Dental Infections And the Degenerative Diseases

(Volume II)
(Part I)

BEING A CONTRIBUTION TO THE PATHOLOGY OF FUNCTIONAL AND DEGENERATIVE ORGAN AND TISSUE LESIONS

BY

WESTON A. PRICE, DDS, MS, FACD

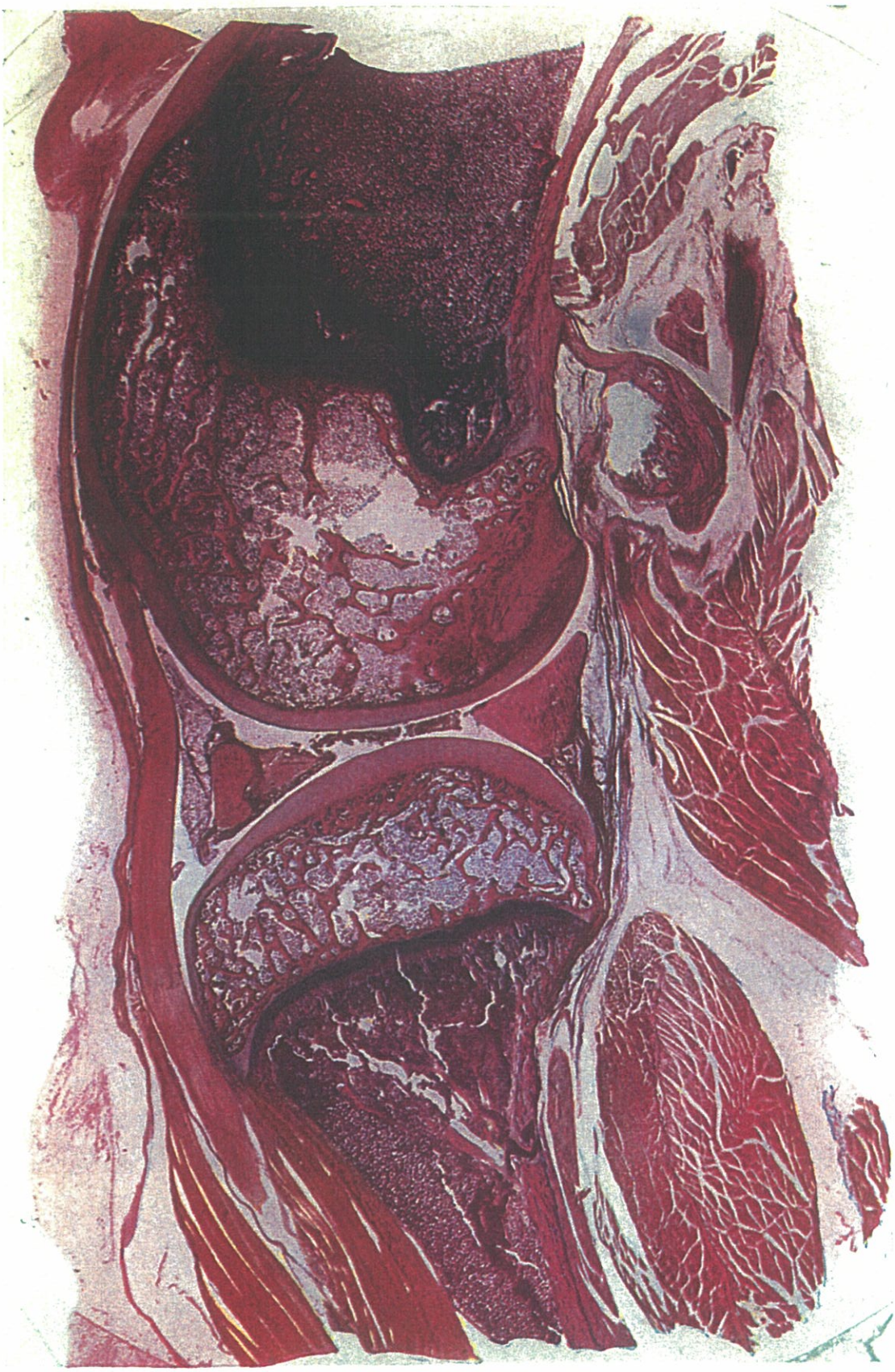
THIS IS THE CLINICAL ASPECT OF VOLUME 1
"DENTAL INFECTIONS, ORAL AND SYSTEMIC"
VOLUME I
PARTS 1 AND II
PRESENTS

RESEARCHES ON FUNDAMENTALS OF ORAL AND SYSTEMIC EXPRESSIONS OF DENTAL INFECTIONS

VOLUME II
PARTS I AND II
PRESENTS
RESEARCHES ON CLINICAL EXPRESSIONS OF DENTAL INFECTIONS

VOLUME II

RESEARCHES ON CLINICAL EXPRESSIONS OF DENTAL INFECTIONS

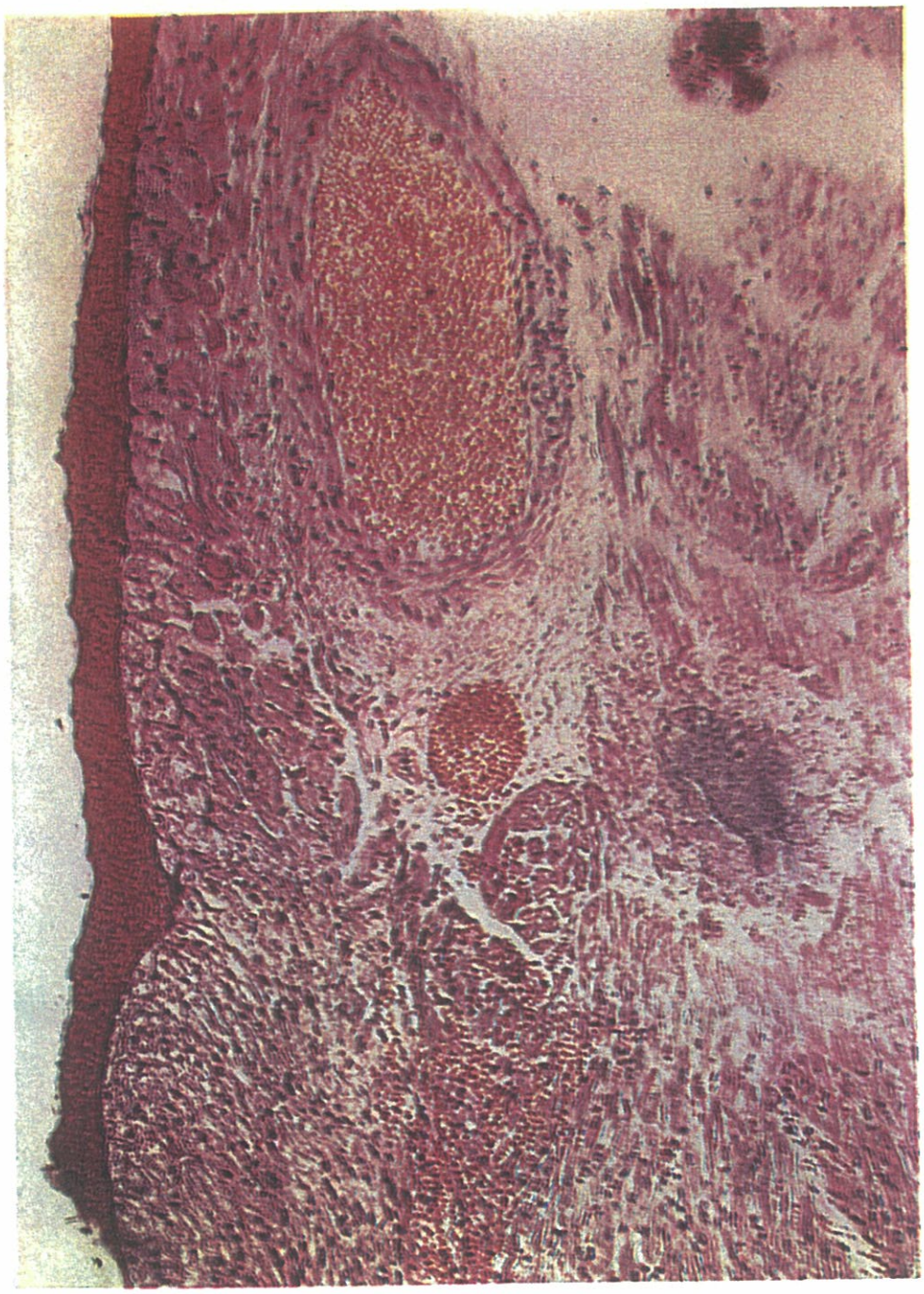


A—Cross section of normal knee joint of rabbit No. 1234.

Frontispiece Vol. II.

B—Cross section of arthritic knee joint of rabbit No. 1234.

Frontispiece Vol. II.



C—SPONTANEOUS INTERSTITIAL HEMORRHAGE INTO HEART MUSCLE OF RABBIT, WITH DEATH IN TWELVE HOURS FROM DENTAL CULTURE. CASE NO. 1346.

FRONTISPIECE VOL. II.

EXPLANATORY NOTES FOR FRONTISPIECES FOR VOLUME II.

A AND B, NORMAL AND ARTHRITIC KNEES.

In Volume I, I have illustrated two quite different types of arthritis, one the **proliferative** *type, characterized by marked proliferation, deformity, and ankylosis, the other, the* **degenerative** *type, characterized by degeneration without fixation but with deformity. Both types tend to destroy the joint cartilages, the first by proliferation changes, chiefly in the synovial membrane and perichondrium, and the second chiefly by degeneration of the body of the cartilage. In Frontispiece A, I have shown a section of a normal knee joint of a rabbit, in which will be seen the normal condition and arrangement of the various joint structures. In B will be seen the other knee of the same rabbit approximately two weeks after the development of an arthritic process resulting from injection into the ear vein of about two-thousandths of a gram of organisms, grown from a tooth. While this magnification is not high enough to show the minute tissue changes, it does demonstrate the gross structural changes. The plane is slightly different from that of the normal shown in A, as it includes the posterior cruciate ligament. The joint capsule was ruptured and the pus had extended into the fascia. The fixed film of congealed pus fell out of the section at the time of sectioning and was lost. There is marked destruction with necrosis of the joint capsule. The articulating cartilages have been practically destroyed, and it would be difficult, if not quite impossible, for this joint ever to return again completely to normal. This is a typical case of suppurative arthritis in the acute stage. (For detailed discussion, see Chapter 64 on Skeletal and Muscular System.)*

C. HEMORRHAGE INTO HEART MUSCLE.

In Volume I, in the chapter on Changes in the Blood Stream, I have demonstrated the ease with which cultures from dental infections may produce marked hematological and serological changes in the blood. These may involve marked change in clotting function of the blood, or produce changes in the walls of the blood vessels re-

sulting in multiple hemorrhages either in special tissues or throughout the body. In Frontispiece C, I have shown in color a section of the heart muscle of a rabbit which died in twelve hours from spontaneous hemorrhages following inoculation with a culture from the teeth of a patient suffering from both myocarditis and secondary hemorrhages. In the upper part of the illustration will be seen an artery in cross section normally filled with blood, the small spheres being blood cells, chiefly red. Note the three layers of the artery wall, the intima, media, and adventitia. Just below it will be seen an arteriole, or capillary, the wall of which has only a single coat, the intima, corresponding with the inner coat of the artery. At the lower part of this it will be noted that this membrane is ruptured and the blood cells are percolating through the tissues and between the muscle fibers as an interstitial hemorrhage. The patient was changed from a distressed invalid to a comparatively normal man by the removal of the dental infections. (For further details, see Chapter 60 on Circulatory System.)

