



# THE PROGRESSIVE DENTIST

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## CONTENTS.

### ORIGINAL COMMUNICATIONS.

Removal of Impacted and Unerupted Teeth — Fred'k K. Ream, M. D., D. D. S.	1
Dentistry in the Talmud.....Samuel Greif, '14	3
Orthodontia — A Failure.....M. J. Emelin, D. D. S.	6
Items of Practical Value.....M. J. Emelin, D. D. S.	9
Asepsis or Antisepsis.....Maurice Green, D. D. S.	10
Tuberculosis of the Larynx (Continued).....Albert Bardes, M. D.	11
To Well-wishers of the "Progressive Dentist".....P. D.	14
Editorial Department .....	10
Care of the Oral Cavity in Infancy.....Dr. Jesse Feinberg	17
Students' Department.....	10
N. Y. C. D.—Mechanical Steps in Anatomical Articulation — A. L. Seldin, '14	18
C. D. O. S. N. Y.—Senior, Junior & Freshman Notes.....	19
Dental Society News.....	20
Dental Hints.....	20

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# The Progressive Dentist

Vol. III

January 1914

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## THE SURGICAL TECHNIQUE EMPLOYED IN THE REMOVAL OF IMPACTED AND UNERUPTED TEETH THE USE OF ANALGESIA AND LOCAL ANESTHESIA FOR THEIR LIBERATION AND A PLEA FOR STANDARDIZATION OF METHODS.

Paper by Fred'k K. Ream, M. D., D. D. S., Aeolian Hall, New York City. Read before Eastern Dental Society, Dec. 4, 1913.

Dr. C. N. Pierce, page 646, Vol. III. American System of Dentistry, says:

"An impacted lower third molar at the base of the coronoid process is capable of giving as much excruciating and persistent suffering as is possible for human nature to endure. There is no abnormality or lesion coming in the province of the oral surgeon which demands more prompt action or for the time, more thoroughly taxes to the uttermost his best judgment and skill.

It is quite natural that the various specialties of medicine and surgery should have rather vague and indefinite boundaries where one many times overlaps the other; and this is quite true of operations in the mouth. The Rhinologist thinks that he should care for all maxillary sinus operations in his own way. The oral surgeon in his; the general surgeon hesitates to refer palate and hair-lip operations to the oral surgeon, more proficient though he may be and more versed in the anatomy of the parts.

And so it is true of operations for the removal of impacted and unerupted teeth. The Exodontist thinks they should be handled in

the office operating room; the surgeon in the hospital. Now I grant you that in days gone by, many such cases should have been hospitalized that were not, just because the average dental office equipment was not designed with any view to aseptic procedure and practically no thought was given thereto. This fortunately is not the case now-a-days, and the office of the extraction specialist should and does rival the hospital in cleanliness and precaution against sepsis. This being true, then why should we subject our patients to the really needless worry and expense of hospital procedure in the dental office. I make this assertion advisedly. It is my belief that the operative technique that these cases demand is carried out with less strain to both operator and patient under office conditions.

The technique that I am in the habit of using for the removal of impacted lower molars is this: Diagnosis is confirmed by a radiograph showing to a nicety the position, shape and extent of impaction of the offending tooth. The patient is then prepared for operation and mouth cleaned as thoroughly as is possible.



Local anathesia or analgesia is used for the preliminary mouth operation, the patient being conscious, suffering no pain or extreme discomfort, and able to give what assistance he may in keeping his head and mouth in the proper position, and emptying the mouth when necessary.

The first procedure is to cut through the crown surface of the impacted tooth with a carborundum disk, freeing it from the second molar. If it is not possible to cut as deeply as is necessary with the disk the cutting may be completed by the use of a fissure bur in the contra angle hand piece. The tongue and cheek being all the time protected from injury. After this the tooth is freed entirely by cutting buccally and lingually with a spear pointed drill, only sufficiently to permit of free engagement of the tooth by the forceps and if necessary, the use of the elevator; cutting is also done over the root portion, the amount being determined by radiogram.

It is advisable to perform the surgical preparation under the almost continuous irrigation of hot iodine or Lysol solutions, by means of a suspended irrigator as is used in hospitals. The tooth is then tested as to its rigidity with the forceps or elevator. If there is no rotation with moderate force it is a simple matter to do a little more cutting where necessary and with forceps and elevator the tooth is raised from its socket, preceeded by complete anathesia.

The patient is permitted now to regain consciousness and after a few minutes of recovery the socket is again irrigated and packed with antiseptic dressing. Swelling and pain can be in a very great degree controlled by the use of hot fo-

mentations which should be constantly applied together with hot antiseptic solutions held in the mouth for the first twenty-four hours. Daily irrigating and re-packing suffice for recovery sufficient to permit of home treatment, and two weeks will practically end all discomfort. After dismissing these patients they should be provided with soft rubber ear syringes for cleansing the wound until fully closed.

Now compare, if you will with this simple and efficient procedure that resorted to by many oral surgeons who under anathesia cut away the soft tissues and chissel away bone sufficiently to permit of the impacted tooth being removed root first, or buccally, without previously releasing it from its impaction.

Aside from the inevitable weakening of the jaw, consider the difference in extent of traumatism to the soft tissues from one operation and the other, which would you rather have done in your own mouth? Consider the rapid recovery on the one hand and the necessary slow rebuilding of tissues on the other! With the proximity of the Mandibular branch of the fifth nerve—compare the pain from one and the exeruciating torture from the other! I doubt if any one of us is justified in subjecting our patients to such tissue destruction thus unnecessarily.

Upon one occasion I administered a nitrous oxid and oxygen anesthetic through the nose, for one hour and twenty minutes for the removal of an impacted lower third molar. The operation was performed in the hospital by a prominent oral surgeon. The patient was confined in the hospital for one month and incapacitated

for three months. The tooth was liberated by mallet and chissel and large surgical burs.

With other impactions than those of the third molars, the procedure is practically as simple. The radiogram eliminates nearly all necessity for exploitary work, and our office facilities are indefinitely better in this work than those of hospitals. Of course, it is difficult to command as large a fee for these office operations as by hospitalization, but in how very many cases can the patient ill afford, or not at all afford, this extra expense! And of the patients who can afford it, all of them, if permitted to choose, would decide on that operation that is manifestly easier, better and safer, and promises the more rapid recovery, viz., the office operation which I have outlined.

To summarize—I plead for a

standardization of methods. Let a number of different cases be selected and handled by advocates of the various methods and note that conditions as follows: 1st. Time required in operating; 2nd., general past operative condition of the patient as regards traumatism to hard and soft tissues; 3rd., general condition of patient after operating and time required for complete recovery.

A report from an impartial committee by way of comparison showing radiograms of each case would be educational and of infinite value to the profession at large.

I shall present a few slides of typical cases as they appear in office practice in order to clinically verify my operative technique.

(Discussion by Drs. Hasbrouck, Green and Lederer, and a reply by Dr. Ream will follow in the next issue.)

## DENTISTRY IN THE TALMUD.

### A Valuable Contribution to the Early History of Dentistry.

By Samuel Greif.

