

Nebraska Dental Journal

VOLUME I

OMAHA, JANUARY, 1914

NUMBER 7

NEBRASKA STATE SOCIETY PROCEEDINGS

Continuation of Afternoon Session, May 20, 1913.

(President Bruening: at this time introduced Dr. H. M. McClanahan of Omaha, who read a most excellent paper, "Why Does the Operation for Adenoids Frequently Fail to Relieve Mouth Breathing?" All this we omit, together with the discussion, as the paper was not handed in to the editor. Of this we are truly sorry, and cannot understand why, as the reading was given good attention and the discussion was taken up by the members with keen interest.)

President Bruening: The next order of business is the report of the legislative committee. Dr. Cox, as chairman, will make the report.

Dr. W. A. Cox, South Omaha: (Report read and same has been filed with proceedings.)

Evening Session, May 20, 1913.

President Bruening: Ladies and gentlemen, I am informed that reports of committees are being arranged for another time.

Our first paper for tonight is by a man who has delivered lectures on this subject before. He has given these lectures not only in the United States, but Europe, where for a number of years he has received an invitation to appear every other year. His last lecture was given in Norway, and it is expected that he will go again next year, not only delivering lectures, but to teach along the line of his subject matter tonight. His lecture was very well received at the National last year, and it gives me great pleasure to present to you tonight Dr. John L. Kelley of Chicago, Ill. His subject is "Removable Bridgework."

Mr. President and Members of Nebraska State Dental Society:

Removable bridgework is one solution in most extreme cases of pyorrhea, but it is the only solution where a few teeth remain, and when this art will have been mastered it will be extensively used. Had its use been more general, Dr. Hunter's tirade on American dentistry would never have been written. He says that one of the worst cases of sepsis he ever saw was brought him by a doctor who said that the patient's mouth had been carefully seen to and was in good order; his mouth was to all appearance clean, for it was one solid mass of gold caps, crowns and bridges, fixed dentures, built in, on and around diseased teeth, forming a mausoleum of gold over a mass of sepsis, to which there is no parallel in medicine or surgery.

Why is the fixed bridge used instead of the removable bridge? Is it because it is less expensive to the patient, or less difficult of construction to the operator, or is it because of a lack of skill and knowledge in the construction of the removable?

The most expensive work to the patient and the most trying and

unsatisfactory to the conscientious dentist is the unsanitary and uncertain kind. We know that extensive fixed bridgework is both, therefore it is expensive at any price. We should explain this to our patients, who are familiar with the fixed kind only, for they believe that all bridge work is permanent, but we know that all extensive fixed bridges are failures. I acknowledge there is a place for fixed bridges, but we should know the possibilities of both kinds in order to judge which is indicated. Each individual case needs our best skill and judgment. The more we use removable bridges, the more satisfied we become with the results, and the more convinced that it is the only solution in the extreme or extensive cases. The patient should be told that two roots will not support, for any length of time, five or six teeth. There are none so stupid nor obstinate as to be willing to suffer and pay for work that will not only not last, but that is actually a menace to their health. In any event, the dentist should not allow the patient to decide. A surgeon does not permit a patient to instruct him in his work.

The aim in all dental work should be preservation of the roots; and therefore the method offering the greatest opportunity for this should be employed. The points that should be considered are sanitation and stress, and because the removable bridge is more sanitary, and causes the least amount of stress of any other denture when correctly made and adjusted, especially in extensive cases, it should be used. I have classified the cases as follows: The first group includes cases where there are a number of teeth in both jaws, all so loose from pyorrhea and other causes that when the teeth occlude they move abnormally, thus increasing irritation. The second group show cases where the anterior teeth only remain, producing the same conditions as in the first group. The third group includes cases where the posterior teeth only remain, showing the above conditions. The fourth group are the cases where a number of anterior and posterior teeth are missing.