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By

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(Discontinued)

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With Deepest Gratitude and Sense of Indebtedness
for the Devoted and Loving Coöperation and Cheerful Sacrifices
of

My Wife and of Our Deceased Son, Donald,

Who, at Sixteen, Paid with His Life
the Price of Humanity's Delayed Knowledge
Regarding These Heart and Rheumatic Involvements
This Volume is Lovingly Dedicated

Etiology

"In Full Fair Tide Let Information Flow—
That Evil Is Half Cured Whose Cause We Know."

—*CHURCHILL: Gotham,*
Book 2, 652.

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PREFACE

SINCE *this Volume is an analysis of the clinical expressions of systemic dental infections, it is primarily a discussion of their broader symptomatology. I have not, therefore, deemed it needful that I discuss these problems here from the standpoint of furnishing more data in substantiation of the systemic expressions and effects produced by dental infections, since Volume I furnished abundant data to that end. The data, which these researches have developed, are so ample and convincing to me that I see no escape from the conclusion that many of the degenerative diseases—as nephritis, myocarditis, endocarditis, arthritis, neuritis, gastric ulcer, cholecystitis, appendicitis, neurasthenia, psychoneurosis, iritis, retinitis, myositis, pancreatitis, etc., etc.,—have as one of their important, and in many cases their chief causative factor, dental infections.*

The researches recorded in Volume I, on the oral and systemic expressions, make clear why nearly all have been misled by the mistaken premise that absorption of bone is an effect of infection and its extent its measure, confusing activity of the host as being activity of the invader. We mistook reaction for invasion. Potentially, various infected teeth are more nearly comparable than we have thought, the difference being in the reactive defense of the host; and when an adequate defensive reaction does not occur close to the source of infection, it only means that that combat must take place somewhere else. Every individual with an infected tooth, therefore, must have either an efficient quarantine station immediately about that tooth, as a granuloma, or have, as the result of that warfare taking place elsewhere, some systemic effect, which effect will appear in the weakest tissue, not the strongest. The weak tissue will be determined, as I have shown in Volume I, by inheritance in part and by overloaded or injured tissue in part. It is probably seldom, if ever, the case that the dental infection is the only contributing factor.

I have not repeated over and over, out of fear of being misunderstood, that I do not believe dental infections to be the only sources of these systemic troubles because of my confidence in the good sense of the readers. This is not a work on the systemic expressions of focal

infections of other types, as, for example, the genito-urinary tract. It is, however, applicable to all forms of focal infections of streptococcal origin, especially when existing in bone, for the same laws of susceptibility, defense, overloads, etc., will obtain; and a streptococcal (or staphylococcal) infection will finally contaminate and assist that infection which will finally take the lives of nine out of ten of us as we go out with some one or more of the degenerative diseases. Where will the streptococcal culture come from? In many cases from infected teeth and the secondary lesions planted by them throughout the body. In nine out of ten of us that final combat may come as a premature so-called old age or degenerative disease, and many years before it should, not only because of needless dental infections, but also because of other overloads, one of the most important of which is faulty nutrition and diet. I have shown, for example, that a normal rat will exfoliate an infected tooth, when planted beneath the skin, in an average of six days, while it will take over forty days for rats on a deficiency diet to do so. As I see it now, the diet deficient in mineral bases produces many organ and tissue lesions, such as those of the kidney and blood vessels, which weakened structures readily become infected if a source, such as an infected tooth, exist, and together they produce a grave nephritis. Time after time, however, we have seen the albumin disappear from the urine after the removal of the dental infection without changing the diet. It is better, of course, to do both. Similarly, this volume will detail many cases of heart involvements relieved so completely as to justify a new prognosis for many of these heretofore grave cases.

The importance, if not grave necessity, for these intensive researches is suggested by the following facts:

(1) In the statistical areas of the United States, as also of England and Wales, the percentage of deaths of all ages attributed to premature failure of the heart function exceeds 10 per cent.

(2) The percentage increases very rapidly above forty years of age, and at sixty-five being above 20 per cent.

(3) It is estimated that subacute endocarditis is caused in 95 per cent of cases by Streptococcus Viridans. (Libman: J.A.M.A., Vol. 80, No. 12: Characterization of various forms of endocarditis.)

(4) In the culturing of several thousand teeth with pulp involvements more than 99 per cent have been found to be infected with diplococci or streptococci (mostly green-producing or viridans).

(5) Statistics of the United States Public Health and Census Departments indicate that while the death rate from infectious

diseases is decreasing, it is increasing for heart involvements, kidney involvements, and other degenerative diseases.

(6) The great majority of adult individuals are carrying seriously infected teeth, potentially capable of producing degenerative diseases if the local and systemic quarantine breaks down.

(7) The great majority of adults and children are, therefore, carrying as dental foci, the strains of organisms which are found in a great majority of heart, kidney, joint and muscle, and nerve lesions, and which are potentially capable of producing these in the absence of an adequate defense.

If mankind be now passing through the third great transition forward—the first being the development of the thumb, perfecting the hand; the second, the development of the stone implements, and this, the third, his mastery over his parasitic enemies—an opportunity has come to the members of the medical and dental professions, infinitely greater than to any other of the sciences of mankind, to contribute to man's upward march to the position of a superman. Could any compensation compare with this aristocracy, the members of which have been selected for the unique service of lengthening days and wiping away the tears from many eyes? How the words of Christ "Ye shall know the truth and the truth shall make you free" are being fulfilled over and over these days by the ridding of the world of the great devastating infective plagues! May it not be that likewise the chief remaining plague—the degenerative diseases—shall likewise be reduced and ultimately banished from civilized society as it is from the simply living animal world and some of the simply living human tribes?

In the Journal of the American Medical Association (September 15, 1923) there is a report from the London correspondent, under the subtitle "The Dental Condition of the Population," calling attention to a report from a government committee as follows: "It was now known, on the authority of a government committee's report that one-third of all the diseases in the country was due, directly or indirectly, to dental disease." If that be true, and I believe it is in many communities, that third of human misery can be, and will be largely banished: first, by proper nutrition and mastication; second, by proper prophylaxis; and third, by proper dental surgery, the latter being unnecessary in proportion as the other two are efficient.

This volume contains a review of cases which are typically illustrative of their classes. They have been selected from many thousand, most of whom have been benefited, and many very greatly. The

chief messages, therefore, of this volume are first to demonstrate the types of degenerative disease that may be benefited by removal of dental infections; second, to demonstrate the types of cases that may be prevented and, therefore, never require to be corrected, and third, to demonstrate the conditions, which, when established, may never be relieved and may constitute a living death more horrible than any inquisitor's rack, and, at present, preventable only by an adequate preventative program.

I am profoundly indebted to these patients for their complete and helpful coöperation, without which these researches could not have been carried foward and recorded; and the testimony of their extended years of life and comfort constitutes the only answer that is needed to the question of the relation of dental infection to the degenerative diseases.

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September, 1923
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CHAPTER LVIII.

INTRODUCTION TO CLINICAL APPLICATIONS OF NEW INTERPRETATIONS.

DISCUSSION.

In the following chapters we will review the results of applying these principles in approximately two thousand cases with systemic involvements, and from these we will select typical illustrations of various types of lesions and outline, in more or less complete detail, our methods of study and the clinical results, and in a large number of cases will present the results of animal experimentation with the cultures taken from the case in question. The basis on which the cases have been selected, to illustrate the applications, has been quite largely the degree of completeness of the data. For example, in cases where we could not secure quite complete family histories, we have excluded these charts from the records included on susceptibility, or where individuals have gone out of our direct observation. We have endeavored to show exceptions to rules in order that we might explain our interpretations for them; and, particularly, we have tried to select typical failures as being quite as helpful as successes.

Our basis of classification has been that suggested by Raymond Pearl,* and is based upon the biological classification of tissues. It has the advantage, that lesions in associated tissues may be considered consecutively and in more intimate relationship, than would be possible with the ordinary anatomical classifications.

It should be noted that the patients coming to a diagnostic clinic would tend to be quite dissimilar from those presenting in an ordinary dental practice. It, therefore, will not be possible for general practitioners and specialists to make direct comparisons of general data, though they may of special, for there is constant danger that the specialist seeing, as the majority of his patients, those in the breaking class, will tend to read into pathology of lesions a much greater danger, than the general practitioner who is dealing largely with well people rather than ill, and who sees

*From Proceedings of National Academy of Sciences, Dec. 1919, Vol. 5, No. 12

such large proportions of his clientele without apparent injury. This latter operator must keep in mind that whereas the former, the diagnostic specialist, is quizzing every patient in detail and therefore disclosing many affections which the patient was not associating, although important and definitely established, the general practitioner will usually have no knowledge of such conditions if they exist, both because he is used to seeing so large a proportion of his patients free from such lesions and because he makes no special and adequate effort to disclose the conditions, even when present.

We will, accordingly, take up the study of these problems in the order implied by the following classification of tissues on the basis of their biological characteristics:

1. Circulatory system.
2. Respiratory system.
3. Primary and secondary sex organs.
4. Kidneys and related excretory organs.
5. Skeletal and muscular system.
6. Alimentary tract and associated organs.
7. Nervous system and sense organs.
8. Skin.
9. Endocrine system.
10. All other tissues.

As I proceed in the following chapters to make an application of the data developed in the preceding researches, I shall be compelled to leave out of this report detailed statements involving methods of procedure. Laboratory methods are of great importance and, of course, fundamental for the individuals making the particular determinations. It is not feasible, however, to combine in a single book a manual of laboratory technic with a discussion of clinical and structural pathology. I am, accordingly, accumulating for a separate publication, various data that will be most helpful in diagnosis, prognosis, treatment, and prevention. This text will be too voluminous without that extensive discussion. All biological chemists will be familiar with the literature and methods for the various chemical procedures involved in the determinations herewith presented. As a further assistance to them I am presenting as an appendix to this, a bibliography of the reference literature involved.

In Volume I, I have presented a quantity of new data which has indicated the necessity for important new interpretations of fundamentals, one of the most urgent of which is a complete change in conception and understanding of the meaning and significance of the various types of reaction about infected teeth. Much of the present diagnosis is based upon a misconception of the nature of the defensive reactions about an infected tooth. I have shown that that individual or animal is most safe that can carry on the most vigorous reaction immediately about the infected tooth and that the structural changes that take place are primarily an indication of the activity of the host rather than of the invading organism. To impress further this point I am showing here four views of the reaction produced by a rat, which animal has a higher defense for streptococcal infections than either humans or rabbits.

