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DOMINION DENTAL JOURNAL

(Official Organ of the Canadian Dental Associations.)



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VOLUME XI.

TORONTO:

THE DOMINION DENTAL JOURNAL COMPANY.

1899.

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Dominion Dental Journal

Vol. XI.

TORONTO, JANUARY, 1909.

No. 1.

Original Communications

G. LENOX CURTIS, M.D.

We are very glad to be able to give our readers the portrait of Dr. G. Lenox Curtis, who has made a reputation for himself as an operator in the special lines of oral and facial surgery, which enabled him some years ago to abandon the practice of dentistry, to devote himself exclusively to these branches. Canadian dentists who are in the habit of attending our various conventions, and who have witnessed some of the brilliant operations in oral, facial and nasal surgery by the doctor, will remember his skill in working almost exclusively through the mouth, and without opening or scarring the face. The success of several of these cases was clearly due, to the special skill and experience the doctor enjoyed for many years as a practical dentist. The training in the every-day use of the dental engine, and various mechanical devices, led him naturally to resort to their assistance more than the ordinarily trained surgeon would be apt to adopt. Many of the methods and mechanical devices which we have seen the doctor use, were the outgrowth of practical experience as a dentist, and several of the best are his own invention.

Dr. Curtis is, we believe, the only practitioner who gives his exclusive attention to his specialty, and we therefore look to him for the greatest advancement in his line. The same determination which characterizes his success, and caused him to lead in his profession, is seen in his love of a life in the woods, where he spends a large share of his summer vacation with gun and rod. He has travelled over most of the world and brought back with him thousands of photographs made with his own camera. He is a member of most of all the societies for which he is eligible, including the American Author's Guild, and for years has taken a very active part in them, and on several occasions represented his

profession at the International Medical Congress. He follows no beaten track in his work, for his inventive genius has led him to branch off in original methods by which he has achieved eminent results. He is a strong advocate of advancement in science; and in nearly all his writings he urges the medical schools to adopt the new methods in oral and facial surgery, by adding to their curriculum men qualified to teach the treatment of diseases resulting from affections of the teeth. The present high-standing requirements to enter upon the study of dentistry in the State of New York were, we know, the outcome of his suggestion and work.

Dr. Curtis is often called into consultation, not only by observing men in dentistry, but by general medical and surgical practitioners, and his genial nature has made him many friends among the latter who have witnessed the skilful and original treatment of difficult oral and facial cases in his hand.

SOME SUGGESTIONS ON THE TREATMENT OF PYORRHEA ALVEOLARIS.*

BY G. LENOX CURTIS, M.D., NEW YORK CITY.

In my remarks I shall not attempt to exhaust this subject, which is broader than the present status of knowledge. I, however, make a few suggestions, with the view of drawing out discussion that may lead to widening this field. I shall not think it strange if some of my hearers disagree with me, for I differ somewhat with most authors upon the subject. I think that Dr. Pierce has fallen into the error made by some other writers, who claim that uric acid is the cause instead of the result of rheumatism and gout, of which pyorrhoea alveolaris is a symptom, seen only in certain classes of the discrasia. I have found that it is not always safe to adopt some views, especially those found in some books. Not only dentists, but physicians sometimes depend too largely upon literature, for their practice in most oral diseases.

Perhaps all dentists do not have facilities for thorough experimental work, but they certainly deserve credit for the persistent manner in which they have endeavored to cure, by devoting their time almost wholly to the treatment of a single symptom. I believe that very few recognize the importance of general treatment, with the view of eradicating from the system the conditions

* Read before Alumni Association of Boston Dental College, 14th Dec., 1898.

that aggravate this disagreeable and offensive malady. There are physicians—even those of prominence—who seem to fail to observe one symptom familiar to every dentist—that is, they do not appear to connect the local aspect with a systemic disorder. In both of these professions the lack of general knowledge concerning the intimacy of the systemic with the local (directly or indirectly) is something surprising. The present plan of medical teaching is far from being equal with that known to the educated dentist more familiar with oral diseases. The medical curriculum will not be effective until its students are better educated upon oral diseases. The etiology of Pyorrhea Alveolaris or Loculosis Alveolaris, to my mind, is best presented by Dr. Eugene S. Talbot, who attributes the principal cause to careless dentistry and degeneracy of some of the oral tissues.

The clinical features are best described by Dr. J. N. Farrar in his articles in the *Independent Practitioner*, April and September, 1886.

Among the local causes for which I believe careless dentists are responsible, is extraction of one or more teeth, leaving thereby imperfect antagonism, improper contour fillings, overlapping fillings between the teeth, ill-fitting root bands and plates, ligature, file and emery strip wounds; possibly too hard malleting is a factor; certainly bunglingly-made regulating machines, V-shaped spaces between the teeth, whether caused by file or wedge, allowing lodgment of food, salivary calculi and cheesy deposits. Any local condition that leads to degeneracy, or any medicine that causes salivation should not be overlooked in the diagnosis and treatment.

I regard rheumatism, gout, and syphilis as potent causes of this malady, but, of course, it does not necessarily follow that these affections always accompany pyorrhea alveolaris. I sometimes think that physicians do not always appreciate the importance of retaining the natural teeth, or substituting artificial ones where only one or more are lost. As the treatment of socket diseases more properly belongs to the dentist, and many of them do not thoroughly remove the deposits from the teeth, and a less number have a practical knowledge of the best principles in the treatment, I think more surgical and medical education should be taught in dental colleges, and more dental education taught in medical colleges. Most dentists are general practitioners in their calling, attempting all parts, and do not follow exclusively any one branch until they find that they excel in it. Instead of advising their patients to go to a specialist for treatment of that in which they do not excel, they too often skim over that, making a feint at treating the disease, or, what is more unpardonable, adopt the "do-nothing-plan," and tell their patients this trouble is incurable.

I believe pyorrhea alveolaris can be cured. This I feel I can

prove by tabulated cases. Treating this disease, while practiced by dentists, belongs as much to surgery as the reduction of fracture of a bone. Of course, only the deft in skill can properly treat it. Dr. Dunlap truthfully said, "A doctor can be made in five years, but it requires twenty-five years to make a first-class physician."

A clear knowledge of the condition of the patient is an important matter. The surgeon generally tries to learn this, while the dentist too often overlooks it. The restoration of the general health is essentially the cure of pyorrhea alveolaris, but the general health cannot be accomplished so long as this particular disease exists in an aggravated form. The ordinary physicians rarely examine the mouth to ascertain whether there are sufficient teeth to masticate with, and overlook the common fact, that there are often pyorrhoeic pockets filled with bacteria and pus, daily being mixed with the food, and continually carried into the stomach. Nearly all persons affected with this disease have dyspeptic ailments, anemia, blood poisoning, and accompanying these there may be various forms of neuralgia and, occasionally, mania. A physician would not expect to cure dyspepsia, or to cure phthisis, until he had first cured nasal catarrh, if present. I believe that the nails and the teeth are among the best indicators in diagnosis of rheumatism. They show certain signs long before other symptoms appear, except those found in the blood. They may be regarded as an index showing when to cease treatment for rheumatism. When the abrasions on the teeth lose their hypersensitiveness, and the nails lose their corrugations and lines, returning to their normal smoothness and flexibility, we will know that the rheumatic poisons have been eliminated. Can not the ridges so frequently found in the teeth be accounted for through prenatal influences, such as rheumatism during gestation? Why should not the tooth germ become marked as well as the nails? The hardness of enamel retains the ridges, while the nails change about every three months, and the indicator may be lost.

The examination of the blood is important in diagnosis, as this pabulum shows the presence of existing diseases. The examination of the blood is, I think, the strongest basis in diagnosis. In many diseases such evidences may, in their early stages, be found in the blood. These are always found before the objective or subjective symptoms. They are the first to come and the last to leave. Dr. Robert L. Watkins claims that fibrin is present in the blood in advance of the general symptoms of rheumatism, apoplexy, organic heart disease, fevers, etc., and is as variable in form as are the diseases themselves. Dr. Watkins has found in the blood of patients suffering from pyorrhea alveolaris different varieties of fibrin, spores of syphilis, eczema, tubercular matter, and the bacillus itself. He found these even when the diseases were

not active. We may, therefore, reasonably base our hope of ascertaining the etiology of the disease by the study of the blood.