#### (Sixth Article)

**Baba Kama 13b, 14a.** Said R. Hisda in the name of Abimi: In a partnership court one partner is liable to the other partner for damages done by the tooth and the foot.—Also R. Joseph taught: In a partnership court and an inn, one is liable for damages done by the tooth and the foot.—R. Eliezer, however, makes them free and explains the mishna that there is no liability for foot and tooth when it belongs to the plaintiff or to both the plaintiff and the defendant.

**Note.** Baba Kama is the first tract of the Seder Nezikin (damages, jurisprudence). The subject

of jurisprudence has already been discussed in the note under the extract of Kidoshin 24a, b. The extracts following, from Baba Kama, Baba Metziah, Baba Bathra, and Sanhedrin, all come under the section Nezikin, and cover the topic of Dental Jurisprudence.

**B. K. 16a.** (Mishna). There are five cases which are considered non-vicious and five which are considered vicious.—The tooth (of an animal) is considered vicious.

(Gemeara). Therefore said Rabhina: The mishna is not completed, and should read as follows: There are five cases which are considered

non-vicious until they are declared to be vicious; the tooth and foot, however, are considered vicious from the very beginning, and this is called the vicious ox.

**B. K. 16b.** When a lion seizes anything (on public ground) and eats it, then (the owner) is not liable, because it is his nature to seize things. It is then like the eating of fruits and herbs (by cattle). So is it with tooth-damages on public ground, which need not be paid for. But the tearing, on the contrary, is not the lion's nature.

**B. K. 26b.** We have learned: When the master is a physician and (the slave) implores him to treat his eyes, and he blinds it, or to drill his tooth, and he breaks it out, then he has tricked his master and goes out free.

**B. K. 27b, 28a.** R. Kahana objected: Ben-bag-bag said, Never enter the yard of your neighbor unpermitted to take what may belong to you (in case the latter refuses to return it), in order that you do not appear like a thief to him. **Better strike his teeth out,** and say to him: I take what belongs to me. The other replied, Keep this to thyself; Ben-bag-bag is alone in his opinion and the Rabbanan dispute him. Rabhina explains: Under strike his teeth out it is to be understood: bring suit against him.

**B. K. 34b.** (Mishna). If his ox blinded the eye of his slave or knocked out his tooth the owner is not liable (i. e., the slave is not to be manumitted), but if he himself blinded the eye of his slave or knocked out his tooth he is liable.

**B. K. 35a.** There was an ox that

belonged to R. Papa who when he once suffered from toothache removed the cover from the beer barrel and drank from the beer to be cured. (See Sabb. 64b.).

**B. K. 73b.** If a man blinds the eye of his slave and thereafter strikes out one of his teeth, he shall manumit the slave for the sake of his eye, and pay him the value of his tooth. If it occurs vice versa, i. e., if a man strikes out the tooth of his slave and thereafter blinds one of his eyes, he shall manumit him for the sake of his tooth, and pay him the value of the eye. He must do so because it is written "for the sake of his eye" which does not mean for the sake of his eye **and** his tooth and "for the sake of his tooth" which does not mean for the sake of his tooth **and** his eye.

**B. K. 83a.** Once a woman went into a certain house to bake, and a dog, through barking at her, caused her to have a miscarriage. Said the landlord of the house: "Fear him not, I have deprived him of his teeth and claws"; but the woman answered: "Throw thy favors to the dogs, the child is already gone!" (See Sabb. 63b.).

**B. K. 92b.** The people used to say: Sixty-fold pains does a tooth experience when it hears another (eating) and does not eat itself.

**Baba Metziah 42b.** There was a guardian of orphans who brought an ox for the orphans and transferred it to the shepherd. The ox had no teeth and could not eat and finally died.

**B. Metz. 85a.** Said Rabbi: I see that chastisements are favored. And he accepted for himself afflic-

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tions for thirteen years, six of them with cold chills and seven of them with **cephidna** (an oral disease—see Yoma 84a). And during all the years Rabbi was suffering from his illness, it never happened that the country was in need of rain.

**B. Metz. 113b.** Samuel said: To all sicknesses I know a remedy except the following three:—and if one takes his meal and immediately goes to sleep without walking four ells (which causes offensive breath). (See Sabb. 41a).

**Baba Bathra 15b.** R. Yocanan said: It is written (Ruth i. 1): "And it came to pass in the days when the judges judged," etc. It means, it was a generation that judged the judges. If, e. g., the judge said to them: "Take out the splinter from thy teeth," they answered, "If thou wilt take the beam out of thy eyes, I will remove the splinter from my teeth." (See also Sabb. 81b, Betz. 33a, b, Arak. 16b).

**Sanhedrin 39a.** From R. Mair's three hundred fox fables we have only three: (a) "The fathers have eaten sour grapes and the teeth of the children were set on edge" (Ezek. xviii. 2); (b) "Just balances, just weights" (Lev. xix. 36); (c) "The righteous is delivered out of distress and the wicked cometh in his stead" (Prov. xi. 8).

**Note.** In the text nothing is mentioned of what the fables were. Rashi, however, explains it thus: The fox said to the wolf, If you would go in a Jewish yard on the eve of Sabbath to assist them in the preparation of meals for Sabbath, they would invite you for their best meal on Sabbath day. And when the wolf was severely

beaten while doing so, he wanted to kill the fox. He, however, told him: This was because your father, in assisting them to prepare their meal, consumed the best of it and ran away. And to his question: Should I be beaten because of my father? he answered: Yea, the fathers have eaten sour grapes and the teeth of the children are set on edge. However, if you will follow me I will show you a place where you can eat to satiation. And he led him to a well in which two pails were pulled up and down by means of a rope attached to a beam. And the fox entered in one pail, which dropped down to the bottom. And to the question of the wolf: For what purpose did you enter the pail? he answered: I see here meat and cheese which will be sufficient for both of us. And he showed him the reflection of the moon on the water, which he mistook for a round cheese. And asking the fox how he can get it, he was told to enter the other pail, which was on top. And to the cry of the wolf: How can I come out? he answered: The righteous is delivered out of distress and the wicked cometh in his stead.

(To be concluded in the February issue).

Though they affirm  
A deadly germ  
Lurks in the sweetest kiss,  
Let's hope the day  
Is far away  
Of antiseptic bliss.  
To sterilize  
A lady's sighs  
Would simply be outrageous;  
I'd much prefer  
To humor her  
And let her be contagious.  
—Exchange.

## ORTHODONTIA—A FAILURE.

By M. J. Emelin, D. D. S., New York.

Barring bad habits from infancy, accidents and man's interference, I believe that deformed jaws and malposed teeth are to be considered as a natural evolution of those irrational modes of life which lead to nasal ills and obstructions to normal breathing, for which progressive civilization is responsible.

I have contended once before that overindulgence and genital disorders lead to nervous diseases and are the pre-eminent causes in the etiology of oral diseases. Since the effect of pleasures is cumulative, each pleasure, no matter how innocent it may be, is "another nail in our coffin," causes another cavity in some tooth, develops another form of pyorrhea or another tooth-irregularity.

Both the medical and dental professions recognize that the Gothic arch, crowded, malposed teeth, open bite, short upper lip, lower lip disproportionately thick and fleshy, deformed jaws, mouth-breathing, depressed spirit, anaemia, sallow complexion, dark-blue rings under the eyes, lips parched most of the time, protruding eyes with a look of fear or guilt, are all symptoms and effects of nasal obstructions.