All cases that came under these four groups are too extreme for fixed bridges, but in most of them removable bridge work may be successfully made. These are the cases which the pyorrhea specialist dreads and the extracting specialist delights to treat, and the extractor gets most of them. It is only when the patient will not consent to wearing plates that the majority of dentists investigate the removable bridge, the fact that they never made one before does not deter them from making the attempt, regardless of their knowledge and experience, both of which are requisites in successful removable bridge work. Because they are skillful mechanics, some men believe they can learn this work in a couple of hours. This is a mistake; the simplest case of the fourth group may be learned in a day, but it would require at least a week to obtain a working knowledge of the cases I have shown.

In teaching this work I begin with the simplest case of the fourth group, one where all the teeth are missing, except the cuspids on the lower. The first step is to cut off the crowns of these cuspids, fill the roots and make a lower plate; this provides the patient with a means of mastication, gives him an idea of plates, holds the jaws in their

correct relation, removes all strain from the roots, and gives the dentist time to study the case and construct the bridge. When the mouth is in a healthy condition and the roots have become firm, they may be prepared for copes. To make these copes I have invented a die plate.

After studying anatomy of teeth I learned that the variation in form at the gum lines of the upper and lower bicuspid, cuspid and incisors, is not usually great. In all these teeth there are usually not more than eight different shapes at the neck.

The central in some cases is the shape of the lateral or lower bicuspid, and vice versa. The upper cuspid, in some cases, is the shape of the lower cuspid, and vice versa. The upper bicuspid generally varies from an ellipse, being concave on one or both sides. The lower incisors are the same shapes as the upper or lower cuspid or upper bicuspid.

To make a cope in the die plate, the measure of the root is first taken to give us the form and circumference, and by comparing the wire form with the dies we make our selection of the type and we determine the correct die, by straightening the wire and comparing it with the scale found just below each row of dies. The next step is to place the metal for the cope—gold or platinum—over this die and tap it with a soft piece of wood, annealing it from time to time, and finally forcing it into place by hammering a piece of pure lead into it. This takes from three to five minutes. The cope is then removed, annealed and trimmed, its edges are filed and sharpened, and it is ready to be adjusted to the root. It is adjusted by pressing it on with a soft piece of wood, after which a hole is punched in the cope opposite the root canal and a pin adjusted and soldered to place. The cope is now completed and placed on the root. Then a wax bite and plaster impression are taken, the copes are lined and the pins are slightly coated with vaseline and the impression is run up. The model is then prepared and mounted on the articulators.

I will now describe to you the attachments I use and how they give retention.

When the retention of a removable bridge depends upon a clasp, slide or screw it is unreliable, because the clasp or spring weakens or breaks, the slide loosens or becomes clogged, breaking the bearings, the screw strips making it useless. Having the experience with these and finding them unsatisfactory, I devised an attachment that gives retention by its relation to another attachment or to undercuts formed by the projecting tissues, or to both.

The attachments consist of a bar of round iridium platinum wire, 12 to 16-gauge, called "holding post," and two tubes; the one telescopes the holding post and is called the "adjusting tube," the other telescopes the adjusting tube and is called the "bridge tube," because it is carried by the bridge.

Holding Post, Adjusting Tube, Bridge Tube—

The holding post is soldered on the cope so that it comes between the teeth in the interproximate space, the mesial and distal of the facing to be ground to fit.

The adjusting tube is cemented onto the holding post and remains in this position until the bridge tubes have been connected by a bar. (They are used to center these bridge tubes upon the holding posts. Later, when the bridge has been worn, they are used to take up excessive play. In this case one or more of the adjusting tubes may be cemented on the holding posts or in the bridge tubes, thus making it possible to adjust the fit or retention of the bridge to any degree.) Then set up six anterior teeth to determine where the holding posts are to be placed in relation to the teeth and tongue. The holding posts are generally placed at the distal of the cuspids or in the interproximal spaces and in such a position that they will incline slightly toward each other, the amount of inclination depending on the length of the post and the distance between them, for the greater the distance and the shorter the posts the more inclination there may be, and vice versa.