Dr. Talbot regards that careless dentistry is the cause for the increase of pyorrhea alveolaris. Dr. Beers touched the key-note when he said: "The gingival margin should not be wounded." When the gum has been wounded, greatest care should be taken to heal the wound without infection, especially is this true in cases of inherited tendencies. While the neurotic patient is prone to pyorrhea alveolaris, exaggerated cases are not infrequent in the phlegmatic patient. Although no outward sign of lesion exists, it is often found that the pulps of some teeth involved are devitalized. Infected tissue from septic tooth canals is often classed as pyorrhea alveolaris, and treated without first removing the cause, and from this the teeth are often lost. Whenever such teeth are extracted (in order to prevent the continuation of the disease) the sockets should be curetted and treated as open wounds until filled in by granulation.

Patients naturally shrink from being hurt, but now that we can safely use a strong solution of cocaine, by first administering its antidote, volasem, the treatment of pyorrhea alveolaris is comparatively painless. I would not have it understood that I believe every tooth involved in this disease can be saved, or that an attempt should be made to save all teeth. To do the greatest amount of good, it is often necessary to make some sacrifice, but because a number of teeth are loose, it does not follow that they should be extracted. The patient's wishes should be consulted, and as they look to their doctor for guidance, they are generally willing to accept his advice. I was recently asked by a dentist to see with him a case of pyorrhea alveolaris that he had been treating for four years. He appeared satisfied with the results, for by the use of ligatures he had been able to hold in position several loose teeth; yet this was done to the detriment of those teeth to which they were fastened. The gums were hypertrophied, boggy and purple, with evidence of calculi beneath them. Four of the teeth which had not been opened contained septic pulps.

Medical treatment for the dissipation of degenerating causes should be given in conjunction with local treatment, and should be continued until the disease is eradicated—that is, the general health of the patient should receive careful attention. Septic canals should be cleansed and filled with a permanent material. Remove all the calcareous deposits, ulcers, abscess sacs, carious bone, irritating roots, and in fact every source of irritation. The greatest care must be observed in curetting and dissecting away every particle of diseased tissue, so as to leave a fresh and healthy wound, which should be treated as such and encouraged to heal as rapidly as possible. Next, boil out all remaining debris with

peroxide of hydrogen. The patient should be instructed to use a sterilizing mouth wash (electrozone is probably the best) every half hour, if possible; then apply tincture of iodine sufficient to flood the wound around the roots. This treatment should be continued every two or three days until the wounds are healed. Care should be observed to avoid blood-letting while treating the wound lest it become infected.

The period of treatment is usually from one to two weeks. The fixation of teeth should be done as early as possible after the first operation by means of a splint, as devised by Dr. Wm. L. Fish. Proper occlusion of the teeth is essential to prevent undue pressure on any one, and to facilitate mastication. Never use acids nor mercury. Operate on a small part at a time. Stop treating the wound when it is healed. When the disease is so extensive that little attachment to the root remains, the pulp being vital, the extirpation of the pulp and the treatment of the canal, if septic, should be done. Instruct the patient to return when any irritation of the gum or jaws is noticed, and every three to six months for examination. It is not always easy to impress upon the patient the importance of this advice. The irritant that caused the disease will reproduce it.

7 West 58th Street.

[The discussion which followed will appear in the February issue.—E.D. D.D.J.]

FRICITION PLATES.*

BY GEO. H. WEAGANT, L.D.S., CORNWALL, ONT.

I have no doubt that my methods of constructing these plates will be quite familiar to most of you, and perhaps inferior, in many respects, to yours. Still there may be points which would suggest improvement or be of value in special cases. It is in the details where the operators are likely to differ, and in the comparing of which we may acquire information. We all know that a close attention to details is an all-important factor in the construction of a perfect apparatus of any kind, and I may be pardoned if I devote some considerable portion of this paper to them.

By a "friction" plate is meant an artificial denture which is held in place by means of mechanical contact with some of the natural teeth remaining in the mouth. In this catalogue might be

* Read before the Eastern Ontario Dental Association.

included partial plates with clasps of metal or rubber, or even plates without clasps bearing against the natural teeth in such a way as to hold them in place—in fact any kind of a plate retained in the mouth other than by adhesion or by so-called atmospheric pressure. I might also except plates retained by means of spiral springs. Most of these plates have their faults, and are usually short-lived and often injurious. I have nothing to say about them in this paper, but wish to describe one special kind of friction plate which when properly constructed has, in no case that I know of, failed to give entire satisfaction ; and, although it may be, and frequently is, employed successfully in the upper jaw, I shall confine my paper more particularly to difficult cases of the lower.

We are all familiar with the old woman or, more to the point, the much dreaded old man, who has lost all but two or three good strong teeth in the anterior portion of the lower jaw. These teeth remain as monuments commemorating the long-ago extracted and almost forgotten row of grinders, which ignorance on the part of the patient, and criminal carelessness, perhaps, on the part of the operator, have scattered to the four quarters of the globe. The alveolus of course has entirely disappeared, except where a huge mound surrounds the remaining teeth, and only a thin line, no longer than a knitting needle, marks the course of the jaw bone. The muscles of the floor of the mouth, having sought out new attachments for themselves traverse this narrow line and rise up in all their strength at the slightest provocation, giving visions of the manner in which a full denture might be expected to retain a tranquil position in the midst of all this mighty upheaval. The dentist is calmly requested to remove the remaining "snags" to the end that when the tissues heal up sufficiently a full lower denture be inserted. And, unaccountable as it may seem, in nine cases out of ten, the request is cheerfully acceded to without the slightest protest on the part of the operator. Trouble lies in store for the dentist, and disappointment and shortened days for the patient.

Now take such a case as I have described, when it is first presented, with two or three strong teeth or roots remaining, what is best to be done? We are not going to consider the question of bridge-work, but of a plate, and the best way to make it secure and firm. I think I hear some of you say "What is the matter with clasps?" I advise you to put not your trust in clasps, they are a delusion and a snare, decay follows in their wake and eventual loss of the teeth, and forcible and unparliamentary language by the wearer.

We do not always find these teeth sound. They are often decayed, broken or worn down to the gum ; but if the roots are strong and firm they will answer our purpose. We also require

that they be parallel with each other or nearly so. If they lean towards or away from each other we must endeavor to straighten them up. If we cannot do so without loosening them, the chances are that our case will eventually fail.

Given the most favorable case and the most frequently met with, namely two cuspids standing strong and firm in their sockets, and nearly, if not quite parallel with each other. My first move would be to grind them to as nearly a cylindrical form as possible, much in the same way as we would proceed in ordinary crown and bridge-work. I might taper them slightly towards the grinding surface; and, if necessary, also shorten them. The next step would be to fit a thin 24 karat gold cap to each of the teeth, letting the band come well under the gum, and having it fit closely the whole length of the tooth, making no attempt whatever to contour, but when complete, to be the same shape of the remodeled tooth; in fact, when in place, representing a mere cylindrical peg, with a flat top, covered with gold. The teeth must then be dried and the caps cemented in place, burnishing the soft gold well under the cervical border. This whole procedure is solely for the purpose of protecting the teeth from decay after cutting them to the proper shape for subsequent operations.

Next, an outer shell of heavier gold, 22 karat, must be fitted in such a way that it will telescope over the gold-covered tooth. It must be made to fit snugly, but not so tight that it will require much force to remove it. The lower edge of the band is trimmed so as not to touch the gum; a flat piece of gold is soldered over top to prevent the outer cap from ever being forced against the gum. If it is desired that these outer shells should conform to the original shape of the tooth, it must be done by adding gold in some way to the outside, care being taken that the inside is not altered in the slightest degree. If a gold plate is had in view for this case, the plate is struck up in the ordinary way, placed in the mouth together with the caps, an impression of plaster is taken, plate and caps removed with it, and caps soldered in the very strongest manner to the plate. If, as in most cases, a rubber plate is decided upon, we must solder to the lingual side of the caps a very strong bar, preferably reaching from one cap to the other, and extending, say half an inch or more behind each cuspid, care being taken not to take up room required for the artificial teeth. An impression is taken with the caps in place, and the rubber plate constructed as usual upon the model. This will make a plate that will never move around in the mouth, nor will it press too hard upon the gums, being prevented from doing so by the caps. There is no danger of decay of the teeth as they are fully protected by the gold covering, and slight liability of the teeth becoming loosened unless too hard work is put upon the plate.

If the patient is wearing artificial teeth in the upper jaw do not allow the caps to strike as they would soon become worn through. Frequently we find a patient who, although advanced in years, still objects to the display of metal necessitated by the foregoing manner of constructing a plate. In such a case we shall be obliged to alter our method to some extent. Unfortunately there is no metal, which we have at our command, having the appearance of anything else than metal. Porcelain is the only material we can use which imitates the colour of the teeth; and how are we to employ it to take the place of the objectionable gold in the case we have on hand? It can be done, as several cases of my own will bear witness: Cases which are now in good shape after five or six years hard and constant wear.