Thus far we have no scientific data explaining the causation of nasal obstructions and the attendant consequences of mouth-breathing, the evil effects of which are not yet fully appreciated. These effects, increasing as they do with the passing of time, tend to make us toothless. Nasal ills and mouth-breathing are the most direct and offensive features we have to consider. Unfortunately, most nasal

disorders are incurable. This is established by the majority of eminent men in the medical world.

Mouth-breathing must have been a common affliction even among the Greeks, for only the widespread existence of this trouble could so alarm the national health-lovers as to induce the pathetic destruction of feeble infants in order to preserve and raise the nation's standard of health. Ancient sculpture also bears evidence of this abnormality and shows that it was one of the national infirmities. Be that as it may, the discussions of these composite and time-defying causes of nasal ills and tooth-decay, linked in the chain of other causes, must ever be agitated until we reach a consistent truth, and not until then should we harbor orthodontia as a specialty of dentistry.

Though the meagre knowledge of orthodontia is but an acquisition of recent years, orthodontic subjects were in existence in times past. We should not tolerate the evolution of mechanical devices through the many and prolonged tortures of the very young. **An experimental stage of operative principles, and the perpetuation of a craze should not be practiced upon our helpless children.** The watchful societies for the prevention of cruelty would bestow a kind act in handcuffing the orthodontists, as they muzzle the child at the expense of its health and happiness.

Regulation of crooked teeth will never cure obstructed nasal breathing and acquired habits of mouth-breathing, nor restore normal breathing; neither will mechanical

cleaning alone ever be a preventive of tooth decay. Like every craze it lasts longer while it remains in the hands of the few. However, the conservatives have long since recognized the inefficiency of orthodontia. The general practitioners of dentistry are giving signs of an awakening in which I see the decline of orthodontia as a specialty. We should welcome the last days of the orthodontic fallacy—of the mutilating of the young for money.

On general principles we seek to deal with the causes, and if possible remove them. Orthodontia could claim the garment of science if it should learn to correct the effects by first eliminating the causes which have produced them. To remedy the effects is but a secondary consideration. In most instances, the cause having been removed, nature takes care of the rest. The orthodontists disregard this cardinal principle of surgery. They endeavor in a few months to correct an effect which nature has taken from four to six years to produce. Would one dare to push bulged eyes in or sunken eyes out, change the dark-blue rings under the eyes, stretch down the upper lip? Ah, right here people know something! Would that the orthodontists could destroy these unmistakable signs of mouth-breathing!

It is known that the development of teeth as that of all other organs supplied with nerves and blood, is retarded through lack of use, or growth may even be arrested to the point of malformation, as a result of some protracted disease with high fevers. We are all familiar with the yellowish stripes and pits that are observed on the surface of the enamel. This pitted enamel deformity, so displeasing to the possessor and of-

ten impossible to remedy, is quite expressive of the time and seriousness of the illness which kept the child's life for days at a low ebb.

Certainly all tissues have suffered; but the enamel is the only structure which survives to tell the tale. All shocks to our nerves, pleasurable or otherwise, are cumulative in their effects. Whether it is an illness for days or a torture for months, we must pay the price, we must suffer the consequences—and we do. This once accepted we can readily perceive how persistent orthodontic forces, in their own way, interfere with the normal tooth development and severely disorganize the enamel. We need not dismiss the inference that therein is convincing reason for the fallacy of the orthodontia practice.

Time again we have blundered in good faith until experience has shown us our errors. We all remember the grave mistake introduced by Dr. Arthur, whose faulty principle had been practiced by the foremost men of the profession. Recognizing this and other facts, an orthodontist of national reputation at one time wrote, "Most deplorable in the statistics of orthodontia practice is the discouraging percentage of failure." Thus it is gratifying to observe that the dental profession in its struggles for the good and humane, is realizing that orthodontia, like most fads, must fall in **disfavor**, sooner or later. It should be sooner.

For obvious reasons orthodontia will never become fashionable. The orthodontist will soon realize that he is not as yet on the highest plane in the development of dentistry, but is a microscopic part of it, a dental corruption. Think of an orthodontist who looks down

on the dental fraternity and tells them that "they are **stoppers of holes**, as a rule"! This bold attitude is rather in keeping with the rest of the orthodontic measures. Apart from this ungratefulness, also the fact, of petty discord among the different schools of orthodontia is not agreeably regarded by the dental profession and is decidedly an evidence of a lack of fellowship.

"Man, proud man, drest in a little brief authority, plays such fantastic tricks before high heaven, as make the angels weep."

We justly protest against, and have long outlived, the name of "tooth-pullers" fabricated by "yellow journalism," yet, to our sorrow, there still thrives a large element, who, though knowing better, malpractice dentistry for the dollar by shamefully extracting useful teeth or roots for the substitution of artificial dentures. We know that malposition of teeth invariably follows the untimely extraction of the first permanent molars. While the cause of malocclusion is mouth-breathing, we are able to maintain that the enormous and wrongful extraction of teeth in days gone by is the direct and most exciting cause of general malposition of teeth. The actual existence of orthodontia is a rebuke to those few dentists who are largely responsible for the careless, nay, criminal extraction of the first permanent teeth.

Just as orthodontia ushered itself into the profession to correct in some measure the above-mentioned errors of the past, it will likewise disappear in proportion to the weeding out of that offensive element which dishonestly extracts teeth that could easily be saved. The correction of one or two malposed teeth in instances where

one has suffered unwarrantable extraction, but who is **otherwise a normal breather**, may be needed and could be done without cruelty, with simplicity; and to some advantage to the crippled mouth, but these cases are so few that neither a whim nor a specialty is required. Such corrections for the **good** of the patient and for **the good only**, are justifiable when the malposed teeth interfere with the proper construction of a permanent denture, which is to render good service.

Only a year ago, or thereabout, Dr. Kingsley said: "The success of orthodontia as a science and art now lies in the retainer," while in the same paper he frankly admits that: "The ideal retainer has not yet been devised." The **retainers in most cases fail to retain**. The most recent regulating appliances are defective in the point of retention. These, like all wires, bands and clamps are **true causes of enamel decay**, and should be condemned. The regulating devices, by their presence and long **interference with the functions of the saliva**, directly induce enamel decay in the form of spots and lines. The polishing out of this form of decay is but another incriminating apology. Moreover, these speculative methods are employed at an age when teeth most readily yield to causes of delay.

The **metal-poisoning** alone is an established fact, and the use of these regulative devices **cripple mastication** for many long months. These truths could hardly be told to the patients!

(To be continued)

An article on "Dental Concrete" by S. Greif appeared in the December issue of The Dental Cosmos.



## ITEMS OF PRACTICAL VALUE

By M. J. Emelin, D. S. S., New York City.

The profession has long realized the inefficiency of the ordinary tooth brush. The most ideal modern tooth brush deserves condemnation. There is much harm in its use, and few, indeed, give this subject and the brush itself sufficient care. In consequence our patents are advised to use silk floss and quills in addition to the tooth brush, and plenty of water. Most people, feeling that they have done their duty with the brush, and relying, as they do, on its good work, resort to no other means of cleaning, and in this lies much danger, because the brush but poorly accomplishes its purpose.