In Figure 262-B will be seen a granulomatous type of tissue which is the defensive structure produced by this animal. This surrounds completely the apex of the infected tooth. This rat with its high defense is able to carry his warfare up to and into intimate contact with the tooth's surface. The no-man's-land between these two engaging forces is somewhere in the tooth structure, whereas in most humans on some parts of the tooth it is some distance away from the tooth structure. Only those individuals are able to absorb an infected tooth who can carry their attacking forces completely up to the tooth surface and as the host's defense goes down this point of contact moves back away from the tooth until in broken defense it is distributed all through the body. In A of Figure 262-C, it will be noted that this warfare of the host is actually busy tearing down the infected tooth to dismantle it. These cells have as their primary function the defending of the host. In B two foramina are shown, which penetrate the cementum, and it will be noted that these defensive cells have penetrated deeply into these minute chambers in search of the enemy by a process of chemotaxis. In Figure 262-D will be seen a higher magnification of this process, which shows in a most graphic and striking way their effort seemingly to crowd each other away in order that they may be able to get at the enemy.

In Volume I, I have shown these cells passing into glass tubes in search of the enemy by this same fundamental law of chemical attraction of these defensive cells toward attacking in-

FIGURE 262-B. GRANULOMA-LIKE DEFENSIVE MEMBRANE CONSTRUCTED ABOUT THE ROOT OF AN INFECTED TOOTH, IMPLANTED BENEATH THE SKIN OF A RAT. NOTE ITS HIGH VASCULARITY AND INTIMATE CONTACT WITH THE ROOT, WHICH IS BEING ABSORBED BY IT. RATS HAVE RELATIVELY HIGH DEFENSE FOR STREPTOCOCCAL INFECTIONS.

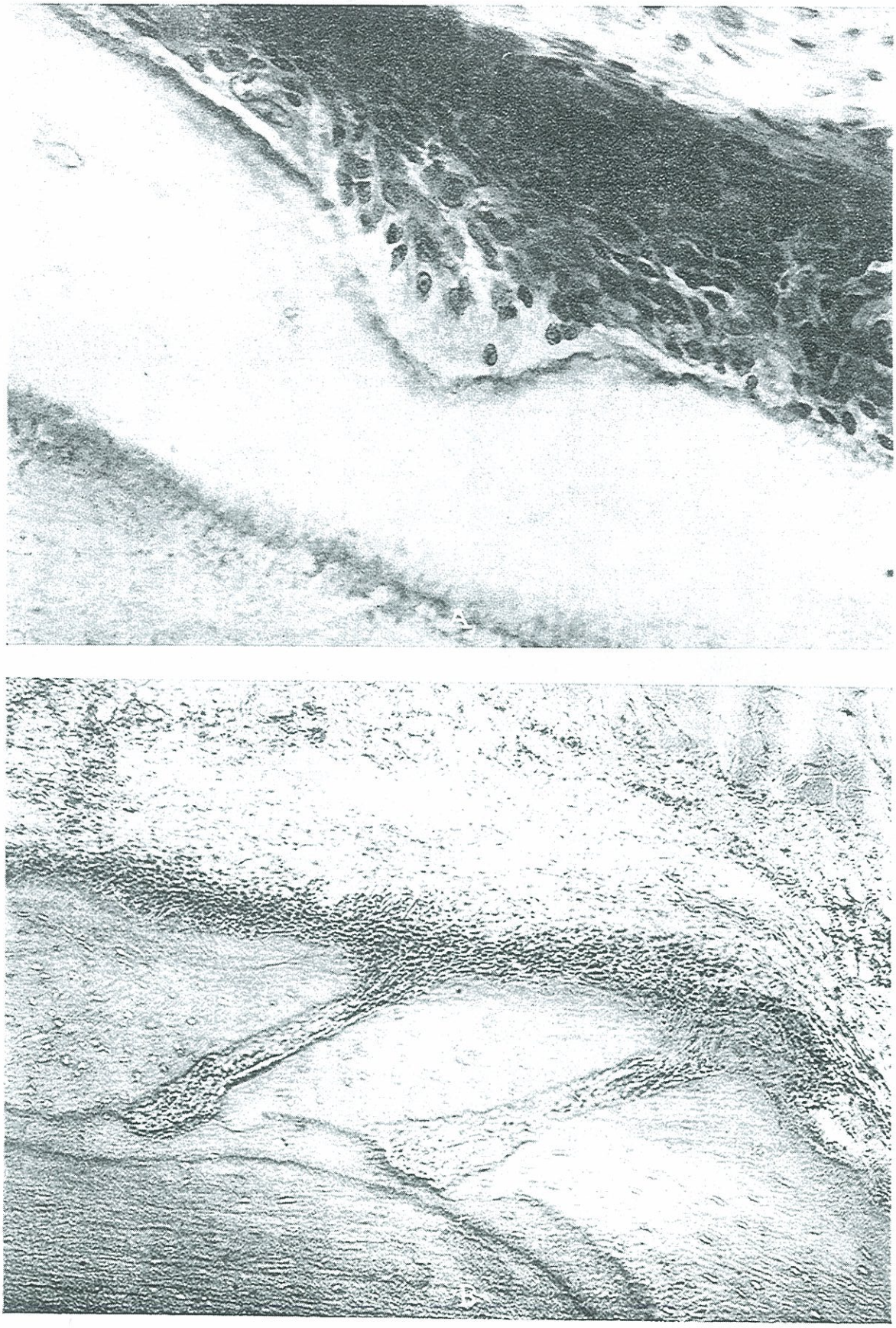

FIGURE 262-C. HIGH POWERS OF DEFENSIVE REACTIONS OF THE RAT. A SHOWS ABSORPTION OF THE CEMENTUM BY CELLS WITH AN OSTEOCLASTIC AND DEFENSIVE FUNCTION; B, THESE CELLS PENETRATING TWO FORAMINA BY CHEMOTAXIS.

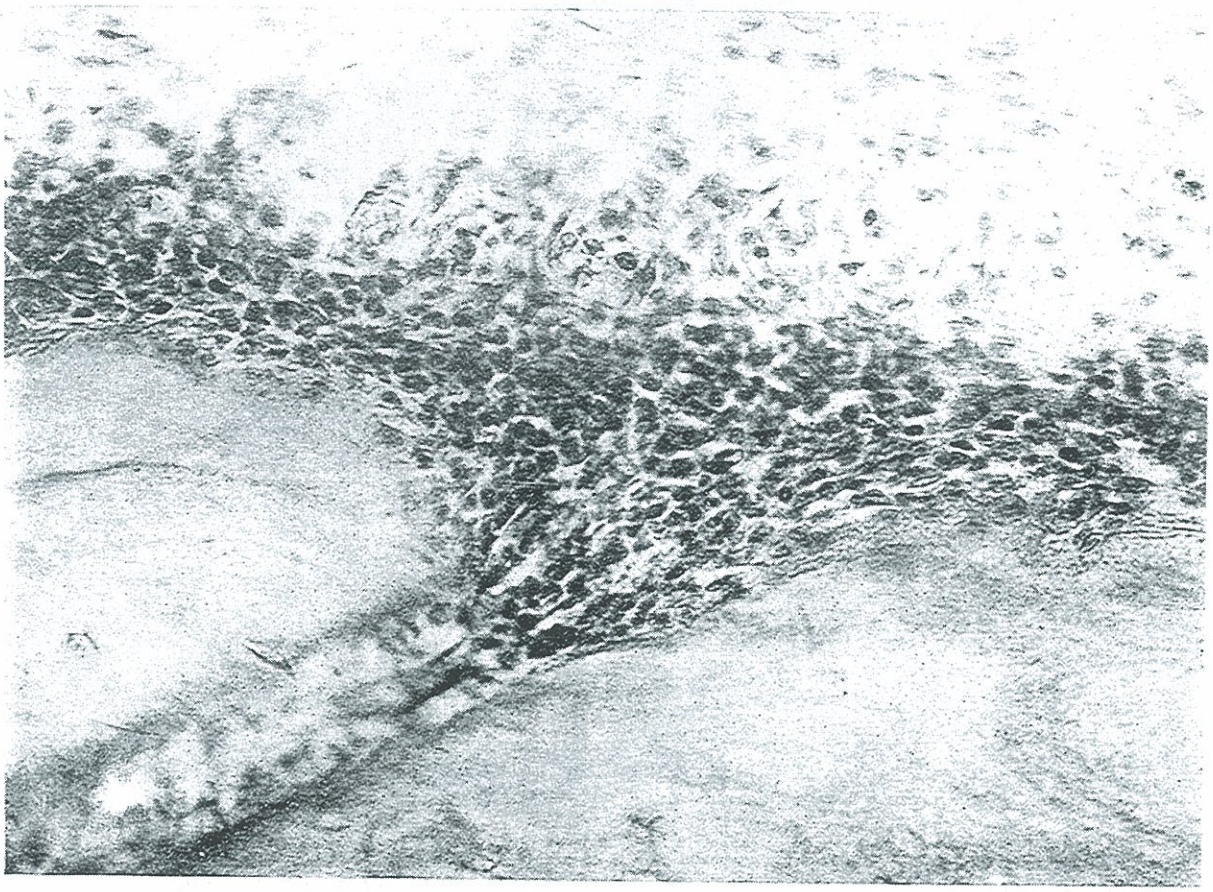

FIGURE 262-D. HIGH POWER OF ONE OF THE FORAMINA OF PREVIOUS FIGURE. NOTE THE EVIDENCE OF A COMMON RESPONSE TO A GENERAL FORCE—NAMELY, CHEMOTAXIS—BY WHICH THESE CELLS ARE ATTRACTED TO THE TOXINS AND THE BACTERIA PRODUCING THEM. THEY ARE ALSO ABLE TO FUNCTION AS OSTEOCLASTS. EACH CELL IS A FLOATING GLAND CARRYING ANTIBODY AND ANTITOXIN TO NEUTRALIZE THE ANTIGENS AND TOXINS PRODUCED BY THE BACTERIA. HIGH DEFENSE IN HUMANS OR ANIMALS, AS DEMONSTRATED BY THIS RAT, IS DEPENDENT UPON THE DEVELOPMENT AND DELIVERY OF A LARGE ENOUGH QUANTITY OF THESE DEFENSIVE SUBSTANCES TO CARRY THE AGGRESSIVE WARFARE TO THE IMMEDIATE ZONE OF THE STREPTOCOCCAL INVADER, OR AS CLOSE AS IS PHYSICALLY POSSIBLE, THE LIMITATION BEING THE PHYSICAL PROTECTION IN THE MECHANICAL ENVIRONMENT WHICH IS PROVIDED BY AN INFECTED TOOTH STRUCTURE, FOR THE DENTIN OF A SINGLE-ROOTED TOOTH CONTAINS APPROXIMATELY THREE MILES OF CLOSED CHANNELS SUITABLE FOR BACTERIAL GROWTH.

fections, provided that (and herein lie the tragedies that constitute this volume) the individual does not have these defensive forces, either lacking by inheritance or by overload, or overwhelmed by the presence of the infection through the instrumentality of its toxins. If we will keep this important interpretation in mind as we study the successive illustrations of the clinical expressions, which accompany and are the result of a broken defense, it will, in a most important way, help to clarify the involved problems.