Porcelain, being a brittle substance, requires to be of considerable thickness to give it the necessary strength, and we must provide room for this extra thickness. After trimming the natural teeth to a cylindrical form, as in the case for gold caps, we must grind out the labial surface as much as we can without endangering the safety of the pulp. Sometimes, but not often, these teeth are extremely sensitive, and consequently it would be advisable not to grind too deep. The patient would consent to a little extra thickness or prominenee to the two cuspids, in order to escape the pain and to avoid wearing a conspicuous gold tooth.

Having trimmed the tooth to our satisfaction we proceed to cover with thin 24 karat gold as described before, care being taken to make a perfect fit. The outside shells are to be constructed of pure platinum instead of gold. A platinum wire is to be soldered all around the cervical edge for extra strength, also a sort of frame of platinum wire on the approximal sides of the hollow place reserved for the porcelain. This last is designed for the purpose of making a distinct margin for, as well as assisting in, the retention of the porcelain. A heavy piece of platinum must also be soldered to the grinding surface, projecting forwards sufficiently to well protect the porcelain from danger of fracture during mastication. We now have a complete frame work for our porcelain facing; but to make the attachment of the latter doubly sure, the entire surface of the platinum to be covered with porcelain must be roughened with a graver leaving little points of metal sticking up in all directions. All soldering ought to be done before the porcelain is put on; so, if possible, the clingers or bars to attach rubber work may now be soldered in place. It may not be practicable to use a connecting bar between the two caps.

A word here as to the solder to be used. It should be of a very high grade, so high indeed that I doubt if many dentists ever employ it. It is an alloy of pure gold and pure platinum—about three of gold and two of platinum. This requires a much higher

degree of heat to melt than pure gold ; but in small pieces such as we have in hand, can be readily worked with any form of blow-pipe. Pure gold may be used instead of the gold-platinum alloy, but it is apt to run all over the piece when placed in the furnace, filling up the roughened surface and interfering with a perfect adhesion of the porcelain.

When all soldering has been completed a plain artificial tooth, to match the case in hand, must be selected. The entire back part of the tooth, pins and all must be ground away until we have simply a thin facing to fit as nearly as possible the receptacle provided for it. This is attached with porcelain body and fused in a furnace in the way familiar to all porcelain workers.

If it is found necessary to do any subsequent soldering pure gold may be used, or even a high grade, say 22 karat gold solder. It is advisable, however, to do all soldering before the porcelain is attached, as sometimes small fractures occur from soldering afterwards. We might be called upon to make a gold plate in connection with the porcelain faced caps. In this case, of course, we would be obliged to solder the plate and caps together after the porcelain was attached, using a solder of a lower grade than the plate. I find that any grade of solder lower than 24 karat or pure gold, does not always take well on platinum, and I always take the precaution to first flow pure gold over that part of the platinum to be soldered.

I might say a few words in reference to cases where the crowns from some cause have been lost, but the roots are strong and firm. After proper treatment to render them safe from the attacks of disease, they should be trimmed as for crown-work, and collars, caps and strong platinum and iridium posts fitted. It will not be necessary to construct a full-sized crown unless we like. Simply a strong, straight round post continuous with the post placed in the root will do, and a gold tube closed at the top, fitting over this post, with the lower end resting on the top of the cap to form the attachment to the plate. The tube may be embedded in the rubber, leaving plenty room for a plain, flat-backed tooth to be attached to the plate immediately over the root.

DO MEDICAL COLLEGES STRIVE TO THOROUGHLY EDUCATE THEIR STUDENTS?

BY G. LENOX CURTIS, M.D., NEW YORK.

In considering this subject, especially during the past year, I have reached the conclusion that these institutions are conducted largely for personal gain and aggrandisement, and any innovation which might tend to defeat their purpose is frowned upon to their discredit, and to the detriment of their pupils. If knowledge is the acme of education why do not the presidents of colleges see that men best fitted for certain positions are placed in them? Is it because their own prominence depends on those members of the faculty who oppose investigation and research of new methods set forth by an unassuming practitioner, who has spent his hard earned dollars and years of his life in original investigation? A new theory, backed by scientific experiments, is rarely favorably received, unless advanced by men at the head of the profession—to follow whom is the fad of the day.

The medical profession is full of young men who have for years been working on original subjects with astonishing results, but fear of failure of recognition and unjust criticism have prevented them from making public their discoveries. If American colleges would cast politics aside, and open their doors to such investigations, this country would lead the world in medical science. Could this condition exist, the tide of students flowing to European colleges would be turned, and foreigners would finish their education in America.

What Koch so ignominiously failed in, the treatment of tuberculosis, has been accomplished in America, but the profession frowned upon the treatment, and compel the discoverer to retreat into the background, and to seek irregular methods for making known his discovery. In the search of the blood for diseases of the body new methods have been evolved. By these methods we are shown that the natural secretions of the body yield signs of early and obscure disease, which the methods now in vogue fail to bring to light except when the disease is far advanced and often too late to save life. The art of instantaneous micro-photography is partially responsible for this new method as it demonstrates what the naked eye cannot see, and even shows such objects as the tubercular bacilli and the spores of syphilis floating in the serum of the blood. It would seem that every disease has its distinct representation in this organ. This can be discovered when the disease is in embryo, and treated before the general system is impaired. How many physicians there are who are at

their wits end to know from what their patients are suffering, because the disease is not sufficiently developed, who would gladly hail the knowledge which would lead them to a solution of the problem. The examination of the blood is nothing new, but the examining and photographing the fresh blood within a few seconds from the time it is drawn from the circulation is new. By this process the disease may be found before pathological change has been produced, and yet the discoverer of this method cannot have the advantage of a college laboratory because he has not a pull with the faculty. To get recognition in America for discoveries like these it would seem necessary to first take them to Europe and have them returned with a foreign label.

CONCERNING FEES.

BY B.

If we would only stop to compare some of our professional fee customs with the customs of the plumber, we could learn something from the latter. For instance, the plumber's charges for "time" begin the moment he leaves his shop, and saunters to your house. He is "a gentleman of leisure." Every step he takes towards you means a debit in his books, and he is distinguished for the slowness of his steps. Intensely so, he is a strict adherent to the custom of charging for "time," and while he gossips with your cook, or strolls back to his shop for a forgotten tool, his bill runs on all the same. If you examine his bill the "details" amaze you. Every screw, tack, bit of solder, etc., are enumerated. You need not imagine that he will overlook anything or give any of his time, experience or materials for nothing.

But we who are incorporated by law as one of the liberal professions, carry out our liberalism more liberally. Time, experience, and materials are given repeatedly without any request for compensation. Patients treat us with a superciliousness they would not dare show to their plumber. People who expect to be charged the uttermost farthing for every moment of time, and every scrap of material used by the man who is down in their drains, expect the same from the dentist gratis. Indeed it seems to me, as if many dentists act as if they were obliged to apologize to their patients for charging them at all! "I never charge physicians anything," said a confrere to me. "And does your physician charge you?" "Oh! yes," he replied, "but somehow or other I got into the way." Did any one ever hear of such insanity?

A case came to me several months ago which will illustrate, not only the hereditary mischief done in this way, but the unadulterated gall and ignorance of a certain class of the public. A pompous patient sailed into the office, and dictatorially wanted an appointment to have a tooth filled. "I had it attended to by Dr. — and he botched it, and I had to get the filling out. Dr. — then filled it again, and he's another botch. I just want you to fill it again." I explained to her that both of the gentlemen she libelled were among our best and most experienced dentists; and that she doubtless was to blame in not letting them treat the tooth as they probably wanted to treat it. "Oh! I don't believe in that at all; if a tooth is filled properly it ought'nt to ache." I told her that proper treatment of the roots was necessary; that it would be an expensive experience financially that might or might not succeed, but she replied in her superior way, "All I want you to do is just to fill up the cavity again, and I'll try it." I acceded to her desire under protest, and conditionally, that if my prophetic assurance of trouble was fulfilled, she would at once return. She returned and made an appointment for the purpose of extraction, or beginning the treatment, which ever she would decide upon. She did not come back, but suffered exactly what I predicted, and then placing me and my reputation among her choice list of "botches," she went to another dentist. By that time she had concluded to let the dentist be the judge of the proper way to manage such a tooth, submitted to an expensive treatment and had the tooth saved. This is one of the many cases which provoke us in practice, but which we cannot deal with, simply because we do not get the chance.

Proceedings of Dental Societies

TORONTO DENTAL SOCIETY.

