the arch, my method of procedure would be to first use as an anesthetic either gas or some local application. After gaining the effect of the anesthetic, I would use a three-quarter inch disk steel saw mounted on a mandrel in the engine, and cut a deep incision through the gum and process on each side of the tooth (mesially and distally), extending the incision as far toward the apex as possible. Then place a block of hard wood, previously prepared, so it will rest upon the teeth on either side of the tooth being operated upon, the block cut out so as to allow the tooth to be moved forward into line with the others ; then take a pair of narrow beaked incisor forceps, place one beak upon the block of wood (held in position with the left hand) and the other on the lingual side of the tooth to be moved. Force the forceps well up on the tooth, then with a gradual, steady pressure, force the tooth forward, carrying with it the block of process and gum tissue attached to the labial side of the root until the tooth is in the desired position ; you are then ready for the retaining appliance. Use either ligatures, tying the tooth solidly to the central and cuspid, or if something more firm seems advisable, fit gold bands to the incisor and cuspid with an open tube soldered to them, so that a stiff piece of piano wire may be placed in the tubes and secured by pinching tightly with a pair of flat nosed pliers. Then tie a ligature firmly about the lateral incisor and fasten it to the wire, keeping the retaining appliance in place until the tooth becomes solid.

The patient should be seen every second day and the parts thoroughly cleansed until the gum tissue has healed. In my opinion this operation can be successfully accomplished in any case without fear of destroying the pulp, providing the patient is under twenty years of age, the apical opening of the root being large enough to permit of more or less stretching or straining of the pulp without breaking it loose from the surrounding tissues, or causing inflammation sufficient to destroy the pulp. In an adult. as you know, the pulp canal is small and the apical attachment so small that we run a greater chance of destroying the pulp, although out of a number of cases in my own practice where I have operated for adults I have caused the destruction of but one pulp. My reason for operating for adults in several cases has been because of a tendency, or even advanced stages, of pyorrhea alveolaris resulting from the patient being unable to properly cleanse the parts and to keep the gums hard and firm around the necks of the

teeth. In each case where I have had this condition, the result of placing the tooth in position where it will receive the proper amount of care I have found a complete cure for the pyorrhea alveolaris.

While I believe in being conservative and have no radical tendencies, I do believe it is time for the dental profession to take advantage of their knowledge and skill as oral surgeons and in cases whereby a neat, clean surgical operation (be it ever so simple) we can accomplish good results and overcome many trying, long drawn-out corrections of irregularities, it should be done.

I may have made it seem that this operation is so greatly limited that it is of no consequence; but my idea has been to simply bring out the successfulness of the operation, and allow individual judgment to decide when it is applicable.

Those of you who attended the World's Columbian Dental Congress will remember the paper read by Dr. Geo. Cunningham, of Cambridge, England, and the discussion which followed upon this subject; his paper made a fixed impression upon my mind and this impression grew as from time to time I came in contact with vexing cases of irregular teeth. I read and reread his paper in the published transactions of the World's Columbian Dental Congress. But although I give Dr. Cunningham credit for the ideas I have on the subject, I must say that Dr. Cunningham's paper does not encourage one to try the operation. He held that the apex of the tooth could be freely moved and that it was preferable to perform the operation for adults. My opinion and experience differ from his upon those two points, as previously expressed in this paper.—*Chicago Dental Review.*

PRACTICAL POINTS.*

BY DR. C. W. GRAFF, TECUMSEH, NEB.

Two things enter prominently into the make-up of a practical man or woman, namely, thoughtfulness and thoroughness, in the every-day duties of life. If I wished to be truly successful in the highest sense of the term, and could not have both these elements, I should choose the former. You can be too thorough—sometimes overdo a thing—but you cannot be too thoughtful; the more thoughtful we are, the more useful we become.

When a case, simple or complex, is presented to us for diagnosis or treatment, if we will but stop to think before passing our judg-

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* Read before the Nebraska State Dental Society.

ment upon it, of the possible results of the different modes of treatment, weighing carefully the conditions as we know them to exist, relegating to the rear for a moment the financial standing of our patient, our decision is very apt to be reasonable and practical.