Since the clinical data and procedures recorded in this volume are the result of the application of the data developed in Volume I, I am repeating herewith for ready reference and guidance the *New Interpretations* along with the *Old*, from which they were developed but have not given here the data on which the new are based. These will be found in the various research chapters, 1 to 44, in Volume I, and in the twelve chapters on interpretation, 45 to 56 inclusive. Problems 1 to 17 are current or old fundamentals for diagnosis, prognosis, and treatment, for which I have given new interpretations. In Chapters 18 to 44 I have presented new problems which I consider to be additional fundamentals.

OLD INTERPRETATIONS	NEW INTERPRETATIONS
NO. 1. ROENTGEN-RAY LIMITATIONS	
(a) Roentgenograms of teeth will reveal the presence of infection. *(b) The apparent extent of the absorption is the extent of the infection.* *(c) An area of absorption, if present, can be disclosed by the roentgenogram.*	**(a) Roentgenograms do not reveal infection, and may or may not reveal its effects.** **(b) The extent of the absorption does not express the extent of the infection, except in part as that individual's reaction to the infection is understood.** **(c) An area of absorption of the supporting tissue at the apex of a tooth, or laterally, may not be disclosed because of any of the following conditions; (1) Being hidden by a part of that tooth, such as another root; (2) A heavy mass of bone, such as the malar bone; (3) A layer of condensing osteitis obscuring the rarefying osteitis.**
NO. 2. BACTERIAL CAUSE.	
If dental infections produce disturbance in other parts of the body, it is because the organism that has chanced to invade that tissue is one having the specific qualities for that invasion and localization regardless of the host, much as the organisms of erysipelas and mumps will respectively select the skin and parotid gland.	**Dental infections involving root canals and their apices and supporting structures practically always contain streptococci, of which, biologically, there are many types or strains, any one of which may be the important causative factor for any of the various types of rheumatic group lesions, regardless of biological classification. The elective localization and attacking qualities are developed by the environment and are, consequently, a factor of the soil or host.**

OLD INTERPRETATIONS	NEW INTERPRETATIONS

NO. 3. LOCAL-ORAL-STRUCTURAL CHANGES.

(a) Dental infection in bone will express itself as absorption.

(b) A given dental infection will express itself in the local tissues of the mouth approximately the same in all people.

(a) Dental infection in bone may express itself as absorption, even extensive absorption, or may be attended by very little or no absorption, or may even produce a marked increase in the density of the bone.

(b) A given dental infection will not express itself in the local tissues of the mouth approximately the same in all people. People tend to divide into groups with regard to this matter of local reaction, which groups are very dissimilar.

NO. 4. SYSTEMIC REACTIONS. ARE HUMAN BEINGS COMPARABLE?

Human beings are similar in their susceptibility to reactions to dental infections, or sufficiently so, that they may be considered comparable and be judged by the same standards.

Human beings do not react with sufficiently uniform similarity to justify the premise that they can all be judged by the same standards and, therefore, may be considered comparable in their susceptibility to systemic involvement from dental infections. They can, however, be divided into groups, the members of which are sufficiently similar to be judged by the same general standards, and they of that group may, therefore, be considered comparable. On the basis of this quality of susceptibility, they readily classify into three groups; namely, those with an *inherited* susceptibility, those with an *acquired* susceptibility, and those *without* a susceptibility to rheumatic group lesions.

NO. 5. RELATIONSHIPS BETWEEN LOCAL AND SYSTEMIC EXPRESSIONS.

Since, according to the presumption all individuals are similar, and since dental infections are entirely dependent for their characteristics upon the type of organism which has chanced to secure access, therefore there are no characteristics of the local tissue pathology which are related to the degree of susceptibility or nature of systemic involvement.

Local dental pathology about an infected tooth has variations which make grouping and classification easily possible on this basis, which groups have a direct relationship with similar groupings that can be made on the basis of susceptibility to rheumatic group lesions. The local and systemic expressions are not only related, but are both symptoms of the same controlling forces and conditions.

OLD INTERPRETATIONS	NEW INTERPRETATIONS
NO. 6. VISIBLE ABSORPTION AND TOOTH INFECTION.	
(a) A tooth without visible absorption at its apex is not infected. *(b) A tooth with visible absorption at its apex is infected.*	(a) Teeth without absorption at their apices can be, and frequently are, infected in the pulp, dentin, and apical tissue. (b) Teeth with periapical absorption can have the same produced by irritating medication or trauma.
NO. 7. CARIES AND PULP INFECTION.	
Pulps of teeth not exposed by caries are not infected.	Teeth with moderate caries frequently, and with deep caries generally, have their pulps already infected to some extent through this channel.
NO. 8. PERIODONTOCLASIA AND PULP INFECTION.	
Pulps of teeth with pockets from periodontoclasia not involving the apex are not infected.	Teeth with shallow or moderate pockets from periodontoclasia frequently, and with deep pockets from periodontoclasia usually, have their pulps already infected to some extent from that source.
NO. 9. CARIES. AND SYSTEMIC INVOLVEMENT.	
There is no relationship between caries and systemic involvements.	Susceptibility to dental caries and systemic involvements from dental lesions are proportional, both as cause and effect and as related symptoms.
NO. 10. PERIODONTOCLASIA AND SYSTEMIC INVOLVEMENT.	
With an increase of susceptibility to periodontoclasia, there is a marked increase in susceptibility to rheumatic group lesions.	Individuals with marked susceptibility to periodontoclasia have, as a group, a decreased susceptibility to the rheumatic group lesions during the period of its active development (in its secondary stages it may contribute to rheumatic group lesions); or expressed otherwise, individuals with a very marked susceptibility to rheumatic group lesions tend, in general, to be free from extensive periodontoclasia; and when rheumatic susceptibility does develop, it would generally be classed as an acquired factor.

OLD INTERPRETATIONS NEW INTERPRETATIONS

NO. 11. PERIODONTAL AND APICAL REACTIONS.

There is no relationship between the extent of apical absorption from a pulp involvement and the presence or absence of a periodontal absorption from a gingival irritation.

There is a direct relationship between tendency to absorption of alveolar bone in response to irritation, whether at the gingival border or at the root apex; and individuals with extensive periodontoclasia have, for a given dental infection, much more extensive areas of absorption at the apices of infected roots, than do patients without a tendency to periodontoclasia.

NO. 12. RELATION OF APICAL ABSORPTION TO DANGER.

The quantity or extent of the absorption is a measure of the danger; or otherwise expressed, the size or extent of the disclosed area of absorption at the apex of the root of a tooth is directly an expression of the quantity of infection and, therefore, a measure of the danger from it.

Since different people react differently, through a wide range, to a given infection, the extent of the area of absorption is not a measure of the danger; but, on the contrary it may be, and frequently is true that the patient suffering severely from a systemic reaction caused by a dental infection shows very little absorption compared with that which the same dental infection would produce in a patient with ample and high resistance.

NO. 13. NATURE OF FISTULA DISCHARGE.

Flowing pus from a fistula is, necessarily, very dangerous to the patient since it is an expression of the quantity of local infection and, therefore, a measure of the danger from it.

Since an adequately active defense against a dental infection, both locally and systemically, produces a vigorous local reaction with attending extensive absorption and the products of inflammatory reaction, namely, exudate and plasma in sufficient quantity to require an overflow, usually spoken of as pus from a fistula, this overflow may be, and usually is, evidence of an active defense and is constituted almost wholly of neutralized products and is often sterile, and such a condition is much more safe than the same infected tooth without such an active local reaction.

OLD INTERPRETATIONS

NEW INTERPRETATIONS

NO. 14. ROOT CANAL MEDICATIONS.

(a) Infected teeth can be sterilized readily by medication.

(b) Usual medications do not injure the supporting structure.

(a) Infected teeth can be completely sterilized in the mouth only with great difficulty, or by the use of medicaments whose irritability readily injures the vitality of the supporting structures of the teeth.

(b) Many of the usual methods used for the sterilization of infected teeth do serious injury to the supporting structures about the teeth.

NO. 15. ROOT CANAL FILLINGS.

Root fillings fill pulp canals and continue to do so.

Root fillings rarely fill pulp canals sufficiently perfectly to shut out bacteria, completely or permanently. Root fillings usually fill the pulp canal much less perfectly some time after the operation, than at the time of the operation, due to the contraction of the root-filling material. The ultimate volume contraction of the root filling is approximately the amount of solvent used where a solvent is used with gutta-percha as a root-filling material. Infection is a relative matter, and quantity and danger are both related to defense, which defense may vary from high to exceedingly low.

NO. 16. COMFORT AS A SYMPTOM.

Local comfort and efficiency of treated teeth are an evidence and measure of the success of an operation.

Local comfort not only is not a certain index of success or safety, but may constitute both what is probably one of the greatest paradoxes and one of the costliest diagnostic mistakes through injury to health, that exists in both dental and medical practice, because it may only mean the absence of local reaction which would, if present, incidentally make the tooth sore and fundamentally destroy the infection at its source whereas, the absence of this local reaction and its consequent destruction of the infection products, permits them to pass throughout the body to irritate and break down that patient's most susceptible tissue, which tissue can be anticipated very frequently, if not generally.

OLD INTERPRETATIONS

NEW INTERPRETATIONS

NO. 17. CAPACITY FOR INFECTION OF ROOT-FILLED TEETH

When infected teeth produce disturbance in other parts of the body, it is primarily because the patient is overwhelmed by a large quantity of infection.

When infected teeth produce disturbance in other parts of the body, it is not necessary that the quantity of infection be large, nor is it demonstrated that it is necessary that organisms always pass throughout the body or to the special tissues involved, but the evidence at hand strongly suggests that soluble poisons may pass from the infected teeth to the lymph or blood circulation, or both, and produce systemic disturbances entirely out of proportion to the quantity of poison involved. The evidence indicates that this toxic substance may, under certain conditions, sensitize the body or special tissues, so that very small quantities of the toxin or of the organisms which produce it, may produce very marked reactions and disturbances in that tissue.

The preceding research problems cover the fundamentals that have been in general consideration in problems of dental diagnosis, prognosis, and treatment. My researches upon them have opened up many additional problems, twenty-seven of which I have presented in the latter part of the preceding chapters. There cannot, therefore, be given for these latter problems, an old and a new interpretation. I will, accordingly, present herewith, some general interpretations growing out of the general applications and later researches, and in place of the statement of the problem as an old fundamental in the left-hand column, as in the first seventeen chapters, will simply state the problem.