It occurred to me (over four years ago) that the common brush for fresco painting, size No. 1, held with the bristles against the tip of the left forefinger, and cut on opposite sides to a chisel-shape with small, sharp scissors, would make an ideal addition to our present mechanical cleansing means. In practice I find that the soft bristles of the brush thus shaped readily pass between all the teeth, follow the line of the gums or into unhealthy pockets and massage the gums to a normal state. The daily use of such brushes raises the standard of cleanliness about the teeth and prevents most pathological conditions of the gums.

Unfortunately, these brushes were not intended for dental purposes, and are neither properly shaped nor made with bristles of good quality. For the reason that one brush becomes ineffective after passing it over several teeth, the use of four brushes is advisable. After use, the brushes are washed, dried and are again available for the next application.

All who will give these brushes a long and earnest trial will undoubtedly find them indispensable, as the beneficial, nursing operation of these little brushes soon becomes evident.

To the needy ones this is a suggestion how to be able to gargle. It especially refers to the large number of people who say: "I can't gargle—it chokes me." One can gargle as deep down the throat as needful by pressing the palm of the left hand upon the epiglottis and quite hard directly above and against the thyroid cartilage. Do not press upon the cartilage sideways, in a manner of choking, but against its anterior part only, covering about two inches of its outer surface. Instead of the palm of the hand, one may use the tips of the thumb and all the fingers of the left hand closely arranged in a curve and adapting them to the trachea. My suggestion has not failed in the most difficult cases, and should be tried until it is correctly followed. Patients should receive these instructions and be shown how to gargle, as above described.



## ASEPSIS OR ANTISEPSIS?

By Maurice Green, D. D. S., N. Y. City.

The Humble Tooth-Brush is a Soldier of the Common Good.

The tooth-brush, as a power for either good or evil, possesses powers not dreamed of by its average users.

The great majority of the laity fondly imagine that they are keeping their brushes in an aseptic condition by merely rinsing after use. A few of the more meticulous carefully replace the brush in a glass tube with a cork at each end, to keep dust from it.

Asepsis cannot be attained or maintained by mere rinsing with water. It is, of course, only a passive condition—the state of trying to be free from germs—and does not imply the active effect of antiseptics.

Antiseptic, rather than an aseptic, condition of the tooth-brush is essential to true oral hygiene.

That means that the brush must be so treated as to resist and destroy germs.

Even the laity are beginning to understand that the oral cavity teems with germ-life. Especially after eating and after sleep, the teeth in particular are a fertile breeding ground for microbes.

These germs are transplanted upon the tooth-brush—ready to be re-introduced in larger numbers—and, where several brushes are kept in close proximity, to go calling upon their neighbors and so pass around the seeds of diseased conditions.

The importance of keeping the

mouth and teeth free from germs is obvious. A germ-laden mouth may lead to tonsillitis, catarrh and other affections of the mucous membrane lining the throat, and nose and in fact the entire respiratory tract.

Must the tooth-brush then, be condemned as a "common carrier of germs"?

The answer, of course, is that the brush must be rendered antiseptic.

Peroxide of Hydrogen of certified quality (the writer uses Hydrox Certified) is an ideal antiseptic. A few drops sprinkled on the tooth-brush before using, will help to remove the germs from the mouth, and if immersed in the same media after using will kill any microbes that have gained a foothold. Thus does the humble tooth-brush become a real "soldier of the common good"—by preventing infection.

Dentists would do well to recommend this as a regular habit, for their patients. It is much more important that the tooth-brush should be kept thoroughly clean, than the hair-brush, because the former affects conditions that have to do with one's health and even life itself.

Just as "preventive medicine" has become the watch-word of the medical profession, the modern tendency among well-informed members of our own profession is to inculcate the principles of "prophylactic oral conditions."

**TUBERCULOSIS OF THE LARYNX.**

By ALBERT BARDES, M. D.

(Continued from last issue.)

Indiscriminate giving of cough remedies has done much irreparable harm to this class of sufferers. Frequently the cough is lessened, but it is at the expense of the health and the appetite. When the diagnosis is finally made, much valuable time has elapsed and the disease has made serious inroads. Coughs are of two kinds, bronchial and throat. The former is usually a salutary measure and should be encouraged, since its purpose is the removal of secretion from the chest. The latter is generally caused by a supersensitive throat or by a foreign body, and must be treated differently. The amount of energy expended in coughing is often very great. It is estimated that a person who coughs or clears the throat once every 15 minutes for 10 hours, uses up power equivalent to 250 heat units. This equals the nourishment contained in three eggs and one pint of milk. In normal respiration the air is expelled from the lungs at the rate of 4 feet per second, while in violent coughing it may attain a velocity of 300 feet. This waste of energy is highly injurious to tuberculous subjects. The assimilative functions of these people are already working under great disadvantages and the inability of the digestive organs to assimilate the additional food that is required to offset the loss of vitality induced by the coughing, causes emaciation.

Rest to the voice is one of the best ways of overcoming a laryngeal disorder. When this cannot be secured, a compromising measure is to advise speaking in a subdued voice. If the occupation is prejudicial to the throat, it should be changed. There is no use trying to cure a tuberculous larynx if the voice is unduly used, or if it is exposed to dust, draughts, or to a cold and raw atmosphere. Fatigue, worry, and crowded, dark, or ill ventilated places should be avoided. The patient should live in a temperature as nearly uniform as possible and should refrain from doing anything which might cause his temperature to rise. An increased temperature favors the development of the tubercle bacilli, hence the frequency of tuberculosis in the cow, whose normal temperature is 102 degrees F.

Perhaps the greatest restoratives in tuberculosis are rest and sleep, particularly in the open air. Coughs that occur when a person goes from a warm room into a cold, usually disappears by sleeping in the open. Foul air, and not cold air is accountable for most colds and coughs. Esquimaux are seldom sick in their native land. It is not until they live in houses that their health departs. Perry and his men were free from colds and coughs as long as they lived out of doors, but as soon as they slept in houses their ailments returned.

Tuberculosis is seldom contracted in summer, for this is the season of the year that people live a more natural life and get the benefit of the fresh air and sunshine. Tuberculosis has been termed the bedroom disease. The very air that is so wholesome in summer, in winter, in a closed room, becomes contaminated and is converted into our worst enemy. It seems that the luxuries that provide us with comfort, in

winter deprive us of our vigor and disease resisting power. Infinitely more diseases are contracted in crowded cars and stuffy theaters than by exposure to cold. Cold air is more beneficial than warm, even though the latter is be just as pure. It is well known that invalids in the Adirondacks enjoy better health in winter than in summer. The cold air energizes the lungs in the same way that a cold draught stimulates a flame.

Fewer people would suffer from throat disorders and from tuberculosis if they would expose their bodies more freely to the air. It is a common observation that whenever feminine fashion calls for an exposed neck and chest women have comparatively little trouble with their throat or bronchial tubes. Most of our celebrated singers have learned that to harden their vocal organs to atmospheric changes insures them against vocal disorders. The cutaneous respiration of a healthy person is 5 per cent, that of the lungs, and the percentage is much higher in a person whose lungs are not functioning properly. It is imperative, therefore, that all sufferers from tuberculosis should derive as much benefit as possible from cutaneous respiration. Upon the mountains of Germany and of Switzerland, certain sanatoria for tuberculosis have been established, where the inmates are obliged to live in a state of comparative nudity the year round. I have been told that the results from this treatment are the best yet attained. In the height of winter children can be seen playing around on snow-shoes, with only a bathing suit on. A few months before these very children were wasting away with tuberculosis.