At the regular meeting of the Toronto Dental Society, held November 8th, in the Board room of the Dental College, the newly-elected officers were installed in office as follows: Hon. President, Dr. A. J. McDonagh; President, Dr. J. E. Wilkinson; 1st Vice-President, Dr. W. C. Trotter; 2nd Vice-President, Dr. A. J. Husband; Secretary, Dr. C. E. Pearson; Treasurer, F. D. Price. Membership and ethics committee—Drs. J. F. Adams, Roberts and Swann. Programme Committee—Drs. McDonagh, Trotter and Eaton. Dinner Committee—Drs. McDonagh, Trotter and Eaton, W. E. Willmott and J. E. Wilkinson.

The evening was devoted to clinics in the college infirmary. Dr. A. J. McDonagh demonstrated the use of Solila gold. Dr. Webster gave a clinic on tin and gold in combination. Dr. C. E. Pearson gave a clinic on using fellowship alloy, and Dr. Wilkinson, showed method of removing pulp alive after injecting cocaine solution.

Gen. Sec.

ONTARIO DENTAL SOCIETY.

The annual meeting of the Ontario Dental Society will be held at the college, Toronto, February 15th and 16th. Dr. Calvin S. Case, of Chicago, will be present and present some features of Orthodontia. A special feature of this years meeting will be the large number of clinics. In addition to Dr. Case the best clinicians of the Province will demonstrate their methods in special lines of work in which they are expert. The executive expect to make this meeting so practical and beneficial that all who attend will be well repaid. Further particulars next month.

G. S. MARTIN, *Pres.*

W. CECIL TROTTER, *Sec.*

Correspondence

LETTER FROM DR. W. C. BARRETT.

IN lieu of an original communication which we had hoped to give our readers from Dr. W. C. Barrett, we are permitted to publish the following inspiring letter in reply to the invitation to the "At Home" of the Royal College of Dental Surgeons. From our earliest recollection of professional matters in Ontario, no one of our good cousins over the lines gave more personal and journalistic help to our Canadian efforts at reform, than Dr. Barrett. This is a fact well-known and as well appreciated.

We venture to state, with reference to the fraternally patriotic sentiment which ends his letter, that the dental societies of the border States and of Canada, have in their own way, for many years contributed to the silent growth of that good feeling which now happily exists between John Bull and Jonathan. When statesmen were trimming their political sails, and frequently pitching nasty phrases at one another, the dentists were exchanging fraternal greeting, both in the United States and Canada. Loyal to the core to our own Imperialism, and preferring annihilation to annexation, Canadian sympathies have gone out to Jonathan in his

new national responsibilities. We Canadians ask to be understood and respected in our love for our own land and empire, and we mean to do all we can to forget our differences, and to deepen the friendship of the two people.

DEAR PROF. WILLMOTT,—I am in receipt of an invitation to attend the annual "At Home" of the Faculty and students of the Royal College of Dental Surgeons of Ontario. Believe me when I say that I fully appreciate the courtesy extended, and were it not that the time unfortunately falls upon the date of my regular visit to Chicago, and would thus interfere with my course of lectures in the Chicago College of Dental Surgery, I should certainly accept and be present at the time indicated. A delegation from this College will, however, it is expected, be present, and they will convey to your school the fraternal greetings of the Faculty and students of the Dental Department of the University of Buffalo, which they are duly commissioned to extend.

I believe that the Ontario College has initiated a custom and established a precedent that it will be well for other like institutions to follow. There is far too much of selfishness and exclusiveness among professional institutions and men. We forget that we all belong to the same beneficent calling, have ends and aims in common, and that which advances one must work to the benefit of all. Each school and each individual too often seem to be inspired by a belief, that a higher plane can only be reached by climbing over or upon another. Practitioners look upon honorable competitors as malicious enemies to be suppressed. Mean jealousies and malignant enviousness take the place of magnanimous emulation. If a rival for professional favor can be dragged down below the level of reputable professional standing, many imagine it a personal advancement; whereas, in the opprobrium that is thus brought upon the whole profession all are depressed, and especially he who has labored to bring this about. It is only by comparison with that which is base that anyone can thus be made to appear better. I am the gainer by whatever raises the general status of my profession. That which tends to make another college more efficient, and to better its instruction, elevates the one with which I may be connected, and it is in that view that I individually rejoice in the prosperity and renown of the Ontario Dental College. If you have an excellent and intelligent class, I can but know that when they go out into practice and bring credit to their college and profession, I shall be a sharer in it, because I also belong to the same profession. If the Faculty of another college gains distinction in teaching, and becomes famous for turning out skilful and thoroughly trained practitioners, as a teacher myself some of their glory can but be reflected upon me. My profession cannot

be lifted without carrying me with it, and it cannot be depressed without lowering my status. Hence, I repeat that I have good cause to rejoice in your prosperity.

There should, in my opinion, be some college and public acknowledgement of this feeling. The students of our schools should be made to appreciate it, and there should be such an interchange of courtesies between the teachers and undergraduates of different professional institutions, as would impress upon them the great fact of their solidarity and unity of interests. To this end I have done what I could, to encourage the very evident spontaneous desire of the students of this college to send a delegation to attend your annual festivities, and to carry with them the fraternal greetings of Buffalo dental students and teachers. I heartily commend to you and to your Faculty and students the representatives of this school, who are charged with such a pleasant duty, and we all trust that representative delegates from the Toronto College will at no distant day be welcomed to the college home of those, who now forward their most cordial salutations and heartiest expressions of good will. I can assure you that they will be warmly received, and I hope when they do come they will be accompanied by some delegate teacher of your Faculty. I need not say if it is yourself, the satisfaction will be all the more pronounced.

Let me in closing offer a sentiment that we will always strive to exemplify, and which I am sure will arouse an answering echo in your every heart.

Two separate amicable nationalities: many separate friendly individualities: but only one united professionality, to whose best good we will all devote our future professional lives.

Fraternally yours,

W. C. BARRETT.

BUFFALO, N.Y., December 1st, 1898.

NEW YORK LETTER.

To the Editor of DOMINION DENTAL JOURNAL:

Sir,—As some of you Canadians were wont to fellowship with that much-honored Association of New England dentists, the Connecticut Valley Dental Association—but now extinct—it may be of interest to know that a substitute has taken place in the interests of many New England practitioners. While it has not as yet drawn to its ranks all of its old timers, still, it has drawn to itself not a few of the larger practitioners. It was our pleasure to be at this gathering of dentists at their October meeting in Hart-

ford, Conn. No pleasanter place could be selected. We regard Hartford one, if not the pleasantest, of inland cities. It has wealth and blue-blood, both in genealogy and theology. It has culture of more than an ordinary quality. Among such surroundings there should be an incentive to attractive skill in all departments. The dentists of Hartford have, during the last years, done themselves much credit in forming an association for monthly gatherings. To us a much increased spirit of personal cordiality was decidedly noticeable. This is needed in every community of twenty-five or more practitioners. As we grow into more personal respect for each other it will enhance the respect of the community around us. Hartford has suffered for want of such an association as they are now generously sustaining. This was all dispelled by an atmosphere laden with fellowship so decidedly manifested towards the North-Eastern Dental Association. This gathering was one of unusual good feeling, which prevailed throughout the sessions of two days. The papers were all of good quality. Some were noted for their shortness,—not any too often so,—but they were termed five-minute papers, and full of practical suggestions. We are disposed to emphasize Dr. Strong's, of Bridgeport, Conn., on combination filling, which he has earnestly commended before. It consists of amalgam and the phosphate cement. These are ground together in a mortar about $\frac{1}{3}$ to $\frac{2}{3}$ proportions, (amalgam $\frac{1}{3}$.) then mix as common. One benefit it has, its wearing quality is enhanced; second, its solubility much lessened. He produced good evidence that he has the facts made real by a demonstrated practice. We say this because Dr. Strong is a practitioner of marked ability in gold filling, and he does not commend this method as a make-shift only, because in certain places and conditions it is a decided benefit in a prolonged salvatory point of view. It only needs a faithful trial for proof. Demonstration is the best teacher.

Dr. Geo. Welds read a paper on Chemical method for filling root canals. There can be no doubt of the growing interest in this practice, for the doctor is called on for the re-reading of this paper in many places, and is yet under invitations. The clinical lecture that follows the paper is of decided interest.

Dr. Smith's paper on Prophylaxis had one emphatic recommendation—the polishing of children's teeth as a preventive of decay. We are glad to give a sentence of certain approval to this. We know its value by practice, beginning back as far as '66. We say here as we did at the meeting: "If the dentists in general do not know of the possibilities and value of tooth filling, then they have something to learn." This applies to adult teeth particularly. With young teeth it does stimulate the structure decidedly. Demonstrate it for a year and then report.