NEW PROBLEMS

NO. 18. STUDIES OF PULPLESS TEETH.

Have pulpless teeth injurious contents other than microörganisms?

Infected teeth may contain in addition to microörganisms toxic substances, which produce very profound effects upon experimental animals, and which tend to prepare the tissues of the host, at least in some cases, for a more ready invasion by the organisms growing in that tooth.

NEW PROBLEMS NEW INTERPRETATIONS

NO. 19. HEMATOLOGICAL CHANGES IN THE BLOOD.

What changes are produced in the blood and sera of the body by dental infections?

Dental infections may produce very serious changes in the blood and sera of the body, some of the most frequent of which are leucopenia, erythropenia, lymphocytosis, and hemophilia.

NO. 20. CHEMICAL CHANGES OF THE BLOOD.

What are the chemical changes that are produced in the blood by acute and chronic dental focal infections?

Dental focal infections tend to produce, in many instances, one or several chemical changes in the blood, which changes tend also to be produced in animals when an infected tooth is placed beneath its skin, and, similarly, with certain methods of inoculation with the culture grown from these teeth. Some of the changes most frequently found involve:

(a) The ionic calcium of the blood.

(b) The presence of a pathologically combined quantity of calcium in the blood.

(c) A reduction of the alkali reserve of the blood.

(d) The development of acidosis.

(e) An increase in the blood sugar.

(f) An increase in the uric acid.

(g) The development of nitrogen retention.

(h) The development of products of imperfect oxidation.

NO. 21. CONTRIBUTING OVERLOADS WHICH MODIFY DEFENSIVE FACTORS.

What are the contributing factors causing a break in resistance?

Dental infections, while potentially harmful, may not be causing apparent or serious injury until the individual is subjected to some other overload, at which time a serious break may come. The chief contributing overloads are influenza, pregnancy, lactation, malnutrition, exposure, grief, worry, fear, heredity, and age.

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NO. 22. ELECTIVE LOCALIZATION AND TISSUE AND ORGAN SUSCEPTIBILITY PHENOMENA.

Do the organisms of dental infections possess or acquire tissue affinity and elective localization qualities?

Dental infections may or may not contain organisms with a specific elective localization quality for certain tissues of the body. When they do so it is generally because the host is suffering, or has previously suffered, from an acute process in that tissue, which acute process frequently, entirely and permanently, disappears with the removal of the focus of infection. There is evidence to indicate that the complete removal of an organ so affected does not destroy that elective localization quality in the microörganisms of the focus. Defense and absence of defense to streptococcal infection as an organ and tissue quality, seems definitely to be related to inheritance and, as such, obeys the laws of mendelian characteristics.

NO. 23. ENVIRONMENT PRODUCED BY INFECTED PULPLESS TOOTH.

What are the characteristics of the habitat and environment furnished for bacteria in an infected pulpless tooth?

Since an infected tooth is a fortress for bacteria within the tissues of the host, and since, in accordance with the laws governing the behavior of solvents and solutes, the dissolved substances within the tooth can pass to the outside of it, and, similarly, the dissolved substances outside the tooth can pass to the inside of it, together with the fact that the defensive mechanisms of the body are quite unable to enter and reach the bacteria within the tooth except in exceedingly small numbers through the natural openings of the root, which openings will, however, permit the organisms to pass at will from within the tooth to the outside, we must conclude that an infected tooth furnishes a condition and environment that is tremendously in favor of the invading organism inhabiting it, as compared with the host, since the latter may only rid itself of the menace by exfoliating it or absorbing it.

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NO. 24. ELECTIVE LOCALIZATION AND ORGAN DEFENSE.

Do diseased organs and tissues modify bacteria growing in the distant focus, or create in them a capacity for localization for those diseased tissues?

We are led to conclude from the available data, that we do not as yet have sufficient information to draw a close distinction between the influences of the organisms on the affected organ, in contradistinction to the influences of the diseased organ upon the organisms in the focus. The available data suggest strongly, if they do not definitely indicate, that both these conditions exist, in some instances, either one acting entirely alone, and in some others there are indications that both exist at the same time.

NO. 25. RELATION OF IRRITANT TO TYPE OF REACTION.

Have we different products from dental infection?

The evidence available indicates that infected teeth elaborate two distinctly different products, one being bacteria, and the other a toxic substance or group of toxic substances, which, independently of the organisms developing them, may produce various and profound disturbances in tissues in various parts of the body, one of the important group of disturbances being that of the blood stream.

NO. 26. CHEMOTAXIS AS A MEANS FOR INCREASING DEFENSE.

Can defense for streptococcal infections be increased by introducing enterally or parenterally (by ingesting or injecting) chemicals?

These preliminary experiments would seem to suggest that, means can be developed which will effectually assist, by chemical means in the defense of the body against the invading streptococcal organisms of dental origin or from other sources which produce the rheumatic group lesions.

NO. 27. THE EFFECT OF RADIATION ON DENTAL PATHOLOGICAL LESIONS.

Can periodontoclasia and apical abscess and inflammation be cured by various types of radiation?

(a) These three forms of radiation—namely, Roentgen-ray, radium radiation, and ultraviolet as generated from mercury vapor and quartz tube—have definite effect

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on cell resistance and proliferation, and thus directly upon tissue reaction expressions such as pus, bacterial invasion, and granulation.

(b) Some of these forces are apparently definitely harmful; others are apparently definitely helpful.

NO. 28. GINGIVAL INFECTIONS, THEIR PATHOLOGY AND SIGNIFICANCE.

Are the present theories regarding the etiology of periodontoclasia, or so-called pyorrhea alveolaris, correct?

(a) Inflammatory processes of the tissues about the teeth are a direct expression, and therefore a measure of the vital capacity for reaction of that individual to an irritant, during those stages of these lesions, characterized by an abnormally high vital reaction.

(b) The individual, who has had this capacity for a very active reaction to the presence of irritants, may pass into a condition or state in which he or she has lost that high defensive factor, at which time several changes develop including a cessation of the absorption of alveolar bone, a lowering of the alkalinity of the periodontoclasia pockets, a change in their bacterial flora, all of which may provide under these later conditions a focus for systemic infection of the most dangerous type, though they may have ceased to have evidence either of local inflammatory disturbance, or exudate as pus.

(c) To the ordinary observer, lay or professional, these two very dissimilar states are considered to be similar or identical though they are potentially very different.

(d) These different peridental expressions or reactions to irritations are accompanied by, and doubtless related to, changes in the ionic calcium and alkali reserve of the blood.

NO. 29. ETIOLOGICAL FACTORS IN DENTAL CARIES.

What are the dominant etiological factors in dental caries?

Dental caries is dependent upon the following factors:

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(a) A reduction in the hydrogen ion concentration of the normal environment of the tooth.

(b) An acid producing bacterium.

(c) A change in the chemical constituents of the pabulum bathing the tooth.

NO. 30. THE NATURE OF SENSITIZATION REACTIONS.

Do dental infections produce sensitizations of an anaphylactic character?

(a) Teeth contain substances other than bacteria to which the individual may become sensitized, and which substances may, in addition, have strong toxic properties.

(b) The evidence here presented suggests that dental infections are capable of producing in an individual a state of anaphylactic sensitization, which condition may entirely and apparently permanently disappear with the removal of the dental infections. These disturbances may occur in dermal tissues, mucous membranes of the nose and throat, lacrimal tissues, mucous membranes of the bronchioles and air passages, as asthma, and the mucous membranes of the digestive tract and a number of other types of tissues.

NO. 31. PRECANCEROUS SKIN IRRITATIONS.

Are there relationships between precancerous skin irritations and dental infections?

The evidence available suggests:

(a) That dental infections may produce localized anaphylactic reactions, as irritations of the skin and mucous membranes.

(b) That these sensitizations may develop into precancerous conditions.

NO. 32. DENTAL INFECTIONS AND CARBOHYDRATE METABOLISM.

What, if any, is the relationship between dental infections and carbohydrate metabolism?

Dental infections may produce marked changes in carbohydrate metabolism and probably structural and degenerative changes in the islets of Langerhans of the pancreas, with the production of hyperglycemia and glycosuria.

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NO. 33. MARASMUS.

Why do people with rheumatic group lesions tend to be underweight?

Dental infections, when they affect the patient systemically, frequently, if not generally, produce a depression of the individual's weight; and marasmus, whether mild or severe, may be considered one of the diagnostic symptoms in studying the relation of dental infections to general health.

NO. 34. PREGNANCY COMPLICATIONS.

Do dental infections have a bearing on pregnancy complications?

(a) These researches have shown that in animals, infections from dental origin may have a very far-reaching effect on each the expectant mother and her fetus, which latter may be prematurely expelled or may be rendered lifeless.

(b) Inasmuch as a large number of our serious cases of rheumatism, heart, and kidney involvements, have their origin at the time of pregnancy in humans, in which cases our clinical histories show that there have been present extensive dental focal infections, it is suggested as important, if not imperative, that expectant mothers shall be free from dental focal infections, both for their own safety and efficiency and for the continued vitality of the fetus.

NO. 35. SPIROCHETE AND AMEBA INFECTIONS.

Do organisms other than streptococci enter the human system through dental infections?

While the streptococcus seems universally to be present in dental infections in practically all cases of systemic involvement, in addition to this variety the evidence seems to establish that each staphylococci and spirochetes may pass from infected teeth to other tissues and proliferate in localized areas; and, similarly, that when certain mixed strains are injected into experimental animals, localized spirochete infections may develop in their tissues. Systemic involvements from spirochete infections and their localization in experimental animals are, however, relatively rare.

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NO. 36. NUTRITION AND RESISTANCE TO INFECTION.

What is the relation of nutrition to resistance to dental infection?

The data at hand suggest:

(a) That the effects of variations in the diet do not express themselves quickly in specific defense.

(b) That variations in diet by the limitation of various vitamines produces effects which, in general, are similar to those of overload.

(c) Deficiency diets, particularly disturbances resulting in a calcium hunger, tend directly to lower the defense to dental infections.

NO. 37. THE RELATION OF THE GLANDS OF INTERNAL SECRETION TO DENTAL INFECTIONS AND DEVELOPMENTAL PROCESSES.

What is the relation of the glands of internal secretion to dental infections in developmental processes?

We would summarize these studies as follows:

(a) Disfunctions of various of the glands of internal secretion are often very materially corrected, and sometimes completely so, by the removal of dental focal infections.

(b) Involvements have frequently been produced in similar endocrine tissues of the animals by inoculating them with the cultures from the teeth of the involved patients.

(c) The administration of the extracts of the glands of internal secretion, particularly of the parathyroid, is shown to be of distinct benefit in certain cases of depressed ionic calcium of the blood, due in part to dental focal infections, where this improvement has been absent or slow following the removal of the dental infections.

(d) An improvement has been produced in individuals, which we interpret to be due to a stimulation of the pituitary body, which in turn doubtless stimulates other ductless glands and together with them produces a marked change in both physical and mental states.