Every person with tuberculosis and every tubercular suspect should have the throat examined periodically in order to guard against the larynx becoming diseased. In most sanatoria for tuberculosis the larynx is occasionally inspected, but oftentimes the work is done in a perfunctory way and very little good is accomplished by it.

The use of the time honored cotton swab with which to apply an astrigent to the larynx should be dispensed with in incipient tuberculosis of the larynx, where there is no abrasion. We should refrain from inflicting additional traumatism and causing greater suffering by useless local meddling. This matter of making applications to the larynx whenever that organ is diseased, is unscientific and unwarranted. Fortunately the swab seldom reaches the interior of the larynx. When it does, it strangles the patient and otherwise causes needless distress. A fine down spray atomizer and a simple alkaline wash, such as Dobell's solution, is sufficient to cleanse the larynx and produce comfort. Finely powdered iodoform suspended in olive oil or albolene can be sprayed into the larynx to relieve the cough of an irritable larynx, or it can be applied by means of a piston syringe with a long bent canula. Inhalations of cresote or guaiacol in oil serve a similar purpose. Night coughs may be relieved by tying a cold damp cloth around the neck, or by sipping warm milk, preferably with the albumen of an egg. Sedatives are to be withheld as long as possible.

In the ulcerated stage of laryngeal tuberculosis, laryngeal applications are often useful. From time to time certain drugs have been advocated as having special advantages in the treatment of tuberculosis of the larynx. Lactic acid, orthoform, formalin and ichthyol, are the drugs principally recommended. In my belief not one of them is generally applicable excepting ichthyol, which stimulates the ulcer to healing. Re-

cently much has been written about the advantages of injecting alcohol into the sensory nerve of the larynx, the superior laryngeal. The results have been disappointing. Much was hoped from the tuberculin, but this far it has been found wanting. Unquestionably the serum treatment of tuberculosis will eventually be perfected, but until it is, we will be compelled to use older and tried methods. A distinct advance in the treatment of tubercular ulcers has been made by the introduction of fulgeration. By this method the lesion is seared, as with a hot iron, with the sparks from the high frequency current. The sparks are caused to jump from an insulated applicator to the raw surface, the other electrode being fastened to the neck.

Most physicians display too much timidity in dealing with all open lesion in the larynx. They are apt to resort to topical applications and sedatives when more radical measures are demanded. If the fundamental principles of surgery are observed there is no fear of infection, hemorrhage or septic pneumonia. A laryngeal ulcer should be treated in precisely the same way that a tubercular ulcer elsewhere is treated. Our purpose is to convert a sluggish ulcer into one with a healthy granulating surface. To do this we must provide cleanliness, free drainage and stimulation. Surgery of the larynx should only be attempted during the quiescent period of the disease. Of course when respiration is embarrassed owing to the lesion, immediate relief is called for. The instrument best adapted for cleansing and stimulating a laryngeal ulcer is a sharp curette, carefully and thoroughly applied. A week or two afterward the curette can again be used if some unhealthy granulations remain. An edematous swelling is an occasional occurrence in tuberculosis of the larynx. Multiple linear scarification generally relieves this condition.

Perhaps the greatest distress that these patients have comes from the swollen epiglottis, which makes deglutition painful and difficult. It is essential that an excess of nourishment be taken and this can be done only under the most favorable conditions. If the ingestion of food causes pain very little is eaten and the disease makes great headway. For a long time I hesitated to remove a swollen epiglottis, fearing hemorrhage or inspiration pneumonia. Experience has taught me that the epiglottis can be removed with impunity, and that it is not essential to the well being of the larynx. My procedure is to grasp the epiglottis with a tonsil forceps and to make traction, then by means of a tonsil snare the entire ledge of the epiglottis is removed. The pain is very slight. The relief is very great.

The question of nourishment is an important one in any form of tuberculosis, particularly in the laryngeal form, on account of the difficulty in swallowing. Early in the disease the amount of food taken may be moderate, just enough to keep the body weight from declining. In the advanced stage the food should be abundant in quantity and rich in carbohydrates, to overcome the loss induced by the disease. Thick demulcents can be taken with less discomfort than thin fluids. A good way to administer food when swallowing is painful is with a catheter passed through the nose, and past the epiglottis. Spraying the throat with a  $\frac{1}{2}$  per cent. solution of cocaine frequently enables food to be taken when it is refused without. Rectal feeding is often beneficial when the throat and the stomach need rest.

128 East 34th St., New York.



## TO ALL WELL WISHERS OF THE PROGRESSIVE DENTIST.

BEGINNING WITH THIS ISSUE, THE PROGRESSIVE DENTIST WILL BE PUBLISHED BY A STRONG ASSOCIATION OF DENTISTS WHO HAVE ORGANIZED UNDER THE NAME OF THE "PROGRESSIVE DENTIST PUBLISHING ASSOCIATION". THOSE OF YOU WHO WOULD LIKE TO JOIN IT WILL PLEASE SEND YOUR NAMES AND ADDRESSES TO THE PUBLICATION OFFICE, 346 EAST 10TH STREET, N. Y. CITY, SO THAT YOU MAY BE NOTIFIED AS TO THE ASSOCIATION'S MEETINGS.

WE HAVE BEEN VERY FORTUNATE IN OBTAINING THE SERVICES OF A VERY ABLE AND WELL KNOWN MAN, TO EDIT THE MAGAZINE. HIS NAME IS STILL HELD BACK SO AS TO COME AS A SURPRISE TO THE READERS OF THE "PROGRESSIVE DENTIST". HE WILL TAKE CHARGE OF THE EDITORIAL DEPARTMENT BEGINNING WITH THE NEXT ISSUE. SEE THAT YOUR NAME AND THAT OF YOUR FRIENDS ARE ON OUR MAILING LIST. IF YOUR SUBSCRIPTION EXPIRES, RENEW IT, IF YOU ARE IN ARREARS, SEND IN YOUR 50 CENTS AND BECOME "STRAIGHT". BY ALL MEANS, SEE THAT YOU OBTAIN A COPY OF OUR NEXT ISSUE.

BESIDES THE EDITORIAL OF OUR NEWLY ELECTED EDITOR, WE WILL HAVE:

1) THE DISCUSSION OF DR. REAM'S PAPER BY DRs. HASBROUCK, GREEN, LEDERER, AND A REPLY BY DR. REAM, ILLUSTRATED BY FILMS OF X-RAY PICTURES;

2) A LECTURE DELIVERED BY PROF. DARBY AT THE KINGS COUTY DENTAL SOCIETY — ON "THE RELATIVE MERIT OF FILLING MATERIALS" WITH COMPLETE DISCUSSION BY PROF. A. R. STARR AND DR. M. L. RHEIN.

3) A LECTURE DELIVERED AT THE EASTERN DENTAL SOCIETY BY PROF. FREDERIC PEESO — ON "CROWN AND BRIDGEWORK WITH SPECIAL REFERENCE TO THE PREPARATION OF ABUTMENTS FOR FIXED AND REMOVABLE BRIDGWORK."

COME; WAKE UP AND BE PROUD OF YOUR DENTAL MAGAZINE!