Dr. Palmer, of Syracuse, long and favorably known by us all, gave the gathering his grateful presence, and a decidedly interesting and intelligent paper. The doctor never looked so genial as now. He is ageing gracefully, as we all might and ought.

Dr. Stockwell, pleasantly known in Canada, (he of Springfield, Mass.), paid a very unique tribute to Dr. Palmer's faithfulness in working faithfully at a time in which he had a decided belief, for in the end they are able to give a contribution of usefulness. Men of Dr. Palmer's skill do not get "cantankerous," but keep delving.

President Ingalls, of Clinton, Mass., certainly did himself much justice in his address. It was above the ordinary. Dr. Ingalls was one of our first callers in our early New England practice, now forty-six years ago. Our fiftieth year is not long ahead, and we are still young and festive. Why not? Never more interested in everything that touches the true necessities of our calling. One thing we especially enjoyed at the Hartford gathering, viz., the ideal election of officers for the coming year. This by a nominating board and one vote cast by the Secretary. Nothing could have been more nicely done. Dr. Strong, of Bridgeport, Conn., was the honored choice—a very worthy member of our profession. We have known him favorably for thirty years. He is always a gentleman, and it is said such "never forget themselves." The Committee of Arrangements at this meeting deserve commendation for the very pleasant carrying out of their plans.

The White Crown Company of California gave an exhibit of their "ideal" gold crown, which was examined with careful interest.

Dr. Lenox Curtis gave an extended talk on his use of "Volasem" as absolute antidote for cocaine. His recital of cases associated with its use gave a decided conviction of its value.

For a January attraction in New York Dr. J. Leon Williams is to favor the Odontological Society with his high order of talent. This meeting is to be the occasion of the season, from the fact that it is to be the thirty-fifth anniversary. This body has had varied history, but one of much profit. To be present at this gathering will afford an opportunity of meeting many dentists much known and heard of during the last thirty years. Not a few that were actively interested so long ago have gone beyond the earthly activities, but men of value. As the programme of this noted gathering can be seen in the journals we refer to them. A good many things are agitating the dental mind in these days, and unless some of them are wisely disposed of they can but widen the discontent that does exist. It is hoped that it will be diverted.

Cordially,

New York Nov. 1898.

G. ALDEN MILLS.

Abstracts

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

COATING the face of a Melotte metal die with vaseline will prevent the counter die from fusing with the die.—*Indiana Journal*.

TO mend plaster casts so that heat may afterwards be applied without affecting the mend, use oxyphosphate.—*American Dental Weekly*.

BISMUTH, 48 parts; cadmium, 13, and tin 19 melts, at the remarkably low temperature of 200 F. It is frequently useful in the laboratory.—*Dental Brief*.

IMPRESSION material from which a die can be cast straight:—Plaster, 1 quart; pumice powdered, 1 pint; chalk, 1 pint. Mix and use same as plaster.—*American Dental Weekly*.

TO make artificial teeth look more life-like, dip in hydrofluoric acid before setting. This will remove the glistening appearance produced by the baking.—*British Journal Dental Science*.

A FEW drops of ammonia in the gold tray will render old scraps of gold sufficiently cohesive to work quite as well as new, provided they have not been wet.—WALLACE WOOD, in *Dental Weekly*.

ROOT FILLING IN DECIDUOUS TEETH.—Make a paste of iodoform in glycerol, of such consistency as can be readily applied on a probe. Fill pulp chamber with temporary stopping and cavity according to conditions.—GEORGE N. WASSER, *Ohio Journal*.

ANTIDOTE FOR ARSENIC ON SOFT TISSUES.—Dr. A. N. Dick, in *Pacific Medical Dental Gazette*, claims that tincture of iodine is a prompt and certain antidote for arsenic coming accidentally in contact with gums or cheek, preventing inflammation and ulceration.

THERE is one thing, if not more, that carbolic acid seems to do better than anything else and that is the destruction of an abscess sack. Other caustics may do very well, but carbolic acid is excellent. It is not time yet to discard this remedy.—*American Dental Weekly*.

NEVER attempt to crown or bridge on roots defective at apex; if you do, it will be safe to predict failure and evil results will follow in a limited period, and patients will realize that there was dishonesty or want of good judgment and skill, either of which will prove hurtful to the dentist and lowering to the profession.—DR. B. F. ARRINGTON, *Dental Weekly*.

PULP DEVITALIZATION IN DECIDUOUS TEETH.—One or two applications of aqua ammonia is sufficient to devitalize an exposed deciduous pulp. Apply on a pledget of cotton in the cavity.—GEORGE N. WASSER, *Ohio Journal*.

LANCING ABSCESSSES.—Dr. Weaver, in *Dental Weekly*, advises the use of a bistoury along the external surface of the bone opposite the affected tooth, in order to prevent an abscess breaking through the cheek. The abscess will open through the incision made, and the tooth may be saved.

THE *British Journal of Dental Science* gives as a formula for a toothache anodyne, the following: One part carbolic crystals and three parts menthol, melted together. The light amber-colored aromatic fluid which results has a burning but not a caustic taste, and is said to possess strong antiseptic properties.

GUM sections in prosthetic dentistry are like chromos in art, they are all made in the same mold. There is no possibility of choice in the manner of setting each tooth to give it an individuality, indicating the character of the man, giving a little twist here, a little turn there, some a little longer, some a little shorter, individualizing the lateral especially, securing the proper relations of each tooth to the lips and the face.—DR. FREEMAN, in *Headlight*.

SILVER NITRATE IN ROOT CANALS.—Dr. L. G. Noel advocates the use of nitrate of silver as a disinfectant in canals of teeth. After applying the dam the canal is filled with the finely pulverized crystals on shreds of cotton. This is left a week or two, when he introduces his root-filling. In small canals he frequently leaves a small twist of cotton, containing a few of the crystals. He finds it especially useful in filling roots of deciduous teeth.—*Headlight*.

To mend a plate temporarily, where a tooth or section has been broken off leaving the pins in the rubber, wash the exposed surfaces thoroughly with soap and water and then with chloroform after drying thoroughly. Coat the surfaces with a mixture of equal parts of guttapercha and resin, dissolved in chloroform lay a thin piece of guttapercha over the broken surface of the plate, heat over a spirit lamp and press the tooth or section to place.—*Indiana Journal*.

To treat the root canals of posterior teeth when the walls are broken down so badly that the rubber dam cannot be adjusted, proceed as follows: Prepare the tooth as for a permanent filling, fill the pulp chamber with SSW dressing seal, allowing the filling to project from the pulp chamber as far as occlusion will permit. Build a wall of amalgam around this and at a subsequent setting adjust the rubber dam, remove the seal and proceed with treatment.—*Indiana Journal*.

TOBACCO chewers' teeth wear away on the grinding surface rapidly, caused by the gritty substance naturally entering into the tobacco. The gums recede and are red and congested, and underneath the gum a narrow line of dark tartar is nearly always present and particles may be found still further towards the apex of the tooth. I am now convinced that tobacco chewing does cause decay of the teeth, especially at the gingival portion of the teeth in the locality in which the cud is held; this is due to the formation of acids produced by the sugar or licorice used to flavor the tobacco.—DR. JOHN G. HARPER, in *Digest*.

TO REPLACE A BROKEN TOOTH.—Where a tooth or block has been broken from a vulcanite plate, it can very often be reliably repaired by drilling a cavity in the rubber, just under the tooth pins, having sufficient undercuts for the retention of the material. Then by filling these undercuts with amalgam freshly mixed, and filling the rest of the cavity, covering the pins with soft solder, scraps of Weston's or Watt's metal preferably. This is accomplished by holding the tooth in place with plaster, or with the index finger protected with a pad of asbestos, while with any small instrument that will serve as a soldering iron, the solder is melted, using muriate of zinc as a flux. The work will be quite stable as soon as the amalgam has had time to harden. The advantages of the amalgam is that it forms a base upon which the metal used as a solder will flow, and averting its tendency to ball up and pull away from the cavity walls in the vulcanite. The solder will form a good union with the amalgam.—DR. ATKINSON, *American Dental Weekly*.

Translation

Edited by Carl E. Klotz, L.D.S., St. Catharines, Ont.

FROM GERMAN DENTAL JOURNALS.

THE DECIDUOUS TEETH AND THE SIXTH YEAR MOLARS; DISASTROUS RESULTS FROM NEGLECT AND THEIR TREATMENT.