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NO. 38. THE NATURE AND FUNCTION OF THE DENTAL GRANULOMA.

Is the dental granuloma a pus sac and its size a measure of the danger?

(a) The so-called granuloma is a misnomer, for it is a defensive membrane and not a neoplasm.

(b) A normally functioning periapical quarantine tissue is Nature's effective mechanism for protecting that individual by destroying the organisms and toxins immediately at their source, and thereby completely prevent the tissues of that individual's body from exposure to either of these agencies.

NO. 39. CHANGES IN THE SUPPORTING STRUCTURES OF THE TEETH, DUE TO INFECTION AND IRRITATION PROCESSES.

What are the changes produced in the supporting structures of the teeth, which are due to infection and irritation processes?

Characteristic localized structural changes develop in the supporting structures of teeth when the latter carry infection within their structures. These changes are, however, determined chiefly by the host and are an expression of the reacting characteristics of the host rather than an expression of the invading bacterium.

NO. 40. DENTAL INVOLVEMENTS CAUSED BY ARTHRITIS.

Can arthritic infections of the body attack and devitalize the teeth?

(a) It will be seen from these data that a systemic involvement of multiple arthritis may, while attacking various joints of the body, also attack those of the joints of the teeth; and, further, that this process of inflammation with degenerative and proliferative processes may cause the involvement and ultimate death of the pulp.

(b) The involvement of these teeth as a result of the progressive systemic arthritis may in turn, and doubtless frequently, if not generally, does aggravate the general condition, for the tooth structure when it becomes infected is even less capable of vascularization and therefore less amenable to the processes of defense than is bone. This stresses the very great importance that individuals having deforming arthritis shall have most careful dental inspection

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and care, and also, since it is one of the most horrible of living deaths, every effort should be made to prevent the beginning of that process; and since the evidence is so overwhelming that the initial infection frequently, if not generally, comes from the teeth, helpless humanity deserves pity until the powers that be shall make a worthy effort to find the means that will prevent this needless catastrophe in so many lives.

NO. 41. VARIATIONS IN THE DEFENSIVE FACTORS OF THE BLOOD.

Is there a difference in the defensive factors of the blood of susceptible and non-susceptible individuals to systemic involvements from dental infections?

There is a marked difference, which is readily measurable in the bactericidal properties of the bloods of individuals of high defense, as compared with those of low defense to systemic involvements from dental infections.

NO. 42. METHODS FOR REINFORCING A DEFICIENT DEFENSE.

Can a temporarily or permanently low defense against the streptococci of dental infections be increased or enhanced either temporarily or permanently?

In some individuals a low defense may be materially strengthened by the use of vaccines and also by the use of all available means for stimulating metabolism and increasing a supply of essential nutritional factors.

NO. 43. SEROPHYTIC MICROÖRGANISMS.

What are the growth factors of microörganisms of the mouth in juices of living tissues?

When the mixed flora of the oral cavity are planted in the normal blood serum or lymph, the varieties that grow are almost entirely limited to the strains of diplo- and strepto-cocci, with occasional staphylococci, with the diplo- and strepto-cocci largely predominating.

NO. 44. CALCIUM AND ACID-ALKALI BALANCE.

What is the role of calcium to the maintenance of the acid-alkali balance of the blood, other body fluids, and tissues?

In the proper functioning of the body, the end products of metabolism are carbon dioxide, urea, and water. When metabolic functions are abnormal, resulting in the imperfect oxidation with the development of less simple acids than carbon dioxide,

these must be neutralized with bases taken from the body and its fluids. In the absence of an adequate supply of these from other sources, the demand must be met by the calcium of the body, first from the circulating ionic calcium, then from the calcified tissues. This latter is the characteristic end reaction involved in periodontoclasia, or pyorrhea alveolaris. This enters into and complicates the etiology of many, if not most, of the rheumatic group disturbances studied in detail in subsequent chapters.

NO. 45. SYMPTOMS AND DANGER.

Since individuals are similar in their reactions to dental infections, both locally and systemically, and since freedom from involvements is dependable, the danger is proportional to the quantity and to the type or virulence of the dental infection involved and the patient's symptoms.

Since patients largely determine the biological qualities of the organisms involved in dental infections by the culture medium they furnish the bacteria, and since the sufficiently high defense of certain individuals will, under ordinary conditions, protect them from systemic injury resulting from their dental infections, and since the local oral expressions of the dental infection are an indication and a measure of that individual's reaction to the dental infection rather than a measure of that infection, therefore, it becomes apparent that the operation that is indicated is an individual factor and concerns the relation of the efficiency of the patient's defense to the attacking power of the dental infections and, accordingly, operations which are strongly indicated for some individuals are as strongly contraindicated for others.

NO. 46. DIAGNOSIS.

An adequate procedure for making dental diagnosis is a roentgenographic study of the patient, for which the only requisite training is a working knowledge of the apparatus and a familiarity with dental anatomy sufficient properly to call the teeth by their names.

An adequate procedure for making a dental diagnosis will involve, as a minimum, the following:

A knowledge of the patient's systemic defense and systemic involvements, both present and past. The securing of this will involve:

(a) A knowledge of the various systemic disturbances that may be produced or ag-

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gravated by the dental infection, with or without the patient's recognition of their existence. A knowledge of the systemic disturbances includes, for differentiating purposes, a knowledge of the etiological pathology of the involved tissues of most of the morbid conditions of the human body, regardless of the type of tissue or the involved nature of the functions. These are based upon a thorough knowledge of the gross and minute anatomy of the various organs and tissues of the body, and the normal functions of those tissues, with special reference to the nervous system.

(b) A roentgenographic study, with a knowledge that it is physically impossible for the Roentgen-rays to disclose much of the essential information, the roentgenogram being simply a record of relative total densities of the planes involved.

(c) A familiarity with the use of the microscope and such laboratory technique as serological study of the fluids of the body, since many of the lesions, being produced or aggravated by dental infections, are in evidence by microscopic and chemical methods long before they appear clinically as symptoms.

NO. 47. DIAGNOSTICIANS.

Dental diagnosis is so simple that any dentist or physician, osteopath, chiropractor, electrical engineer, or laboratory assistant, is competent to perform this simple service.

Dental diagnosis is so intricate and involved that it requires a greater knowledge of the human body, its structure and diseases, and of the various means for understanding the normality and abnormality of the same, than any specialty of the healing arts; and probably no specialty finds such great opportunity for doing injury to humanity, or for extending human life, as does the highest application of intelligence in this field. A competent diagnostician of the local and systemic expressions of dental infections must be familiar with the clinical and structural pathology required for a general medical diagnosis, and, in addition, be completely familiar with each dental anatomy, dental pathology, and dental operative procedure.

There are many phases of these problems that are very involved. Few dentists realize the advantage of preventing the development of a lesion over undertaking its correction or cure, not appreciating that lesions of the central nervous system, that have existed for two years or more, are generally irreparable; and similarly, many lesions of the kidneys, when once established, constitute a permanent and often progressive disfunction. It is, therefore, often too late when the psychosis, atrophy, or nephritis is discovered. This also is particularly true of heart lesions. The knowledge of these facts, then, becomes fundamental for an efficient prophylactic sense. This does not mean that in the absence of a basis for judgment, all teeth should be extracted. This constitutes one of the gravest of tragedies, since to add to a permanent deformity and handicap that of a living permanent cripple is a needless double curse and a reproach to the very name and spirit of the healing sciences. The purpose of these chapters is to illustrate not only that dental infections produce degenerative diseases, *but that the removal of only the involved teeth produces the relief being sought.*

CHAPTER LIX.

APPLICATION OF PRECEDING EXPERIMENTAL DATA IN CLINICAL PRACTICE.

DISCUSSION.

In no part of dental practice does the value and significance of these new data have so great an importance as in the nature of treatment and procedure, for an intelligent application of these fundamentals will not only conserve innumerable good teeth which are now being ruthlessly and needlessly sacrificed, but cause the removal of other innumerable teeth now being entirely overlooked or being passed as not having sufficient evidence of pathology. If, as I am personally convinced, an individual with a marked susceptibility to heart involvement will tend to have the same irritated by the presence of even a small quantity of locked dental infection, it is not safe or wise for that patient to have that small quantity unless we can find a condition in which the service of the involved tooth is so great to that individual that he or she will be done more harm by its removal than by that infection, which condition rarely exists, since a properly functioning heart is so fundamental not only to life itself but to comfort and efficiency of living, for a body cannot function without a functioning heart. And this is quite as true of kidney.

As we have shown, pulpless teeth, even when root filled, can become (and I believe ultimately generally do become) infected, because every tooth may contain approximately five per cent culture medium, even after root filling, unless something has been done, which as yet I have not had evidence can with confidence be accomplished, efficiently to establish a condition in which neither organisms nor degeneration products of tooth tissues can develop. If, then, a given patient can be shown to have an abnormally low capacity for establishing and maintaining a defensive quarantine about every root-filled tooth, and if he or she has a definite susceptibility to an involvement of a vital organ such as heart or kidney, it is my judgment that for that patient pulpless teeth should be extracted, or if filled, should be most carefully watched; and I do not know of any means for ascertaining whether a tooth

in that type of patient is approaching a condition of danger after it is treated and root-filled because of that failure to react.

If, on the other hand, the patient in question can be shown to have the ability to establish an adequately efficient defense and quarantine about even a highly infected tooth or teeth to keep that patient entirely safe, it is my opinion that if a tooth without extensive infection is valuable to that patient and if the peridental membrane has not been seriously involved but the pulp is endangered either from mechanical injury or deep caries, that pulp may be removed under certain conditions and the root fillings may be placed (if such can be done from a mechanical standpoint with very great thoroughness) and produce a condition which will be relatively safe for that patient during the time that he or she has that relatively high defense. I believe, however, that it is true that such a patient's high defense will keep him safe not only because of our dental procedure but in spite of anything that we can possibly do to that tooth. Such a safety on the part of the patient will be due almost entirely to the fact of his or her high defense and not because any operator is capable of placing that tooth in a condition in which it could never become infected. In other words, I believe practically all root-filled teeth, for this has been the result of my extensive studies, sooner or later (and with most very soon) contain organisms, though in the case of the type of patient we are considering with high defense, not in such quantities as are capable of producing toxic substances or organisms capable of invading that individual; for these, as they develop, are efficiently combated immediately surrounding the tooth. Since, however, we can never know when overload will strike even these individuals, such as influenza, grief, physical and nervous strain, etc., we must be very guarded in presuming that these individuals will always have that high defense.

And, further, the age of the patient tends largely to determine that factor of safety; for just as a cannon ball is fired out over the sea and rises higher and higher to its maximum elevation, it can be known that ultimately and soon it must start to come down, and as it starts to come down, the beginning of the end of that flight has begun. And similarly, we must look upon all individuals beyond middle life, regardless of their defense, as approaching the time when that defense must of necessity diminish, and we are not justified in taking the same chances that we could when their defense was normally high and there was a prospect of

its remaining so for some time. In other words, all root-filled teeth should, in my judgment, be considered under suspicion or at least under observation and should be checked up frequently and regularly if that patient's best interest is to be concerned; for, as we will see, there are many forms of systemic disturbance which may be aggravated, if not directly produced, by these dental infections which we have not so considered. The severity of the systemic expression and the contributing factors,—namely, dental infection and contributing overloads,—must all be considered in deciding what type of operation may be made in a given case.