In this day of fast living, we are getting into the habit of not counting the cost of such a course. The more we do and promise, the more the public expect of us, and many are the men and women who go down under this strain every day. This state of affairs looms up before us as a vast monster in all the vocations of life, ruining and unfitting us for the more responsible and practical duties. For example: Why is it that many of us are not often as successful as we might be in certain cases of plate-work, or treatment of the oral cavity in any of its various forms? The trouble frequently lies in the fact that we put an unreasonable estimate upon our mechanical skill, regardless of the sanitary habits of our patients.

Take a beautiful piece of bridge-work—almost perfect in its construction—but will it prove a practical operation if inserted in a mouth that is a stranger to cleanliness? It is our duty to tell such people, in a straightforward but kind manner, that unless they will promise to follow your instructions, you do not think it best to proceed with the work. Often this will have a good effect; of course some will soon forget that they ever had an operation performed, and lapse back in the old habit of neglect.

In practice we find this state of affairs among rich and poor, refined and ignorant, and it is a hard problem to solve. For no matter how much pains we have taken to do the work well, it will soon return to us to be done over again, and if we do not comply with all the unreasonable demands of the patient, they go away and say uncomplimentary things about us and our work.

I always put a higher estimate upon the strict sanitary habits of my patient than I do upon my own skill. It is not this class that gives us the trouble; the work, with few exceptions, giving entire satisfaction, and these persons usually are high in their praise of Dr. —— as a skilful workman. Therefore, we can be more liberal in our promises to the latter, but to the former class we should be extremely careful when they ask us how long we will stand good for any work we may do in their mouth.

Another mistake which I think is sometimes made, is that of putting cement under gold in contour fillings. Frequently it is done to save gold, and time as well. I am speaking of contour fillings only. Dr. Hambly, in the "Practice Builder," says: "The plan is a questionable one." The best foundation for gold is gold. Where the cavity is deep, bordering on an exposure of the pulp, is it not more practical to devitalize—with possibly few exceptions—or fill cavity entirely with cement?

A great deal has been said and written, both pro and con, relative to clasp plates; my observation has led me to regard the clasp plate, or bridge, as impractical. I am drawing my conclusions from what I have seen, and what I read upon the subject. I have never seen one yet that after a time did not wear upon, or loosen the teeth clasped. It is said there is a remedy for this in the crowning of the teeth to be clasped, but many people object to to the extra expense of crowning a sound tooth. At any rate, it seems to me we should use a clasp plate as a last resort, unless the patient is willing to pay for the precautions against injury to teeth and gums by crowning.

"Drugs are a blessing if rightly used,
But a terrible curse when much abused."

For instance, I remember a friend of mine telling of a dentist of his acquaintance who, on the occasion mentioned, was treating a lower cuspid with a fistula opening externally upon the face. His plan was to cure the fistula before filling the tooth permanently and in order to do this he instructed the patient to come to his office every morning, and each time he forced a ninety-five per cent. solution of carbolic acid through the opening. Much to his surprise, after treating thus for two weeks, it was no nearer the healing point than when he commenced. Fortunately for the patient, at this stage of the proceeding, a severe snowstorm swept over the country, and the patient failed to put in an appearance that morning. The next morning it seemed to be better, and when he did return, four days latter, there was no more chance for treatment, the fistula having closed and almost healed externally.

Cases parallel to this one happen frequently among physicians as well. Whatever we do in the way of treatment, let us be practical, not losing sight of the great fact that the drug in itself does not heal when applied, it simply checks disease, giving nature an opportunity to restore the lost part to a normal condition.

I might name many other points wherein we sometimes fall short of being practical, but these are sufficient to remind us that to be thoroughly practical in all that we do requires a thoughtful mind, tact and patience; without these three things we cannot hope for success to any great extent.—*Chicago Dental Review.*

Reviews

The Practice of Dental Medicine. By GEO. F. EAMES, M.D., D.D.S. 38 engravings and 3 colored plates. 240 pages. Philadelphia: The S. S. White Dental Manufacturing Co. 1899.