Although great advancements have been made in dentistry, yet a large gap has been left which requires to be filled in. It seems strange that the deciduous teeth have received so little attention. The numerous authors who have written on diseases of the mouth, and have treated the subjects in a masterly manner, have either totally ignored the treatment of deciduous teeth, or have touched the subject very sparingly. Has this neglect been because they considered the deciduous teeth not worthy of much consideration

as they last only such a short time and are replaced by a permanent set? If this is the case they have made a very grave mistake, as I consider the milk teeth act a great part in the physiology and pathology of childhood, and deserve a great deal more attention than has been bestowed upon them. Their neglect may cause serious trouble in the health of a child whose teeth have been extracted too soon or are so badly decayed as to cause pain in mastication; they cannot properly masticate their food, in consequence of which assimilation is imperfect, which causes a defective bodily development; moreover the irregularity of the permanent teeth so often met with is caused greatly by the too early extraction of the deciduous teeth. To avoid all these disadvantageous conditions there is only one remedy, viz., place the children from their early youth in the care of the dentist, and at the same time let the parents be instructed to watch their children's teeth as much as they do their own.

The eruption of the deciduous teeth is completed between the twenty-eighth and thirtieth month after birth, and from this time on, or say at three years, they should be placed in our hands. It may appear that a child of such tender years is too delicate to undergo a dental operation, from which many a grown up person will shrink. As far as this is concerned, the child does not think about it, and if the dentist understands how to handle these delicate patients, he will have less trouble with them than he has with some of their parents. A great many parents make the sad mistake of speaking in the presence of their children about the operation and the pain they had to endure while in the dental chair. The children may not appear to be listening, but not a word escapes their attentive little ears, and when their turn comes to go to the dentist they go with a prejudiced idea.

The sensitiveness of the nerves is not so highly developed in the child as in the adult. I have found that I could touch an exposed pulp in a deciduous tooth without causing the same amount of pain as in a permanent tooth. We can therefore without much difficulty arrive at our aim, to save the milk teeth as well as the permanent from the ravages of caries, to which they so easily fall victims. We have become acquainted with the disturbances which arise in the health and normal development of children whose teeth have been left to take care of themselves. Not alone does the health suffer, but also the facial expression. The alveolar arch that has lost some of its teeth will contract rather than enlarge with the growth of the child, consequently when the permanent teeth make their appearance there is no room for them, causing irregularity, which is often very difficult to correct without regulating appliances, and sometimes the loss of one or more permanent teeth. And even if regulated the trouble

does not end, as in some cases it is very difficult to retain the teeth in their new position, necessitating the wearing of retaining appliances for months or even a year or more, until ossification is complete and the spaces caused by moving the teeth filled up. If the retainer is taken off before ossification is complete, the teeth will have a tendency to fall back to their original position. Aside from these difficulties, if we consider how many teeth become carious through regulating appliances, we have to admit that it is of importance and necessary to keep a strict watch over the children's teeth from their earliest youth. We are well aware that a great many parents are not convinced of the necessity of this, as the general opinion is, that the milk-teeth are only temporary and do not last long, therefore they require no attention. There are others who think that we dentists only fill the temporary teeth for pecuniary gain. It nevertheless remains our duty to convince the parents of the necessity of giving the children's teeth all the care and attention possible, and dentistry and humanity will profit thereby.

I will now give a short account of the remedies I employ in the treatment of carious deciduous teeth.

The treatment does not vary greatly from that of the permanent teeth, and may be divided into four groups.

1. Superficial caries where enamel and dentine is slightly effected.
2. Deeper caries, pulp not exposed.
3. Deep caries, exposed living pulp.
4. Caries with dead pulp, abscess and fistula.

The treatment of the first, and second groups is very simple; it is sufficient to excavate the cavity and fill with cement for the anterior, and cement or amalgam for the posterior teeth. In treating group three commence with the application of arsenic, for which I use Thomas' Arsenious Cotton in very small quantities, and allow it to remain only twenty-four hours. This preparation does not act as deep as pure arsenic, and is less dangerous. This is then removed and the opening to the pulp chamber enlarged; if painless I apply carbolic acid to the pulp chamber and leave it for two or three days, but if painful again apply the arsenic preparation for twenty-four hours and treat with carbolic acid again. After this I extirpate the pulp, and apply iodoform and fill the cavity temporarily with gutta-percha and leave it for two or three weeks. The gutta-percha filling is used, so that in case of periostitis, it can be easily and quickly removed. Although some practitioners fill permanently immediately I prefer my method, as I have better results with it than with immediate filling. I use the precaution of a temporary filling as it is of importance to inflict as little pain as possible on the children and they will be the more

ready to come for future work. The permanent fillings are the same as in groups one and two, only that the pulp chamber is filled with gutta-percha, avoiding forcing it into the canals. In reference to group four I partly clean the cavity at the first sitting, apply oil of cloves or iodoform and leave it in the cavity forty-eight hours, after which it is thoroughly cleansed. If there is an abscess it is cauterized with the galvano-cautery and an anti-septic injected into the abscess through the root. This treatment is repeated for several days, till fistula and abscess have disappeared, and a temporary filling is inserted leaving it for two or three months, and then insert a permanent filling.

This is my method of treatment. It may, perhaps, appear insignificant, but according to my idea we cannot be too circumspect in assuring ourselves of successful results of so delicate an operation.—*Zahnarztliches Wochenblatt.*

(To be continued.)

Medical Department

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

A CASE OF BRONCHITIS AND PNEUMONIA CAUSED BY THE INHALATION OF THE FILLING FROM A TOOTH BROKEN IN EXTRACTION.

On March 21, 1891, I was asked to see Mrs. F. B. White, aged forty-six, married, mother of three children, the oldest about twenty-three. She is a stout woman, of medium height, with very florid complexion, who had always been healthy except for occasional colds that were hard to shake off, and often caused mild bronchitis. On the day before she had had a tooth extracted, under the influence of nitrous oxide, by a perfectly competent dentist, but he had broken the tooth and had caused her a considerable amount of pain in the operation. She took the gas but once, but did not recover well from its inhalation. She felt very much "stuffed up" after returning home, and breathed with difficulty. She thought that she had taken cold while at the dentist's, but paid little attention to the matter, fully expecting to be rid of it by the next morning. On the contrary, she was much worse; she had a very restless night, sleeping but little on account of the oppressed breathing, and being distressed by a teasing but uncontrollable cough, which was rasping and dry, coming on in paroxysms, but giving rise to no expectoration. I examined her throat and chest very carefully, but could detect nothing wrong; so I ordered a simple expectorant, containing a slight amount of morphine, and told her that she would soon be all right. By the

next day I had reason to change this opinion, for I found her in the same condition, having coughed nearly all night, her nervous system rapidly showing signs of distress, her pulse up to 110, and temperature to 101, and a process of bronchitis developing in the medium-sized bronchi about two-thirds down the right lung and midway between the spine and the axillary line. From this the bronchitis spread in a few days throughout the entire lower third of the right lung, with considerable elevation of temperature and quickened pulse rate, accompanied by great prostration. At the same time her expectoration became quite free, beginning as mucus and froth, but rapidly becoming purulent. Meanwhile the other lung remained perfectly clear throughout. In spite of absolute rest in bed, the best of nourishment, excellent nursing, and various different expectorants and sedatives, she continued to grow worse daily; she lost her appetite, she slept very irregularly and without refreshment, her bowels became costive, her cough continued, she complained always of an oppression about her chest, and began to have a cutting pain in the right lung with each cough or forced inspiration. On April 10th a distinct dull spot was made out just where the original focus of inflammation had been; it was not pneumonic, it had no tendency to spread, but seemed to be a dead, flat spot about as large as a pigeon's egg, surrounded by an area of dull, infiltrated tissue, that faded imperceptibly into the bronchitis surrounding the area. This spot grew slightly larger as time passed, but no new foci developed anywhere else; the upper two-thirds of the lung remained clear and resonant, but the lower third was very dull upon percussion, almost approaching a hypostatic pneumonia, with moist râles in the medium and finer tubes to be heard all through the inflamed area. The left lung showed also some few moist râles, but no dullness. She had every evening a rise of temperature to 102° to 104° F., with a fall during the morning to 99° to 100° F. She was evidently very ill, but unaccountably so. Tuberculosis was thought of, as her family history showed some taint, but the sudden onset and anomalous development of the trouble made it unlikely; however, some of the sputa was examined and showed no bacilli. Her nourishment was forced, and she was encouraged to sit up a while each day, but she was not improved, and asked to be allowed to stay in bed. Quinine and other antipyretics were given, but had no effect upon the fever, which became more and more hectic in character, with chilly sensations before the rise, and the expectoration began to have blood in it in increasing quantities, never any large amount, but quite as much as in pneumonia. By the end of April the original spot showed evidence of softening, and the formation of a cavity soon followed: it was clearly defined, not larger than a walnut, with well-marked amphoric breathing, some agophony, but