After determining the position of the holding posts, the teeth may be removed and the holding posts waxed securely to the copes so as not to be displaced during investing. Invest the copes and holding posts attached to them so that the greater part of the copes are exposed, but the greater part of the holding posts are covered with investment. Apply heat directly to the copes and holding posts with a blow-pipe until white-hot, and then place a small quantity of pure gold at the junction of the posts with the copes and hold heat on it until the gold melts. Next, the complete cope is reinforced with pure gold and then the copes and holding posts are removed from the investment, ground and polished until the adjusting tubes will slide easily over the holding posts. (Caution: Where holding post is soldered to cope it is well to allow a greater thickness of solder.) Then flare the orifice of adjusting tubes so they will fit over the enlargement and cement them on the holding posts, and polish them so that the bridge tubes will easily telescope them, having the orifices of the bridge tubes touch the tops of the copes. Place tin-foil on model, set the teeth again in place, extend a bar (the size and material of which depends upon the material used in the bridge) and wax the end of the bar to the bridge tubes.

In order to remove the bar waxed to the bridge tubes without changing its position, mix quick-setting plaster, very thick, and place it on the bar and attachments. After this plaster has hardened, it is removed, carrying with it the bridge tubes, also the copes with the holding posts. Remove the copes, leaving only bridge tubes and bar in impression. Plumbago or ordinary pencil lead is placed in each bridge tube, allowing one-half inch to extend above. Then a line of wax is run from each joint (to more easily locate them) out upon the impression.

Mix investment and cover the pencil leads and fill the entire impression, except where the line of wax has been run to locate the joints. After the impression has hardened, the joints are located and soldered. The plaster should be removed and the inside of the tubes cleaned and polished, after which they are placed in position on the holding posts.

(Dr. Kelly's Paper with Discussion will be concluded next month.)

Refitting a Vulcanite Denture Which Has Become Loosened Through Absorption of the Alveolar Ridge

The Articulation is correct, the contour and facial expression is good, and to reset the teeth and get the same expression and articulation would be an utter impossibility.

However, the following method will accomplish the thing you and the patient both desire, to the perfect satisfaction of both. We will take for convenience an upper denture, the same method will apply to lowers.

Remove the denture from the mouth and rinse thoroughly. Then take a small quantity of very soft modeling compound and cover the palatine surface with a thin layer of the material,—then to be sure the compound will be soft enough drop the denture into warm water so that the material will become thoroughly softened, insert denture in the mouth and push almost to position, ask the patient to close the teeth and be careful to note the articulation is correct.

When this is found correct, have the patient close tight together to further displace the compound and while material is yet soft press it up well around edge of the denture either from the inside or outside (the writer prefers outside) of cheek and lips and a perfect impression will be obtained.

If it is found on removing the denture there is too much of an excess around the rim of the denture, this excess can be trimmed away with a warm knife and the edge of the impression rewarmed over a small alcohol lamp flame and reinserted into the mouth and pressed to position again.

Remove the denture or impression from the mouth and invest in the lower part of the flask with the teeth down, allowing investment to come up to the edge of the rim of the impression, then proceed with the pouring up of the upper part of flask as in the usual manner thus obtaining a model at the same time. After the plaster has hardened sufficiently, warm the flask and separate. Remove every particle of compound and by the use of burrs and scrapers make a fresh surface on the palatine surface of the old denture and after washing with choloform pack in sufficient rubber, tinfoil and model with No. 40 tinfoil, vulcanize and finish in the usual manner.

If it should be found that the old denture should contain undercuts large enough to prevent separation of the flask, these can be removed before the impression is taken. DR. E. W. FELLERS, (Beatrice, Neb.)

Dr. C. T. Hatfield and Miss Mable Lindell were united in marriage at the home of the bride's parents in Fairbury, December 17. They took a short honeymoon trip to Chicago. Dr. Hatfield is located in Fairbury in partnership with his father, Dr. T. I. Hatfield.