The last few years have witnessed several particularly valuable additions to our pathological literature, and yet the present volume supplies a long-felt need, embracing subjects insufficiently discussed in medical text-books. The author has made a scientific division, covering the general consideration in pathology and the inflammatory process, together with diverse conditions with which the dentist should be familiar, as well as general diseases having local expression in the mouth. Seven chapters treat of the local diseases affecting the soft tissues of the mouth ; fourteen chapters of local diseases affecting the dental and surrounding tissues ; while the work concludes with four chapters on the diseases affecting the adnexa of the mouth. We are more than ever convinced of the necessity, not only for such special works as the one before us, but of the great value to the dental practitioner of a complete course in medicine and surgery. It is quite true that there are parts of the medical curriculum of no practical value to the dentist. But it is equally true that the major portion is not only important, but indispensable to those who aspire to be more than merely practical. It should be too late in the day to make the former any sort of excuse. Such plea could be equally applied to the course of study in the common school and the university. The practice of practical dentistry is illuminated by a knowledge of medicine and surgery. There is no knowledge—outside of specially dental knowlege—of more practical value to the dentist than that of medicine and surgery. Of course these remarks do not apply to the mechanical tinker who has no ambition to rise beyond the level of a tinker. The mechanical expert is fully worthy of admiration. But the general probationer of dentistry must be more than a skilled mechanic. The work of Dr. Eames should be, to such, an inspiration.

Interstitial Gingivitis: or So-called Pyorrhea Alveolaris. By EUGENE S. TALBOT, M.D., D.D.S. 73 illustrations, 192 pages' Philadelphia: The S. S. White Dental Manufacturing Co. 1899.

It is a suggestive fact that while the history of this disease can be traced to the period of the cave-dwellers, and for two centuries it has been a subject of discussion, affording scope for scientific

guesswork and scientific analysis, it is only within the last few years that its etiology has been investigated with any pretence of true pathological system. Still more recently do we seem to be reaching the problem of treatment. It has been generally felt that the most commonly accepted name of the disease is a misnomer, suggesting, as the author puts it, "erroneous etiology," as well as "erroneous treatment," and that the proposed substitute, "interstitial gingivitis," though it has the philologic objections of uniting Greek and Latin terms, does not imply erroneous views as to etiology, pathology, prognosis and treatment. So far, this is a step in advance in nomenclature. The author maintains that the disorder is "a local inflammatory condition of the gums, tending to accelerate their normal tendency to disappearance at certain periods of stress, or involution, of which involution the changes produced by old age are a type." The uric acid hypothesis is now losing its force. It is but one of a number of local expressions of constitutional defect. Prominent among etiologic factors which have to to be reckoned with are pathogenic germs. There is no specific germ which is capable of producing the disease itself, and, furthermore, the pyorrhea stage is merely a complication due to pyogenic germ infection of the already diseased gums. Dogs afford good substitutes for the study of the disease. It is impossible within our limits to do justice to the merits of this work, but the following list of contents will give a comparatively clear conception of the careful manner in which Dr. Talbot has investigated the subject. There are sixteen well-written chapters divided as follows: 1. History; 2. Introduction; 3. Transitory Structures—the Jaws, the Alveolar Process, Periosteum and Peridental Membrane. Do glands exist in epithelial and peridental membrane? Bone-building and absorption. 4. Theories of the Disease; 5. Uric Acid; 6. Inorganic Salts; 7. Heredity and Environment; 8. Degeneracy; 9. Neurotic, Diathetic and Degenerate Children; 10. Interstitial Gingivitis in Dogs; 11. Mercurial Interstitial Gingivitis in Dogs; 12. Bacteriology; 13. Scorbatic Interstitial Gingivitis in Man; 14. Interstitial Gingivitis in Man from Metallic and other Drug action; 15. Conclusions—Pathogenesis of Interstitial Gingivitis, Endarteritis Obliteram, Absorption of the Alveolar Process. Pyorrhea Alveolaris from Interstitial Gingivitis, Constitutional Effect of Pyorrhea Alveolaris, Caloric Deposits; 16. Treatment. It is gratifying to observe the importance the author places upon prophylasis, more attention to the preventive than the corrective. The gums are too much overlooked in our daily practice. Vigorous stimulation with the finger, as emphasized so repeatedly and so long ago by Drs. Barrett, Tomes and others, is insisted upon. An index of authors is appended to the work. The appearance of the book is a great

credit to the publisher. We can only hope that it will occupy a place in the library and the careful attention of Canadian dentists. The splendid progress made the last few years, in Ontario especially, is largely due, not only to the devotion and ability of the teachers of the R. C. D. S. and the activity of the provincial and local societies, but to the fact that there are so many more practitioners not content, as of yore, to be satisfied with what they learned years ago, but who keep up with the times in the literature supplied by the publisher.