I can best illustrate my interpretation of the best procedure and treatment in each of these types of cases by reviewing the case histories and applying these principles and presenting with each the research data such as elective localization of these strains in animals, serological and bacteriological studies on both the animals and patient, and the after-history, for it has not been possible for us to come to these conclusions except in the light of the fundamental results obtained in clinical practice.

Before taking up in detail the clinical study and pathological conditions of the body and their relations to dental infections under the various groupings, it will be to our advantage to review a typical case with the application of these general principles. We are coming to find by experience that a large number of heart cases may have a much better prognosis than the general experience with hearts would suggest. They seem to be in a state of very acute irritation, with the production of symptoms quite similar to, if not identical with, those of acute endocarditis. And probably in no specialty of medicine is it more important that those trusted with the chief responsibility of that part of the body shall use preventive programs; and, above all, that they shall not create, let alone maintain, the type of focal lesion which will make possible the development of the irritant for these sensitive and already injured hearts. Their sensitiveness is often, however, our fundamental danger. The injury that has already been done to a valve cusp may have been largely compensated by Nature. Such a case is the following:

Case No. 383.—The patient at the time she presented, five years ago, was twenty-three years of age. She had been incapacitated from her work by lassitude, shortness of breath, and acute rheumatism. Her net weight was 131 pounds, height 5 feet 7¼ inches. Family conditions made it necessary for her to work if at all possible.

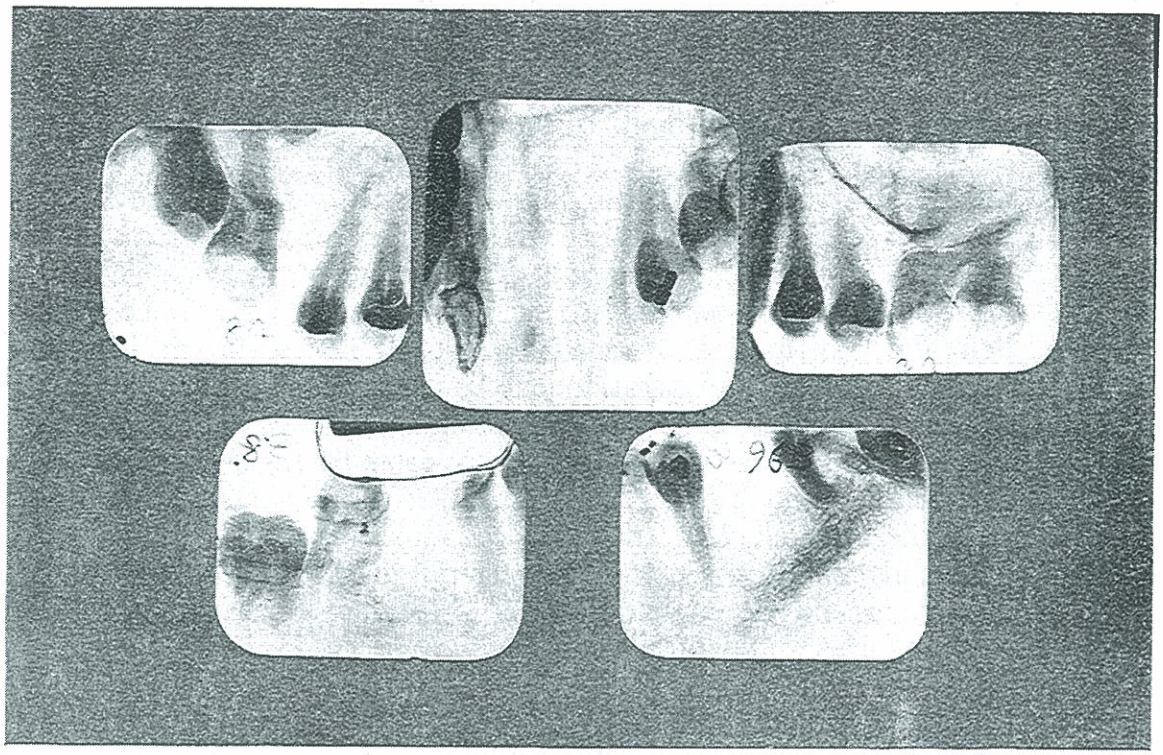


FIGURE 263. ROENTGENOGRAPHIC APPEARANCE OF TEETH OF CASE NO. 385.

Her dental conditions are shown in Figure 263. An examination of her teeth shows that the pulps are vital in the upper right first and second molars, and upper left molars; non-vital without root filling, upper right lateral; root filling with limited periapical absorption, upper left central. I hope the dental readers of this text at this point will visualize what they would do with such a case in their own practice before following my interpretation of what should be done and the description of the program carried out. Is it not true that in a person twenty-three years of age with vital pulps you would be disposed to put gold crowns on these molar teeth after removing the caries; and if the pulps were found exposed, proceed to root-fill? Since there is very little suggested trouble with the lateral, it would readily be taken care of by root filling. I will venture to guess that the great majority of the members of the dental profession would carry out a program without extraction of the above named teeth.

But let us study her case a little farther. What is the shape of the roots of these upper molars? Are you sure you could fill around the angles? Or have they angles? Figure 264 shows

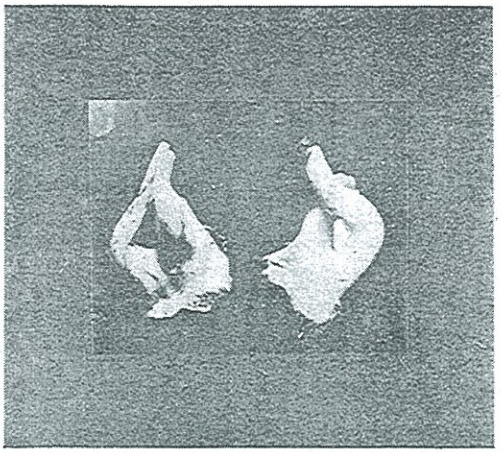


FIGURE 264. PHOTOGRAPHIC APPEARANCE OF EXTRACTED TEETH OF CASE NO. 385. (SEE FIGURE 263.)

photographs of these extracted molars; and it is very certain that no dentist could, with certainty, place fillings in these molar roots that would fill in the sense that we understand root fillings should.

This reminds me that one time at a dental convention a dentist made the bold assertion that he could fill 95 per cent of molar roots perfectly to the apex. A discussion arose and his ability was questioned; not that he was less competent, but even assuming that he was more competent, than the average. It was finally decided that I should select a quantity of molars and send them to him invested in plaster-of-Paris. He was to root-fill them and send them back. That would be an interesting illustration to insert here, but it is aside from the purpose of this volume. Suffice it to say that he did not have 5 per cent of them properly filled to the apices, and in about 25 per cent he penetrated the root walls; this, notwithstanding the fact that green teeth were used and the plaster in which they were embedded was kept moistened.

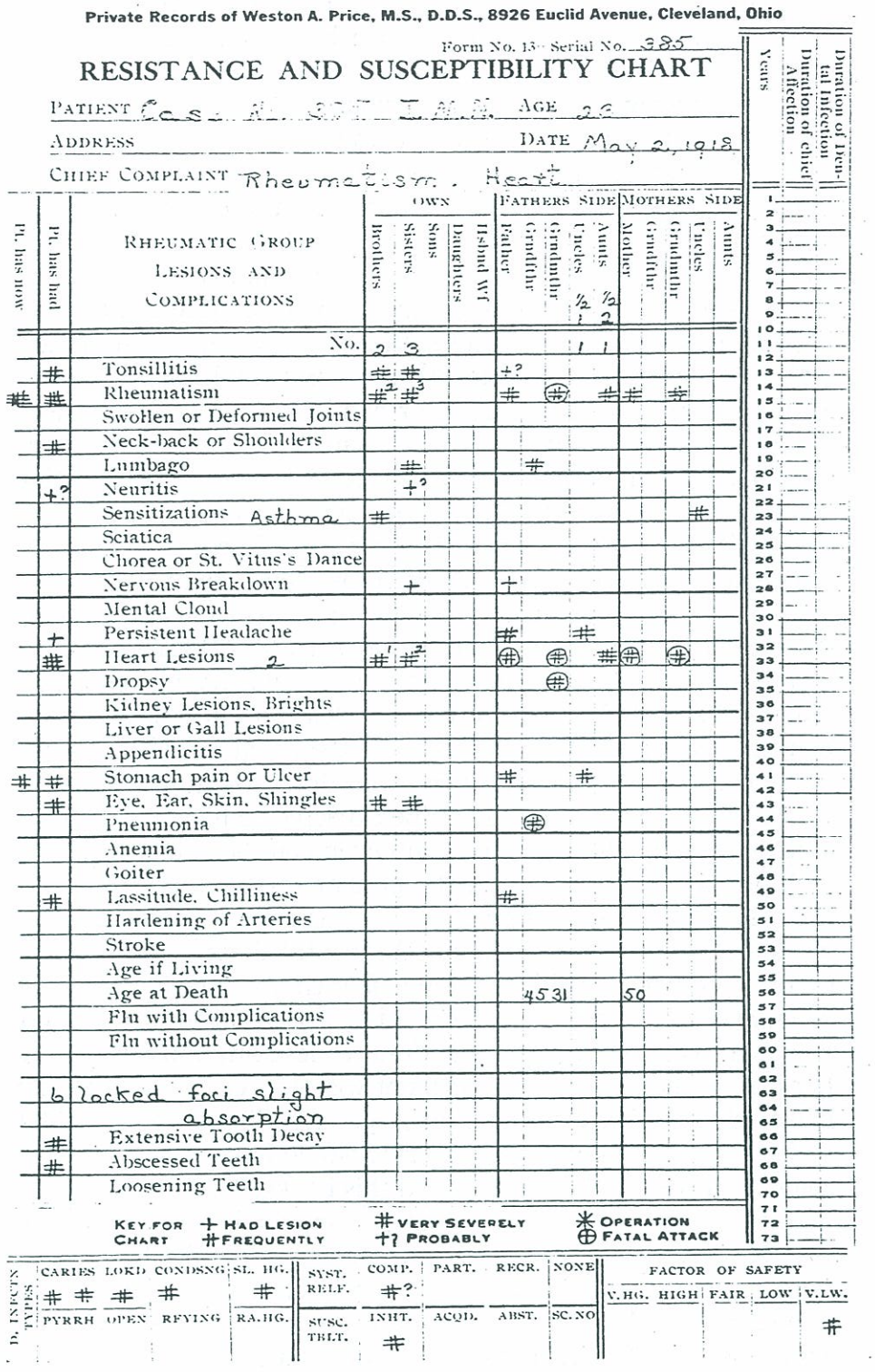
But why root-fill teeth whose pulps are not definitely exposed? And, particularly in young persons, why not place gold crowns on these teeth "until they give trouble"? We have cultured a large number of pulps of teeth with deep caries and practically always find those pulps infected; and in other chapters we have illustrated the production of acute rheumatism in animals with the cultures taken from pulps of such teeth, and which patients were already suffering from acute heart involvement.