A York County Society Organized

York dentists organized with four members, Drs. Wildman, C. A. and A. E. Calkins. Officers, Dr. H. R. Wildman, president; Dr. A. E. Calkins, secretary-treasurer.

Nebraska Dental Journal

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S. A. ALLEN, D. D. S., Editor

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== EDITORIAL ==



I want to say to the dentists who are here that I have been objecting seriously to these long-drawn-out efforts at curing pyorrhea alveolaris. Of all the things that is one among the worst, to keep a patient continually draining pus from these practically hopeless cases for years, and expect them to retain good vigorous health. These patients become anemic and sick in spite of treatment, and we are doing wrong, and I think Dr. Hunter was right when he gave the dental profession a lashing for allowing these foci of infection to continue in the mouth. (Applause.) We had better lose teeth and make plates with which patients can chew food and do it quickly, than to allow these things to run on from year to year and have the alveolar processes melt away, for when such a patient does lose his teeth, his mouth is in no condition for a good set of artificial teeth, because of the loss of the normal alveolar ridges. He is in trouble for the rest of his life. We should not let these things continue.—Dr. G. V. Black, The Dental Review.

Through the efforts of Drs. Cressler, Barber, Whitcomb and others our adv. pages are growing. This in part is made possible by the fact that dental supply firms realize that this is the best way to reach Nebraska dentists. Reliability is the absolute requirement of every advertiser and no other business will be considered. We hope our readers will take this into consideration when buying and when ordering goods mention the Nebraska Dental Journal.

German Students Strike

Because the State will not give them a degree, dental students at the University of Berlin have struck and at a meeting held by them resolved to quit the institution if their wishes are not favorably considered.

Dental Students from other parts of Germany have expressed their sympathy and our report says that hope is held by the strikers that their desires will be granted.

To the Members of the Nebraska State Dental Society:

Attention! Prick up your ears! There is news a-coming! Before very many more days have passed you will receive a very, very important letter from an Omaha committee, announcing an EVENT, yes an event of a life-time, one that you can ill afford to miss and one that you will be more than repaid for attending. Tell you about it, did you say? Well, I would, but they won't let me. It's so good that they want to spring IT themselves. Aside from the EVENT there will be the Auto show and other attractions going on during the same time. WATCH for your letters and give them your attention.

OMAHA CORRESPONDENT.

Central District

This district held a meeting at York, November 26-27, and while the attendance was not equal to some other districts this year it was a decided success when it is considered that many who intended to come by automobile were kept away on account of very bad roads.

Dr. N. C. Davis and Dr. H. A. Shannon of Lincoln, gave some very good clinics and made interesting talks.

A permanent organization is now assured and since so many of Nebraska's most successful dentists are located within the territory of this district, its future is bright. Election of officers resulted in Dr. T. J. Hatfield being reelected president and Dr. C. A. Calkins reelected secretary-treasurer. The next meeting will be held at Seward.

Remember the new dental law. Send one dollar to Dr. J. S. Pierce, Secretary, Fraternity building, Lincoln, Nebraska, before January 1st: otherwise you are subject to the fine of \$50.00 and that of having your dental license revoked.

Dr. J. H. Bond and wife of Fairbury spent Christmas with relatives in Red Oak, Ia.

Normal Restoration in Artificial Dentures

By Dr. C. H. Gietzen, Omaha, Neb.