Question Drawer

Edited by R. E. SPARKS, M.D., D.D.S., L.D.S., Kingston, Ont.

Q. 50.—According to the programme of the recent annual meeting of the Ontario Dental Society, Dr. Moyer was to painlessly remove a pulp. Will the doctor kindly describe the operation in detail in your department of the Journal, for the benefit of those of us who were not fortunate enough to attend the convention and witness the clinic?

A.—In reply *re* painless removal of dental pulp without the use of arsenic, permit me to say that inasmuch as there was nothing original nor new in connection with my clinic, I would prefer having you give credit to A. J. McDonagh, L.D.S., Toronto, for the information you ask of me. In the September number of the DOMINION DENTAL JOURNAL, page 233, he gave the method very explicitly, and quite fully enough to make the application of the method an unqualified success. I shall, however, answer your question and leave the publication of it to your discretion: Apply the rubber dam; dry out and remove from cavity as much of decay as the sensitiveness of patient will permit. Then take a piece of spunk of sufficient size to cover the floor of the cavity; dip this in pure alcohol, and then, after dipping the saturated piece of spunk into crystals of muriate of cocaine, gently press it into the bottom of the cavity. Against this press a piece of unvulcanized rubber the size of the cavity. Continue the pressure first gently, and then with gradually measured force until no feeling of pressure is experienced. Then remove the application thoroughly, expose the pulp, and repeat the application as before. Where there is free access to the pulp the time required to produce perfect anesthesia is from two to four minutes. In case of fractured tooth apply pressure to the spunk. If there is persistent hemorrhage fill at a subsequent sitting. Remove pulp at once as sensitiveness will return in a few minutes.

SYLVESTER MOYER, Galt, Ont.

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TOO MUCH HASTE IN EXTRACTION.

General surgeons formerly emphasized the importance of rapid operat.ons. Mere expedition has yielded to the much more important consideration of thorough cleanliness and asepsis. It is by no means unimportant that the dental surgeon should be guided by the same experience. It is too commonly thought a feat of skill to extract a large number of roots in a few seconds. One consideration was to avoid the accumuiation and possible escape of blood into the asophagus; but by the use of sterilized sponges this is easily obviated. The dangers from rapid extraction include fracture of the crowns on their roots, fractures of the outer plate of the alveolars, destruction of the alveolar septa, injuries to adjoining sound teeth, injuries to the gums, lips, tongue and cheek. Abnormally firm teeth, where exostosis or ankylosis is suspected, should be slowly turned or moved in their sockets, then left alone for a few seconds before the final attempt at extraction is made. Among the contribution to our collection of the brutalities of dentistry a large number of teeth, with large slivers of adherent alveolar, stands as a reproach to two of the dental abbatoirs of Montreal. No skill is needed to extract the large majority of teeth rapidly. But a knowledge of the anatomy of

the parts concerned is necessary to extract teeth scientifically. The general hospitals have not been blameless in the disregard of this fact. Junior students in the past revelled in the pastime of performing tooth-extraction for the patients. There was almost as much fun in it for the students as in a game of football.

ABSORPTION OF ROOTS DUE TO ABUSE OF LIGATURES AND CLAMPS.

We have frequently referred to the mischief done to the gingival margin by the abuse of the rubber dam, ligatures and clamps. Recently we met with a unique case of the absorption of the roots of the six anterior permanent teeth, due, we believe, to the same cause. The ordinary causes, such as the pressure of unerupted teeth, transplantion, immediate torsion in the treatment of irregularity, and blows were entirely absent. The patient had undergone six successive and severe operations of contour gold fillings within two weeks. Each time she suffered intensely when the ligatures were forced down on the gum. In three cases clamps had been used. There were no less than thirty-six gold fillings and four amalgam in the mouth, none of which had given any more than the ordinary pain in preparation, and from none of which she had endured the preparatory and subsequent pain of which she complained in the treatment of the anterior teeth. None of the pulps were exposed in the latter. For over a year after the operations the gums were hypertrophied. It seems evident that the osteoblasts became osteoclasts and thus caused the absorption. The six teeth have been lost.

"ADVANCE, AUSTRALIA!"

We have read, with much pleasure, the *Australian Journal of Dentistry*, a monthly review published in Melbourne, of thirty pages, at 10s. 6d. per year. We shall refer to it again more specially. "Hands all around!"