YOURS,

**THE PROGRESSIVE DENTIST.**



# The Progressive Dentist

Published Monthly by  
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This magazine maintains an open forum. We appeal to our subscribers to avail themselves more extensively of our pages and send in manuscripts on any topic they think interesting. We will provide space for any criticism offered in good faith. We are not responsible for opinions expressed through the agency of the free forum. We limit our responsibility to what is published editorially only. We also reserve to ourselves the right to alter, abbreviate and correct manuscripts if we deem it necessary. Manuscripts we do not publish are not returned unless so requested in which case return postage is to accompany the request.

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## EDITORIAL DEPARTMENT

In preventive medicine, dentistry takes a very important, if not the most important, place. The oral cavity, containing the organs so essential to digestion and nutrition, and forming part of the channel by which the air passes to our lungs, constitutes an object of great consideration in the maintenance of individual health. The diagnosis and treatment of some of these serious diseases specifically found in the oral cavity, within the scope of the dental practitioner; the protection of the dental apparatus from the destructive effect of diseases, is of such vital im-

portance for the nutritional processes of the body, that by virtue of these facts alone, dentistry stands out as a great factor in preventive medicine and public hygiene.

However, for a long time the fact was ignored by the lay public as well as by the medical profession. The dentist until recently has been looked upon as a technician and his work as a craft. It was not until Sir William Osler, the great medical authority, called attention to the important position which dentistry was called upon to exercise in public health mat-

ters, that the medical profession sat up and took notice. Only then it was realized to what extent dentistry, as a scientific profession, was allied with medicine, preventive medicine in particular. It was realized that complex problems of bodily nutrition are related closely with mouth sanitation, and with normal conditions, of oral and dental tissues. It is evident that the field of the dental practitioner's work is not restricted to teeth only but constitutes a part of the great work of keeping the human body healthy.

This changed the attitude toward the dentist on the part of the medical profession and is causing a different attitude towards us with greater demands and place us with greater demands and place us under greater responsibilities as members of the curing profession. It is therefore up to the dental profession to develop this view of the public by proving themselves equal to their demands.

But there is one more step to be gained. We must have the recognition of the national, state and municipal governments to make dentistry a regular and official factor in the departments of public

health. The direct relationship between dentistry, preventive medicine, and public hygiene is so evident that there is no need even to point to the authority of Dr. Charles K. Mayo, who said that the next great step in medical progress is that the line of preventive medicine should be made by the dentists. We have achieved some victories already; let us not rest on our laurels. Let us remember also that the great factor in achieving our victory is our own growth as a scientific and as an ethical profession. We must prove equal to our great task and justify our claims. N. A. P.

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The Editor wishes to announce that owing to the darkness in the room at the time of Dr. Lederer's talk on "Minor Oral Surgery" at the Harlem Dental Society, the stenographer is unable to read her notes; consequently the continuation of Dr. Lederer's article will not appear in this issue; but Dr. Lederer promises the readers of *The Progressive Dentist* that he will re-write the article himself and have it appear in a future issue of the magazine.



## CARE OF THE ORAL CAVITY IN INFANCY."

By Dr. Jesse Feinberg.

(Reprinted by request.)

It often occurs, in the clientele of the writer, that an anxious mother requests advice, as regards the attention she should give the mouth of her baby.

It is this foregoing thought that forms the subject matter of our discussion. We will only endeavor to cover briefly a few essentials.

Absolute cleanliness is always cardinal; and under this consideration the nipples, whether of the breast or bottle, must be kept in a sanitary state. It is good practice to swab the mouth of the little one twice daily with a mild solution of **Acidum Boricum**. This is also indicated when the tongue is furred, and during morbid dentition.

An affection of the mucous membrane, which is the result of uncleanliness of utensils, nipples and the child's toys, known as **Thrush** is often met with. This stomatitis parasitica is due to the fungus, **Oidium Albicans**. This morbid condition is characterized by the presence of diffuse white patches, which appear on the tongue and mucous membrane of the cheeks and throat. These patches are often the seat of bleeding. The child is fretful and refuses food, as a result of the excruciating pain experienced in the affected areas. In combating this condition, removal of the cause is the chief point, therefore, the word **cleanliness** is again brought before us.

The application of a two (2) per cent solution of **Argenti Nitras** to the affected areas is efficacious.

Swabbing of the parts with the following formula affords great relief:

℞	
Ac. Boricum,	ʒi
Hydrogenii Dioxidi,	ʒii
Glycerinum,	ʒiv
Aq. Rosae,	ʒii

Mx.—

Sig.—

The next feature of importance is "**Dentition**."

We realize the fact that dentition is a normal process of development. No fixed time can be set for the eruption of the deciduous teeth. These words should be fixed in the minds of our young mothers, as this is often the cause of great anxiety.

The process may be delayed, by improper feeding, debility and rachitis.

The most common symptoms of ordinary dentition are:—

**Irritability of temper;**

**Loss of appetite;** and a **Condition** in which the child cannot digest the average amount of food, it is wont to be fed.

Indications of treatment is absolute cleanliness of the buccal cavity; rest to the child; and avoid forcible feeding. Undoubtedly most of us are acquainted with an approximation to the periods the deciduous teeth are most frequently erupted. All who have children should be instructed as to the value of the preservation of the deciduous arches of teeth until the initiative in eruption of the succedaneous has taken place, the temporary set having a great bearing upon the normal development of the arches of the permanent teeth.

## STUDENTS' DEPARTMENT

### N. Y. C. D. NOTES

#### MECHANICAL STEPS IN ANATOMICAL ARTICULATION,

By A. L. Seldin, N. Y. C. D. '14.

In presenting this article to the readers of the Progressive Dentist I do not pretend to have discovered or devised any new methods in the field of anatomical articulation. All it is intended for is to simplify and systemize the mechanical part of anatomical articulation for the earnest beginner, so that when once started he may see his way clear to a successful end.

The steps are arranged in the order which they are to be carried out. I am confident that if closely followed anatomical articulation will prove to be very simple. At any rate much simpler than a good many think it is.

#### Mechanical Steps in Anatomical Articulation.

- 1—Take impression.
- 2—Obtain models.
- 3—Make trial plates, using tin foil to strengthen them or ideal base plate.
- 4—Prepare bite waxes, trimming them down to proper thicknesses. The cuspid eminence should receive attention in this step.
- 5—Mark upon the bite waxes the following:
  - (a) median line of the face
  - (b) angles of the mouth at rest
  - (c) high lip line
  - (d) low lip line.
- 6—Unite the two bite waxes by inserting a wire staple on each side in the region of the first molar.
- 7—Locate the condyle ends of the mandible by instructing the patient to open and close the mouth several times and at the same time holding the finger on the cheek near the external auditory meatus. Indicate these places on the face with chalk.
- 8—Heat the fork of the Snow Face-bow and insert it between the bite waxes.
- 9—Adjust face-bow on chalky dots, using care that the same number of gradations are marked off on the inner side of the arm on each side.
- 10—Tighten the set screws on each side, also the central clamp.
- 11—Loosen the side set screws and remove the face-bow with the bite waxes as one.
- 12—Place the Snow anatomical articulator on the bench setting firmly in the tin base provided with it.
- 13—Push the graded rods of the face-bow in as far as possible.
- 14—Adjust these rods over the projecting pins of the articulator made to receive them and then tighten them.
- 15—Place models in the trial plates, taking care that the face-bow is in line parallel with the bench.
- 16—Mix plaster and mount the models, carrying the plaster up to the sleeves in the upper bow, and to the heels in the lower bow.