My clinic at the recent meeting of the Nebraska State Dental Society was a plea for more care and attention to details in the construction of artificial dentures; showing models of my own mouth from which I had cut the teeth, attempting to duplicate them in form, color and position, from the stock at our command at the dental supply houses. I will attempt to convey in words in this short article what was perhaps more clearly shown in the models I had at the meeting. We need more attention paid to the restoration of tissues lost by absorption after the loss of the natural teeth and also in the selection of the artificial teeth with which we hope to benefit the patient. Our idea in making artificial dentures should be not only to give the patient something to chew with, but we should study each individual case with a view to restoring the lost contours and outlines of the face and to put teeth in their mouths that are not glaringly artificial in appearance and patent to all who see them that their own are gone. In my clinic I used models of my own mouth because they are rather out of the ordinary in that the teeth are very large and occupy positions characteristically their own. It would have been much easier to set up teeth duplicating a more normal mouth, but my idea was to see how near I could come to something more difficult. With those who saw the models of the finished case I will leave the judgment as to what measure of success I had. I could not find any teeth in the ordinary sets that would duplicate the two centrals and cuspids so I took facings and ground them to suit. The ordinary teeth had none of the bulging or bell front shape shown in the natural teeth. In imitating the rugae on the palatal surface of the plate the intention is to do away with that perfectly smooth condition usual to plates as we make them. If you will run your tongue around over the lingual surface of your teeth and the roof of your mouth you will find that those surfaces are far from smooth. The rugae and lingual surfaces of the teeth help very materially in enabling the tongue to control the food bolus as it is cast from one side of the mouth to the other in the act of chewing, and if these surfaces are not restored in the plate it is not surprising that the wearer should have difficulty in learning to chew and goes through antics with the muscles of the cheeks that tend to displace the plate. Most artificial teeth as they come from the manufacturer are too short lingually, though that fault can be remedied by building up with rubber. Those who saw the artificial dentures and the restorations of lost tissues and the contour of the face of the patient shown by Dr. Rusmussen of Omaha at the recent meeting had a very good illustration in actual practice of the ideas I have tried to convey. He was showing a patient past middle age who had lost all of her own teeth quite early and yet her face had lost none of the bloom of youth through the shrinkage of tissues and the drawing of the muscles of the face so usual when the natural teeth are gone. I think we should study our cases carefully and restore as nearly as is possible to determine what were natural conditions.

"My Experience With Novocaine"

By Dr. C. M. Burris, Randolph, Neb.

Less than two years ago I read in one of the prominent papers that two of the largest hospitals in Massachusetts were using Novocaine in dental and minor surgical operations with very satisfactory results. I made several efforts to obtain some of the medicine at that time, but was unsuccessful.

Dr. Frank Platt of San Francisco and Dr. Riethmuller of Philadelphia are pioneers in the use of Novocaine. I was fortunate enough to see Dr. Platt give a clinic at Washington, D. C., at the national meeting last September. The patient was a soldier boy about nineteen, who presented a badly decayed but vital first upper bicuspid. Dr. Platt injected the process by the "Tapping" method, using Peritundo, a solution of Novocaine. It took him about three minutes to make the injection. He then waited two minutes, drilled into the pulp with a small bur, took a broach and removed the pulp without the slightest pain to the patient. From that moment I have been a warm friend of Novocaine.

It is only fair to Dr. Riethmuller to say that he gave a clinic that was fully as successful as Dr. Platt's, but I was unable to watch both clinics. Any one who is thinking of using this method should read Dr. Riethmuller's most excellent paper in the February Cosmos.

I have used Peritundo about 275 times, and must admit right here that I have quite a percentage of failures, about twenty per cent, but as I continue its use, I find that my failures are fewer, and I now use it on all the teeth where I formerly used it only on the upper anterior ten. There are three methods given in the directions. I would advise the "tapping" method. I learned another and I believe most of my failures came from that.

I was on the program at the state meeting for a Novocaine clinic, but as my patient failed to come, we devised another scheme. I had a filling in my own mouth that had failed. Dr. Shannon of Lincoln prevailed on to inject the process, and Dr. Baird of Fremont consented to prepare the cavity. The clinic was given and was entirely successful. Dr. Baird found it necessary to expose the pulp and yet "It didn't hurt a bit." The age of the patient, almost fifty, and the tooth being a lower first molar made it a very unfavorable case, and yet the clinic was perfect.

I use a P. D. all metal syringe, Schimmel needle with a small butt. The short needles having less leverage are not nearly so apt to break. The syringe and needle must be kept clean. I dissolve a P. D. Germicidal Disk in four ounces of water, fill my syringe with this and let it remain for five minutes. At the same time I put a short Schimmel needle in a small butt, and boil for at least five minutes.