very little or no bubbling. In the rest of the lung there was no change in the general condition, the area of inflammation and infiltration did not extend, nor did the bronchitis show any sign of improvement. After consultation the condition was readily agreed upon, but no reason could be assigned for this trouble, nor could a satisfactory prognosis be given. Her cough continued to be always troublesome, interfering much with her rest at night, and giving rise to a very free expectoration of thick yellow stuff, with frequent admixture of a little blood; her pulse was rather hard and jerky, beating about one hundred to the minute, and her temperature was constantly above the normal, with a suspiciously regular rise each afternoon. Except for the inability to find bacilli, and her excellent health in the past, I should have diagnosed tuberculosis without hesitation. All through May and early June she continued in this condition. She had a trained nurse, who devoted great care to her nourishment, that being given the first place in treatment rather than any medicines; of these, various expectorants and tonics were used, including a fair allowance of whisky. As a result she lost no flesh, rather gaining than otherwise, and she presented no appearance of illness beyond the frequent cough with expectoration. Her symptoms, however, pointed to a very serious condition. She described herself as constantly breathing with the greatest oppression, and so weak that the slightest exertion caused her to become faint and brought on severe paroxysms of coughing, although she was forced to get up every day in spite of daily protests. The lowest third of her right lung became gradually waterlogged, with general, diffuse bronchitis through it, giving rise to moist râles everywhere, with exudation and infiltration, especially as the original focus was approached, this being a cavity surrounded by a zone of consolidation. In the left lung some bronchitis appeared also, but this affected only the medium-sized tubes and did not produce much extra-bronchial infiltration. On June 17th she went to Atlantic City, being in the same general condition, with oppressed breathing, frequent cough, much purulent and some little bloody expectoration, no appetite, but taking food under compulsion, sleeping badly, and in a very wretched frame of mind. It was hoped that the sea air would benefit her, but she failed to respond in any way to the change. On July 7th—more than fifteen weeks from the time that she had so suddenly and peculiarly developed her bronchitis—in a severe paroxysm of coughing she spat up, with the usual purulent and bloody mucus, a piece of amalgam filling from the broken tooth, smooth on one surface, but very rough and jagged on the other, where it had been joined to the decayed and excavated remnant of the tooth; it formed approximately a parallelogram measuring half an inch long, three-eighths of an

inch wide, and having a thickness of an eighth of an inch; it weighed 28.11 grains. Although very doubtful of the final outcome of such prolonged irritation, I wrote most hopefully to her, and advised her to stay on at Atlantic City. At first her improvement was very slow, causing her much discouragement, and leading her to leave the seashore early in August for a Blue Ridge Mountain resort; here she grew gradually stronger and better, gaining in various ways. I did not see her until late in September, when I found her practically well, except for the cavity in the right lung, evidently the place where the foreign body had been lodged. This cavity, although perfectly apparent and readily made out, was much smaller than it had been in June, and slowly contracted during the succeeding months, disappearing finally during the winter. She continued, for several years, more than usually susceptible to colds, and always found with each new cold that bronchitis was apt to develop in the right lung with a good deal of pain at the site of the cavity. In time this disappeared also, and she is now (October, 1898) perfectly well.—*Charles O'Donovan, M.D., Baltimore, New York Medical Journal, Nov. 26th, 1898.*

DOES LICENSE TO PRACTICE MEDICINE PERMIT THE PRACTICE OF ORAL
SURGERY?

A curious case for medico-legal decision has arisen in the State of Rhode Island, where registration for medical practice is granted upon application to the State Board of Health by graduates of recognized medical colleges, while dentists are required by a recent enactment to pass an examination before the State Board of Registration in Dentistry. A graduate in dental surgery, and in medicine, after having been registered by the State Board of Health, and securing his license, engaged in the practice of medicine, including dental and oral surgery. He was forthwith arrested for infraction of the law requiring examination and license for the practice of dental surgery, and the case now awaits judicial decision. Logically it would be reasoned that one qualified to practice medicine and so authorized to do by State authority, would at the same time be conceded the qualification and the license to practice any part of medicine, ophthalmology, otology, obstetrics, gynecology, oral and dental surgery, etc. To ask a qualified and licensed medical man to pass a special examination in oral and dental surgery, would not be more ridiculous than to ask him to pass a special examination and secure a special license for the practice of midwifery. It would seem, further, from the legal point of view, that when there is conflict in letter between existing legislation the spirit must be followed, and surely no one would

contend that the part is greater than the whole. The question in Rhode Island seems a very simple one, and the solution should be attended with no difficulty or complication. It all revolves about the point whether an approved graduate in medicine shall be permitted to practise all branches of it.

TREATMENT OF SWEATING HANDS.

The *Revue médicale* for September 28th cites the following as being quoted by *Nouveaux remèdes* from a German source. It is said to have given excellent results:

R Borax,	} of each.....	225 grains ;
Salicylic acid,		
Boric acid		75 "
Glycerin,	} of each.....	100 minims.
Dilute alcohol,		

M. Rub in three times daily.—*New York Medical Journal.*

Question Drawer

Edited by R. E. STILES, M.D., D.D.S., I.D.S., Kingston, Ont.

Q. 47.—A lady having the right upper canine broken for five years, it had become entirely covered by gum tissue. She complained of pus oozing around the margin of the gum. She came to my office to have it extracted. I lanced the gum to admit the alveolar forcep. Upon pressing the forcep up to get a grip upon the root I found no resistance, and the root was pushed up under the wing of the nose, perhaps under the turbinated bone. It was impossible to extract it, except by a long operation, which would come under general surgery. What was the cause of the displacement of the root, and the non-resistance of the alveolus? And am I not right in sending the patient to a surgeon? D.D.S.

Q. 48.—What is the physiological action of arsenic in its operation of devitalizing a pulp? L.D.S.

Reviews

A Text-Book of Dental Pathology, Therapeutics, including Pharmacology, being a Treatise on the Principles and Practice of Dental Medicine. For Students and Practitioners. By HENRY H. BURCHARD, M.D., D.D.S., Special Lecturer on Dental Pathology and Therapeutics in the Philadelphia Dental College. In one very handsome octavo volume of 575 pages, with 388 engravings and 2 colored plates. Cloth, \$5.00; leather, \$6.00. Net. Lea Brothers & Co., Publishers, Philadelphia and New York.

Following the valuable volume of Dr. W. C. Barrett's on "Oral Pathology and Practice," comes this larger work of Dr. H. H. Burchard's. It forms the third of the series of American Text-Books of Dentistry, of which Kirk and Essing were the first two. The author writes as a teacher to students, and with a ripened experience of teaching and practice, he has carefully covered the facts as well as the controversies of his subject. Under the heading of "General Pathology," Section I. embraces chapters on the etiology of disease, general and local; bacteriology, with special reference to dental pathology and therapeutics; disturbances of nutrition, atrophy, degeneration, nervous, hypertrophy, tumors, disturbances of the vascular system, infective inflammations, suppurations, abscess fevers, septicemia and pyemia. Section II. contains four chapters relating to the development and structure of the jaws and teeth, the surgical anatomy of the teeth, dentition, its proper variations and attendant disorders, malformations and malpositions of the teeth. Section III.—Affections of the enamel and dentine, including comprehensive chapters on caries. Section IV.—Diseases of the dental pulp. Section V.—Diseases of the pericementum. Section VI.—Diseases of the deciduous teeth and their treatment, reflex disorders of dental origin, infections from the mouth and sterilization. Section VII.—Dental pharmacology and materia medica. It will be seen by the above list of contents that the author has undertaken a formidable task. Following the systematic and scientific methods of medical teaching, he has enriched the study of the ordinary diseases of the teeth and adjacent structures with higher inspiration. The diseases of the teeth must be studied from the same fundamental point of view as disease elsewhere. Our old text-books directed the students through dark recesses by dim lights. Dental pathology of the day is illuminated on all sides by all the collateral advantages of a broader science. The publishers have, as usual, given us a handsomely printed work.

Anatomy and Histology of the Mouth and Teeth. By J. NORMAN BROOMWELL, D.D.S., Professor of Dental Anatomy, Histology and Prosthetic Technics in the Pennsylvania Dental College, Philadelphia. With 284 illustrations. Philadelphia: P. Blakiston Son & Co., 1012 Walnut Street, 1898, pp. 429. \$4.50. Can be ordered from any dental depot advertising in the DOMINION DENTAL JOURNAL.