**Obtaining the Protrusive Bite.**

- 17—Insert the bite-gauges with the cones pointing upward, into the occlusal surface of the waxes, at the posterior end of the lower trial plate.
- 18—Insert the trial plates into the patient's mouth and before closing instruct him to protrude the lower jaw forward about 1/8 of an inch, until the waxes touch each other in front.
- 19—Insert wire staples into the waxes keeping them firmly together. Join the two waxes with a hot spatula in the median line and in the region of the bite gauges.
- 20—Loosen the back-spring of the articulator, and the set screws which lock the condyle slots.
- 21—Invert the articulator and gently place the upper trial plate with the lower attached to it in the upper model.
- 22—Bring down the lower model into its proper position. The condyle slots will take a certain slant, which depends upon the amount of separation between the trial plates in the posterior section.
- 23—With the lower model in its trial plate undisturbed, tighten the set screws of the condyle slots.
- 24—Remove staples and bite gauges. Retrude the lower trial plate and fasten the back-spring in its place.
- 25—Set up the teeth and finish.

**C. D. O. S. N. Y. News.**

On Dec. 8, Prof. Prothero visited the Junior and Senior Classes. He extended a cordial invitation to visit him at the Northwestern University.

Prof. Prothero spoke very interestingly to the Juniors on plaster impression work and to the Seniors on original and practical method of obtaining the compensating curves, prior to the setting up of the teeth, in the construction of an artificial denture.

A magnificent dental library is promised the college. Several big collections of books were received for the library. There is the William Carr collection of several hundred books worth more than \$1,000. The most recent collection received is the John I. Hart collection of about 50 volumes. There

is the Howell collection and many other valuable books donated by the students; all of which will make our college library the greatest and most complete special dental library in existence.

The Junior Class of 1915 will give a dance on February 21. The affair will take place in Brown Hall, in the college.

**FRESHMEN NOTES.**

The Freshmen have at last elected all their class officers. They are: John W. Shelpert, President; Mary Goldfarb, Vice-President; Harry Jarmulowsky, Treasurer; Ella S. Feldman, Secretary; Chas. H. Wilen, Class Editor; Maxim R. Perlman, Sergeant-at-Arms.



## DENTAL SOCIETY NEWS

**HARLEM DENTAL SOCIETY**—Meets the fourth Thursday of each month at Fraternity Building, 67 West 125th St.

Dr. W. S. ENGELBERG, Sec'y, 2400 Seventh Ave., New York.

**EASTERN DENTAL SOCIETY**—Meets the first Thursday of each month at Cafe Boulevard, 156 Second Ave., Cor. 10th St.

Dr. A. LeWITTER, Sec'y, 330 E. 4th St., New York.

**KINGS COUNTY DENTAL SOCIETY**—Meets the second Thursday of each month at Masonic Temple, Claremont Ave. near Lafayette Ave.

Dr. S. H. FILLER, Sec'y, 220 Stockton St., Brooklyn, N. Y.

### The Eastern Dental Society of the City of New York.

The regular meeting of the Eastern Dental Society was held on Tuesday evening, January 13, 1914, at 8.30 P. M., at Cafe Boulevard, 156 Second Avenue, New York City.

Prof. Frederic A. Peeso delivered a lecture on crown and bridge work with special reference to the preparation of abutments for fixed and removable bridge work.

The paper was discussed by A. M. Johnston, D. D. S., and H. W. Gillett, D. D. S.

Following candidates were proposed: Fannie S. T. Gerber, D. D. S., 347 East Tenth Street; proposed by Dr. LeWitter; J. Zaharia, D. D. S., 86 Second Avenue; proposed by Dr. Erdreich.

A. LeWitter,  
Secretary.

### Harlem Dental Society.

A regular meeting of the Harlem Dental Society took place Tuesday evening, December 30th, 1913, at its quarters, Fraternity Building, 67 W. 125th Street. The meeting, although no lecture took place, was nevertheless very interesting as election of officers for

the ensuing year was held. Many of the candidates, including Dr. Ortman, withdrew their nominations, and Dr. Maurice Green was elected president.

### Kings County Dental Society.

A regular meeting of the Kings County Dental Society was held on Thursday evening, January 8, 1914, at 8.30 P. M., at the Masonic Temple, Lafayette and Clermont Avenues.

The speaker of the evening was Edwin T. Darby, M. D., D. D. S., Professor of Operative Dentistry and Dental Histology at the University of Pennsylvania. The subject, "The Relative Merit of Filling Materials," was a most timely one, in these days of controversy as to whether we should throw away our plugger points, or whether those who have thrown them away, should pick them up again and Prof. Darby, whose appearance in these parts is only too rare, treated the subject so well that none should have denied themselves the treat of hearing him on January 8th.

The discussion was opened by Alfred R. Starr, M. D., D. D. S., Professor of Operative Dentistry

at New York College of Dentistry, and M. L. Rhein, M. D., D. D. S. The paper and the discussion in full will be published in the next issue of the Progressive Dentist.

The following candidates were voted upon at the meeting for admission to membership:

Ralph Chashin, 625 Wythe Avenue; Ira Buchenholz, 258 Hart Street; Edward A. Marks, 442 Kosciusko Street; A. P. Loesberg, 592 Greene Avenue; Isaac J. Hill, 307 Pulaski Street; Boris Shnayerson, 504 Sutter Avenue; Harry Milritsky, 82 Throop Avenue; S. J. Muroff, 957 Blake Avenue; Louis Shankroff, 343 Jefferson Avenue; J. J. Alpen, 1700 Pitkin Avenue; Wm. W. Mandelbaum, 329 Stone Avenue; Benjamin Paaswell, 53 Woodbine Street; E. T. Sternfield, 1205 Eastern Parkway; Emanuel London, 1339 St. John's Place; Bertram B. Machet, 8679 Bay 24th Street, Bath Beach; S. Rosengardt, 329 Pennsylvania Avenue; V. S. Amadoney, 358 Stone Avenue; Abraham Greenburg, 4721 14th Avenue; Stanislaus Chalupski, 4911 12th Avenue; Fanny S. Türk, 236 Carroll Street; Samuel N. Robbins, 258 Hooper Street; J. R. Schwarz, 972a St. John's Place; Wm. Mendelson, 2310 Myrtle Avenue; B. Zuckerman, 375 Bushwick Avenue; Abraham Goldstein, 75 Manhattan Avenue; David D. Teller, 126 Harrison Avenue; D. Laletau, 307 Bedford Avenue; Harry A. Gartnar, 318 East 18th Street, New York City.

#### SPECIAL NOTICE

On Friday afternoon, March 13, 1914, The Kings County Dental Society has arranged to give a series of clinics at the New York College of Dental and Oral Surgery, the ablest men of the Profession having been obtained as clinicians.

More detailed information forthcoming.

Mark down date of clinics in your appointment book today.

#### SOCIETY ANNOUNCEMENTS.

##### National Society Meetings

National Dental Association, Rochester, N. Y., July 7, 8, 9, 10, 1914.