I then empty the syringe of the germicidal solution, and draw boiling water through it three or four times, then screw the needle on the syringe and draw the Novocaine solution into the syringe. You will never have a case of infection if you are careful with your needle and syringe.

Several doctors have told me that if a needle broken off in the

process is sterilized, no bad effects can follow. I have about three reasons for thinking this statement is true.

In conclusion I wish to state that while Novocaine will fail in some cases, I believe it eliminates more pain and allows us to do better cavity preparation than anything yet given to the profession.

Sulphuric Acid in Cleaning Root Canals

By Dr. Percy J. Hunter, Omaha, Neb.

There seems to be a fear among the younger members of the profession in the use of sulphuric acid. To me it is one of the most important drugs in my cabinet. I will deal with it here only in a mechanical way: while I believe it possesses the therapeutic properties that we little dream of, especially in putrescent canals.

First remove decay and have pulp chamber opened with the canal openings exposed as much as possible. Apply the dam always if possible. Start working a liberal amount of sulphuric acid in the canals with as small a steel broach as will fit in the canal without force and as you open the canal and enlarge it you may use a larger size broach to advantage. I always have a saturated solution of bicarbonate of soda to neutralize the acid from time to time, always drying out and cauterizing with carbolic acid if there is a tenderness in the canals or at the apical space.

Always end the operation of cleansing the canals by thoroughly flooding with soda solution, working it in the canals with broaches the same as you did the sulphuric acid. When you feel you have reached the apex snip off the sharp point of the broach at about the first barb and the danger of your going through the foramen will be lessened while you are enlarging the small canals.

In the above way I feel I can remove the partially calcified layer of odonto-blasts and spicula of secondary deposits quicker and more thoroughly than by any other method. The tubuli are left with free open ends, permitting perfect root canal filling. A great many failures in root filling is because this partially calcified lining of the canals has not been removed: it afterwards decomposes.

HONESTY is not only the best policy, but it is the only absolute guarantee of success. Be honest with yourself and you will find it easy to deal honestly with your customers and competitors.

Tri-City Notes.

This meeting being in the hands of the Council Bluffs members, was held on December 23, at the Grand Hotel in Council Bluffs, where we were served an excellent turkey dinner.

A report was made by Dr. W. L. Shearer, favoring the offer of the Western Medical Review to furnish space for any papers which we might wish to publish and also to maintain therein a Professional Directory of Dentists. This report was adopted.

Dr. Blaine Truesdell reported that he had made arrangements with the Metropolitan Life Insurance Company for the distribution of their booklet, "TEETH, TONSILS AND ADENOIDS," in the schools of Omaha and South Omaha in the near future. About thirty thousand of these books will be distributed for the society.

Dr. C. E. Woodbury, chairman of the evening, then took charge and called on Dr. B. F. Gibbs. Dr. Gibbs cited a case in which the buccal aspect of an upper first molar had been split off by a blow struck on the back of the patient's head with a brass knuckle. This tooth was perfectly sound and free from decay. The question is, "How hard was he hit?"

Dr. Scott Covalt gave a very thorough review of two articles from the Dental Cosmos, one being Dr. T. B. Hartzell's paper on, "The Operative and Post-Operative Treatment of Pyorrhea," and Dr. L. M. Ward's paper, entitled, "Conflicting Opinions Concerning the Manufacture and Use of Alloys for Dental Amalgams."

Dr. Woodbury closed the meeting with a talk on the "Sins of Omission," as follows:

1. Failure to make careful examinations.
2. Proper cleaning of the teeth.
3. Failure to fill temporary teeth.
4. Failure to use the rubber dam.
5. Non-aseptic way of handling treatments.
6. Sterilization of instruments.
7. Failure to sharpen instruments.
8. Use of cheap and unscientific alloys.
9. Failure to polish amalgam fillings.
10. Failure to get inter-proximal space and contact.
11. Failure in preparation of roots for crowns.