There is surely no excuse to-day for any dentist or dental student being without a well-equipped dental library. Within the last few years many valuable additions have been made to our literature, and one decided improvement noticeable in those issued by our cousins over the border, is their conciseness and generally practical character, while Dr. Barrett, in his "Pathology," has given us, as well, a model of good English composition. To the best English scholar there has been too frequently in American writings a technical vagueness of expression, which of recent years has been disappearing. Dear old Dr. Atkinson's genius was too often feebly imitated, and in our nomenclature for a time there was a fad for word-coining which set the profession by the ears. Sewill's "Dental Surgery" and Barrett's "Oral Pathology" are models of clear and concise English. This volume is one in which originality is barely possible, and yet the author has admirably succeeded by his method of arrangement of the chapters, in making his subject especially interesting. Part I., which includes twelve chapters on dental anatomy, gives us the usual detail of the oral cavity and its contents; the last chapter, dealing with the development of the teeth, being specially valuable. Part II. is devoted to dental histology specifying the various tissues which make up the hard and soft structures of the mouth. A valuable index is not forgotten. The work is certainly one which every student should possess. In many ways it will become indispensable, especially if teachers and examiners do not overlook its value to themselves. As the first stepping-stone to the dental curriculum a thorough knowledge of its contents will smoothen the way for future and final study. There would be more Barrettonian composition were our writers better grounded in this fundamental part of our studentship. In a work like this it would be puerile and unfair to suggest some faults of brevity. It is a fault which students will condone. The general merits outweigh the special failings. The critical anatomist may find here and there some loosely-expressed views, and even some statements contrary to his opinions. Nothing is so easy as hyper-criticism. Nothing sacred or secular escapes it. The author is capable of observing faults which may be due to haste. But the special value of the work cannot be depreciated.

Dominion Dental Journal

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Vol. XI.

JANUARY, 1899.

No. 1.

ABOLITION OF INDENTURESHIP.

A very unwise suggestion has been made by some one in the Province of Quebec, to abolish the system of indenturing students, and compel attendance exclusively upon the college course. It is often an instinct of newly elected bodies, to revolutionize the existing condition of affairs in the representative position they occupy, and there is every reason to justify heroic measures in some matters. But there cannot be offered a single argument of any weight to justify, for a long time to come, the abolition of a system which has given substantial proof of its value, not only in Canada, but in England, and other countries.

It may be said, that a student may be indentured to a licentiate who is personally incapable, for various reasons, of being a good tutor; that he may indenture himself to a quack, or a quack imitator. That is no argument at all, as it is not possible to deprive a licentiate, even though he be a quack, of any prerogative which the most ethical enjoy. The student is still compelled to attend the college course, and if he does not discover the character of the licentiate to whom he is indentured, it is his own fault. There should be no power given to any licentiate to prevent a student changing his indentureship if he desires to do so.

The indentureship system is an immense boon to the student. Not only has he a practical mechanical training far in excess of any to be obtained in the laboratory of the school, but he has the best superintendence that the tutor can give him, for the plain reason, that the work is for the best paying patients, and that the reputation of the tutor, not the student only, is involved. This is all self-evident. The experience of members of the Board in the past has invariably been, that the students who obtained no other

advantage than colleges supplied, were inferior in the prosthetic department to those who had been indentured. Apart from these facts, the Quebec school is by no means equipped or sufficiently organized to justify the abolition referred to. We observe that such a proposition was not mooted in Ontario until they had one of the very best schools in existence, both as to equipment and the staff, and that it is considered even yet premature in that Province. As it is now, there are students who practice on the sly on their own account. Abolish the present obligation to spend all the time in the office not actually spent at the school, and the temptation during the idle months would be greatly increased. The system existing is very much the best for Quebec for many years to come.

PRIVATE BILLS.

The principle of a legislature granting a private bill to enable an applicant to enter the dental profession, is now not only wrong but inconsistent. If the privileges which legislatures give to a profession are excessive, they should be curtailed. If they are just, they should be protected, and their best protector should be the body which created them, not the courts. No legislature would presume to assert, that its object is in any sense to qualify men to practice. It would be as absurd to affirm that it is able to examine any qualification presented. It is one of the virtues of good government to confine these prerogatives to expert bodies. The Boards of Examiners alone have had delegated to them such powers. To the profession alone is granted the elective power, and if they collectively elect incompetent examiners, the profession takes the consequences.

No applicant for a private bill has as yet ventured to insinuate that he fears foul play from the Boards. As a rule the claims are made, that for reasons which curiously the Acts of Incorporation clearly denounce, the applicant seeks to escape the obligations imposed upon everybody else. As a rule there are no apologies offered for ignorance, or for failure to comply with the qualifications required. The basis of these applications is pure and unadulterated gall. Why a license should be given to any one, who is obliged to ask the legislature to do the very thing which the legislature empowered an expert Board alone to do, is one of the mysteries of presumption which no fellow can understand, and applicants themselves can never explain. If by any reason in the past, a tardy applicant, legally entitled by a former Act to any privilege which an amendment had annulled, the Board would be sure to do him justice, in perhaps consenting to an application for private legislation. It is wise for a Board to show that it does

not aim at despotic powers, yet it has a duty to fulfil in demanding compliance with the letter as well as the spirit of the law.

An interesting case occurred a few years ago where the legislature took issue with the Board. A candidate who had passed the highest matriculation in another Province for entrance to the profession, who had purposely resided for a year as an assistant in the Province, with the object of having it count towards the required term of studentship, and who had acquitted himself well in two different colleges elsewhere, and obtained the license for his Province, applied for a private bill. But all he asked for was permission to appear for the full examination, primary and final, of the Province in which he wished to settle. The legislature plainly decreed, that inasmuch as the said Province possessed no such facilities for education as the candidate was able to obtain so creditably elsewhere, his bill should be granted. The matriculation examinations which he had passed in his own Province was accepted by the examiners, and upon presenting himself for the license he went very successfully through a severe ordeal. Such a case cannot occur again. The same circumstances do not now exist. The amended bill, with all its defects, and the existence of a school with all its difficulties, have removed any reason for a repetition of such an application. Fortunately the candidate was a well-qualified addition to our ranks. But as a rule applicants for private bills are not. They do not want to submit to such an ordeal. If a legislature is to tinker at making dentists by Act of Parliament, it acts inconsistently with the power it has for many years conferred upon the only proper bodies fit to test an applicants qualification. The object of legislation becomes nullified. The public has no protection. It becomes a sort of legislative burglary, whereby the burglar, if he succeeds in entering, is to enjoy the rights as a guest of the proprietor. What these applicants seek is not equal rights, but legislative favoritism. Such a pretension elevates those whom law disqualifies, to the prestige of preferred clients. It not only weakens the vested authority of the Board, but encourages candidates to slip in under the fence, instead of entering by the proper portal.

"FREE DENTISTRY."

There is no fair analogy between the positions of medicine and dentistry with regard to free services to the public in Canada. Everything that has been done by us in every Province to protect the public and improve the education of the student, has been done out of our own pockets. Medicine has been coddled and dry-nursed at the public expense ; its colleges and hospitals immensely

endowed by public benefaction. Its practitioners enjoy many direct and collateral financial advantages unknown in the least degree to dentists. We freely admit the superior claims of medicine, and its greater importance to the public. We rejoice in the generosity of our public men towards more efficient teaching, and improved hospital service. That, however, does not in any way alter the fact, that dentistry in every way is handicapped, and that until the same public in some way endow our teaching bodies and our infirmaries, there can be no justifiable claim for free services. If our infirmaries choose voluntarily to offer such it is an act of charity which had better begin at home. If some way could be devised to obtain material for our students, it would be only just to our noble selves to demand, that if the public expect the same free service from the dentists they get from the physicians, we should be treated in the same way by public endowments.

EDITORIAL NOTE.

Dr. Chas. Brewster has sent us the following clipping, which will interest all Canadian dentists:

A CANADIAN IN THE SOUDAN.

BROCKVILLE, Ont., November 2.—A Brockvillian, in the person of Major Smythe, youngest son of Col. T. W. Smythe, formerly of Brockville, now of Dover, England, comes in for honorable mention by the Sirdar for his services at Khartoum. He was born in Brockville and left here with his father, then Capt. Smythe, of the 100th Prince of Wales Royal Canadian Rifles.

Col. Smythe was practising dentistry in Brockville, and at the time of the war between Great Britain and Russia he joined the 100th Regiment, which was raised at the time in Canada. He was a great friend of the late Dr. Chas. M. Dickinson (who succeeded Spooner), with whom Dr. Brewster studied. Dr. Brewster was very intimate with Capt. Smythe, and used to see a great deal of him, and attended his daughter, while the Major sat by gossiping and regretting that he had left dentistry. He was a first-class dentist, but had the Canadian love of military life ingrained, and when the Russian war occurred he was one of the first Canadians to do duty.