American Society of Orthodontists, Toronto, Can. July 2, 3, 4, 1914.

Panama-Pacific Dental Congress, San Francisco, Calif., 1915.

National Association of Dental Faculties and Institute of Dental Pedagogics, Buffalo, N. Y., January 26, 1914.

##### Sixth International Dental Congress.

London, August 3rd to 8th, 1914.

##### PATRON—HIS MAJESTY THE KING International Congress Museum.

##### SECTIONS OF MUSEUM

1. Dental Anatomy, Histology and Psychology.
2. Dental Pathology and Bacteriology.
3. Dental Surgery and Therapeutics.
4. Dental Physics, Chemistry, Radiography and Metallurgy.
5. Dental Prosthesis.
6. Orthodontics.
7. Oral Surgery and Surgical Prosthesis.
8. Anesthesia.
9. Oral Hygiene, Public Instruction and Public Dental Services.

##### OFFICERS

Chairman: Mr. A. Hopewell, Smith, L. R. C. P., M. R. C. S., L. D. S.

Hon. General Secretary: Mr. F. N. Doubleday, L. R. C. P., M. R. C. S., L. D. S.

##### HON. CURATORS

Mr. H. P. Aubrey, L. R. C. P., M. R. C. S., L. D. S. (Oral Surgery)

Mr. C. F. Peyton Baly, L. R. C. P., M. R. C. S., L. D. S. (Oral Hygiene, etc.).

M. F. Bocuet Bull, L. D. S. (Dental Surgery).

Mr. E. B. Dowsett, L. R. C. P., M. R. C. S., L. D. S. (General).

Mr. A. Hopewell-Smith, L. R. C. P., M. R. C. S., L. D. S. (General).

Mr. A. E. Ironside, L. R. C. P., M. R. C. S., L. D. S. (Physics, etc.)

Mr. S. P. Mummery, L. R. C. P., M. R. C. S., L. D. S. (Pathology).

Mr. J. Lewin Payne, L. R. C. P., M. R. C. S., L. D. S. (General).

Mr. A. T. Pitts, L. R. C. P., M. R. C. S., L. D. S. (General).

**Nature and Scope of the Museum.**

It is intended that the Museum shall be an international collection of objects of interest and be representative of every section of the Congress. Its nature and scope include the following:

1. Specimens showing the Evolution of Tooth Forms and of the Dentition of Man. Histological Preparations bearing upon recent research. Exhibits Illustrating the Chemical Composition and Physiological Action of the Saliva.

2. Specimens of Morbid Conditions of the Teeth, Palate, Gums and Jaws, such as Odontomes, Dental and Dentigerous Cysts, New Growths, Diseases of the Peridental Membrane, etc., Photomicrographs of Oral Micro-Organisms, and Cultures of Micro-Organisms in Test Tubes or in Petri Dishes. New Bacteriological Apparatus and Appliances.

3. Specimens of Teeth, Gums and Jaws affected by "Pyorrhea Alveolaris." Microscopical and Lantern Slides of the same. Exhibits of Various New Methods of "Inlaying" Cavities in Teeth. Exhibits of New Methods of "Crowning" Teeth.

4. Radiographs of the Normal Dental Tissues, and of Diseases of the same and Associated Parts.

5. Exhibition of various kinds

of Articulators. Specimens showing the various Methods of "Pressure Casting." Specimens showing modern forms of Continuous-Gum Work.

6. Models showing Abnormalities in position of the Teeth, and Appliances for the Correction of the same.

7. Specimens illustrating Methods of Dealing with Surgical Conditions of the Teeth and Jaws, including Cleft Palate, Harelip, Fracture and Resection of the Jaws.

8. Specimens illustrating the History and Evolution of Anesthesia.

9. Photographs, Charts, Diagrams, Specimens and Statistics of School Clinics. Methods for the Instruction of the Public in the Principles of Oral Hygiene.

10. Instruction Form, Charts, Diagrams, Specimens and Demonstration Models used in relation to Dental Education. The Specimens will include those employed for teaching purposes, and also Specimens of Work of both Students and Pupils, completed in accordance with the definite courses given.

11. Historical Objects of Interest, such as Books, Instruments, Pictures, etc.

**National Association of Dental Faculties and Institute of Dental Pedagogics.**

The National Association of Dental Faculties will meet in Buffalo, New York, at 10 A. M. on the morning of January 26th, 1914. This is in accordance with the resolution adopted at the last annual meeting, to meet in conjunction with the Institute of Dental Pedagogics. The Executive Committee will meet at 9 o'clock on the same morning.

(Signed) Executive Committee.



THE PRIME REQUISITE FOR  
**LOCAL ANESTHESIA**  
 IS SAFETY IN THERAPEUTIC DOSES.

This is offered to the Dental Surgeons in

**NOVOCAIN-SUPRARENIN**

Ask for Samples of Hypodermic Tablets E for  
 Injection Anesthesia, or for Novocain-Suprarenin  
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- Powdered soap . . . . . 1 part

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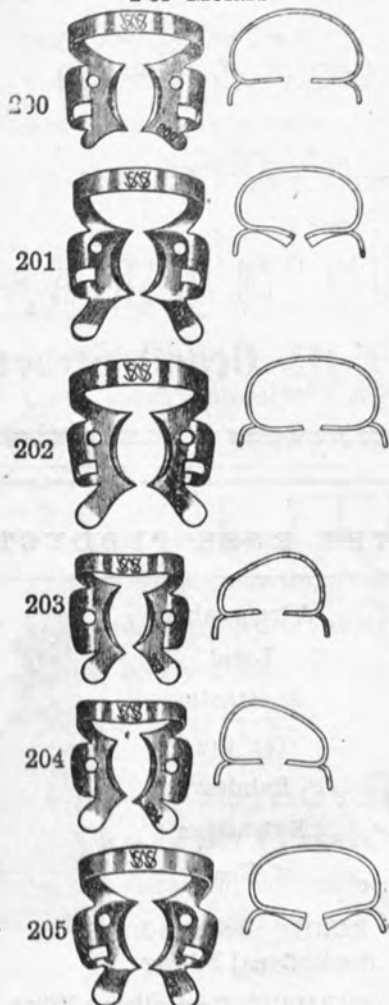
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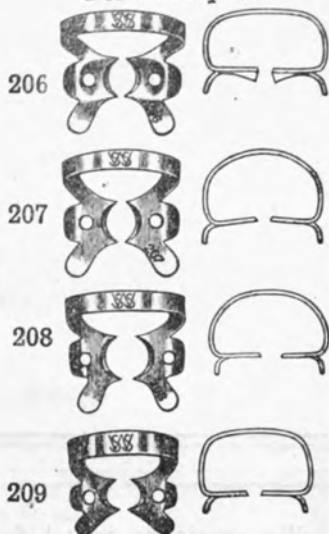
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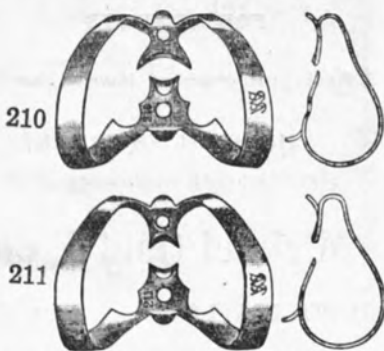
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