He elaborated very nicely on each as he went along and most of us pleaded guilty at least twice during the process.

The next meeting will be held in Omaha on January 20th, with the following in charge: Dr. W. L. Shearer, chairman; Drs. F. F. Whitecomb, H. E. Newton, and C. F. Patton.

A committee meeting of the Western Nebraska Dental Society was held at Bridgeport, office of Dr. W. J. Scoggin, December 9th, to draft constitution and by-laws, also arrange date for Society meeting in February.

OUR NEWS BUDGET



Dr. C. H. Wake has left Omaha to take a position as instructor with the Colorado College of Dental Surgery, Denver. Dr. Wake's unusual ability in cavity preparation and gold foil manipulation had placed him among the foremost dental technicians in Nebraska.

Dr. J. Vernon Jarrett, formerly of Central City, is located at Salt Lake City.

Drs. Calkins Brothers of York, will be moved into their new quarters in the City National Bank building by January 1st. No rooms in the state will be more modern. The building is finished in white terracotta, marble and onyx.

Dr. T. J. Hatfield of York, has postponed his trip to Florida indefinitely.

Dr. M. E. Vance has been appointed secretary for Section 3, National Dental association. Evidently they were looking for one with a will to work hard and at the same time effervesce enthusiasm. If so no mistake has been made and Section 3 at the National next year will show some of the same progressive spirit which makes for Nebraska's growth.

Dr. Clyde Davis has been appointed on the very important committee of Public Health, National Dental association. Dr. Davis, as we have long since learned to expect him to do, went right to work. Through his efforts several articles will appear from time to time in the Lincoln Sunday State Journal along educational lines.

Apply to the gums counter-irritant (aconite, chloroform, iodine, and menthol) before inserting needle. It anesthetizes the mucous membrane and the iodine is the best disinfectant to living tissue. H. C. Brock, D. D. S.

The officers of the Nebraska State Dental Society met at the Hotel Loyal, December 9th, for the discussion of important state society matters. Those present were Drs. J. H. Wallace, F. F. Whitcomb, P. T. Barber, P. J. Hunter, M. H. Dunham and G. B. Baird. There is a determined effort being made by those who have been placed at the head of our state society to make the coming meeting successful along new lines. Just what is meant by new in this case we are not as yet informed, but we do know that Nebraska is about to strike at a weak part in dental society structure—lack of interest at sessions. General sessions should be (for those who would learn) most vital periods. Our state officers are fixing their most serious thoughts on this great society short-coming and if correspondence, hard work, constant consultation, individual contributions in many trips during the year and planning counts for anything, every dentist in the state can well afford to take his time and money to attend this meeting for what he will get from the

sessions. There never has been a set of officers trying more than these. We are going to help: it may be a little but we are going to help.

A committee to be known as the Executive Committee for Nebraska has been appointed by and will be under the control of the Panama Pacific Congress Committee of organization. To organize and bring Nebraska dentists to this congress will be the work of this committee. Those appointed are Dr. E. H. Bruening, Omaha, Chairman; Drs. O. H. Hunt, S. A. Allen, O. H. Cressler, and H. A. Shannon.

Every correspondent was heard from this month; Happy New Year.

Dr. E. J. Perley, '10, Creighton Dental College, was successful in passing the Oregon State Board examination on November 17th, being one of the five to pass out of twenty who took the examination. Dr. Perley will locate in Portland for the practice of his profession.

Wants, For Sale, Etc.

RATE for this space, five cents per word, including headings; initials same as words. Address all communications to Dr. O. H. Cressler, North Platte, Nebr.

FOR SALE—New Model Clark Apparatus and a Stark Somnoform outfit. As I am permanently located with the Colorado College of Dental Surgery at Denver, I will dispose of these at a reasonable price. Address, Dr. C. H. Wake, in care of the college.

ESTABLISHED 1842

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25 " 31.25 (" ")		20 " 25.00 (net cash)
20 " 25.00 (net cash)		25 " 31.25 (5% cash)

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