But this clearly suggests that we must have a basis of discrimination, for certainly many pulps can and will remain vital if properly, protected and such teeth may give very important serv-

ice for a long period of time. In other words, it is true that for many patients teeth like the above are more valuable in the patient's mouth than out, all interests of their lives concerned. But here we are dealing with a different type of patient from the above and I have discussed this from this viewpoint in order that I might stress the great advantage in having a resistance and susceptibility chart for every case in which we have to make so important a decision, in order that we may evaluate that patient's factor of safety, for his or her teeth are only valuable in accordance with their safety from an injury to their health, which would far outweigh the great advantage of retaining the service of the tooth in question.

Figure 265 shows the susceptibility chart for this patient. It will immediately be noted that even at twenty-three years of age she has been breaking seriously as rheumatism and heart, digestive tract and nervous system. As stated, she has been incapacitated from her work for several months because of shortening of breath, (signifying her heart irritation), lassitude, and painful rheumatism. Immediately we see that this patient must have had either a very serious overload to produce an acquired susceptibility in these various tissues, a symptom group which is very unlikely to occur since acquired lesions are so largely in the nervous system, or she must have had a very marked inherited susceptibility or naturally low defense for this type of infection.

To determine the latter we will look to her brothers and sisters who have the same sources of defense. She has two brothers and three sisters, all five of whom have had acute rheumatism; and one brother and two sisters have had heart involvement. This suggests immediately that they, too, must have had either a marked susceptibility or a very unusual overload. A study of her father and his immediate relatives shows that he was an invalid with heart involvement, with recurring attacks of rheumatism. He had not been able to do much more than half a man's work for many years and for long periods had been virtually an invalid. He has since died, at the age of fifty-seven, of acute heart involvement after a protracted bedridden illness. The father's mother died also of heart involvement with dropsy as an expression. The father's sister is an invalid at this time with heart involvement and hypertension, nephritis, and acute rheumatism, and has had one stroke at sixty-two years of age. On the other side of the ancestry we find this patient's mother died at fifty years of age of malignant endocarditis, about two years before the



Private Records of Weston A. Price, M.S., D.D.S., 8926 Euclid Avenue, Cleveland, Ohio

Form No. 13 Serial No. 385

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT Case M. 20 T. M. AGE 20

ADDRESS DATE May 2, 1918

CHIEF COMPLAINT Rheumatism. Heart

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf	Fathers Side: Father	Fathers Side: Grandfthr	Fathers Side: Grandmthr	Fathers Side: Uncles	Fathers Side: Aunts	Mothers Side: Mother	Mothers Side: Grandfthr	Mothers Side: Grandmthr	Mothers Side: Uncles	Mothers Side: Aunts
		No.	2	3							1	1					
	#	Tonsillitis	#	#				+?									
#	#	Rheumatism	#2	#3				#	⊕			#	#		#		
		Swollen or Deformed Joints															
	#	Neck-back or Shoulders															
		Lumbago		#					#								
	+?	Neuritis		+?													
		Sensitizations Asthma	#													#	
		Sciatica															
		Chorea or St. Vitus's Dance															
		Nervous Breakdown		+				+									
		Mental Cloud															
	+	Persistent Headache						#			#						
	#	Heart Lesions 2	#1	#2				⊕	⊕		#	⊕	⊕		⊕		
		Dropsy							⊕								
		Kidney Lesions, Brights															
		Liver or Gall Lesions															
		Appendicitis															
#	#	Stomach pain or Ulcer						#			#						
	#	Eye, Ear, Skin, Shingles	#	#													
		Pneumonia							⊕								
		Anemia															
		Goiter															
	#	Lassitude, Chilliness						#									
		Hardening of Arteries															
		Stroke															
		Age if Living															
		Age at Death						45	31				50				
		Flu with Complications															
		Flu without Complications															
	6	locked foci slight absorption															
	#	Extensive Tooth Decay															
	#	Abscessed Teeth															
		Loosening Teeth															

Years 1–73

Duration of Dental Infection

Duration of chief Affection

Key for Chart: + Had Lesion; # Frequently; #? Very Severely; +? Probably; ✳ Operation; ⊕ Fatal Attack

D. INFCTN.	CARIES	LOKD	CONDSNG	SL. HG.	SYST. RELF.	COMP.	PART.	RECR.	NONE	FACTOR OF SAFETY: V.HG.	HIGH	FAIR	LOW	V.LW.
STAT.	# #	#	#	#		#?								#
	PYRRH	OPEN	RFYING	RA.HG.	SUSC. TBLT.	INHT.	ACQD.	ABST.	SC. NO					
						#								

FIGURE 265. RESISTANCE AND SUSCEPTIBILITY HISTORY CHART OF CASE NO. 385. NOTE NINE CASES OF HEART DISEASE IN FAMILY, WITH FOUR DEATHS.

patient presented, after a long bedridden illness, and her mother, the patient's grandmother, died of heart involvement. Both this patient's mother and mother's mother had also suffered severely from rheumatism. The patient's father and a brother had each suffered severely from a type of nervous indigestion.

We find, then, an illustration of what we have found so many times in these studies: that when an hereditary susceptibility comes in from both sides of the ancestry, the offspring tend to break in these same tissues; and further, that while they break in the same tissues, the break tends to come much earlier than in the ancestry. We have, then, a family of six children, the oldest of whom was twenty-five, all suffering from acute rheumatism either at this time or had in previous time, and three of whom were suffering from acute heart or had in the past. This clearly establishes that this patient's best is far too low to withstand the normal overloads of life, if we would assume some dental infection as being a normal overload for a normal individual.

But there are other overloads, as we have shown so frequently, which combine with dental infection overloads greatly to aggravate them. Young people with invalid parents to sustain, having the care not only of their own maintenance but of the maintenance of the invalids, are very likely to have a capacity physical load which may easily become more than a load; or, in other words, a distinct overload. We must consider then that notwithstanding every overload that we may take from this patient, including the dental involvements, she should be expected to have to maintain a struggle throughout life to retain even comfortable health.

A physical examination of the patient revealed a mitral murmur and an accentuated pulse rate, so typical of an irritated and weakened heart. What should the dental diagnosis be in this case? And before making it, remember that as she appeared she brought all the vanity of an ignorant girl. She did not want to lose her own front teeth. She was afraid to lose any molars for fear her face would settle in. She did not wish to wear a plate for fear it would affect her expression and speech. She looked just like, so far as the ordinary dental observer would have appreciated, all the rest of the girls of her age; and this background that we have worked out was not any information that she brought to us, but was information that we had to go after. I stress this because we tend to justify our diagnoses on the presumption that we have a knowledge of the patient, adequate for making the important decisions. My fear is that this is seldom true.

The incidence of heart disease as a cause of death increases

very rapidly and constantly with age. This has been most strikingly brought out by Dr. Louis I. Dublin,[1] statistician for the Metropolitan Life Insurance Company, who, in a paper read before the Boston Association of Cardiac Clinics, Boston, May 18, 1922 (published in The Nation's Health for August, 1922), stated as follows:

"The first point that comes to view from an examination of the tables and of the graphic illustration is that the incidence of heart disease as a cause of death increases consistently with age. At the age period 35 to 44 when persons should be at the height of their productivity, one white person dies from heart disease in every thousand living and two colored persons out of each thousand. At the age period 65 to 74, the number of deaths from heart disease has increased to about 15 in each one thousand living, or to put the facts in another way, deaths from heart disease constitute 9.3 per cent of all deaths at ages 35 to 44, but, at the older period, 65 to 74, they are responsible for 21.9 per cent of the deaths. There is no exception to this rule. The rates are also very much higher for colored persons than for whites. The sex ratios of heart disease mortality are also rather interesting. The rates are usually higher for females than for males up to age 30. From that age onward, the rates for males are higher, the difference becoming regularly greater with advancing years."

These studies of the Metropolitan Life Insurance Company are particularly important in connection with the data that we have accumulated from our clinical practice and research. An analysis of the data shown in Chapter No. 4, Systemic Structural Changes, reveals the important fact that 100 per cent of the individuals suffering from heart involvement have extensive caries. This is also shown in Figure 83 of Chapter 9, The Relation of Dental Caries to Systemic Disturbance. If, then, the percentage of death from heart involvement increases very rapidly after the age of forty-five, is it simply a coincidence that these patients, in nearly 100 per cent of cases, have extensive caries and consequent apical involvement? It is too early to undertake to publish extended statistical data on this point, but the evidence at hand demonstrates that the incidence of death from heart involvements is very greatly reduced for the same age periods among the individuals with a history of heart involvement who have had their dental infections removed, as compared with those with that history who have not had their dental infections removed.

In other chapters, we have discussed and interpreted the path-

[1] See bibliography.

ology about the infected tooth in comparison with the same condition in other patients and its significance in relation to the systemic defense. We have shown that the changes in the supporting structures about a root apex are primarily records of the reactions of that individual patient to that type and quantity of infection, and that that reaction is a protective one in that it is largely Nature's effort to maintain a quarantine about the tooth, or is the effect on the one hand with a patient with high defense and relative safety, or a record of the reactions of the local irritants upon the supporting structures which are not adequately contributing in an adequate defense for the patient.

Applying that information to this patient's case, we find that the total quantity of infection involved in the lateral tooth with the putrescent pulp is sufficient in normal patients to develop a very acute inflammatory reaction about the root apex with the production of soreness, and therefore a tender tooth, and usually with a fistula. This patient's lateral tooth with a non-vital pulp not only has no fistula, but has no extensive area of absorption, has no history of soreness. What I wish to stress is that the very absence of these symptoms is a bad sign and not a good sign, and argue for the extraction of this tooth and not for its retention, since it has as much infection as would be available in a putrescent pulp. Our diagnosis, therefore, was that her immediate safety demanded the removal of all dental infection possible, which included not only teeth with putrescent pulps and chronic apical lesions, but those with deep caries involving, as did her molars, the major portions of the crowns of the teeth even though the pulps were vital. And these molar teeth were condemned not only because of the difficulty of being certain regarding the amount of infection in their pulps and the difficulty of determining how completely Nature might eliminate that infection, but because the probability of these pulps' dying under any restorations that might be put upon them is so great and the effect of such an outcome would be so serious that we are gambling the patient's health and very life against the problem of a questionable service of these teeth. The odds in such a case are far too great against the retention of the tooth. Even a toothless patient with a heart that will work, even with a murmur, is infinitely better than a quantity of gold crowns or any other type of more approved dental restorations, and they incapacitating the patient. That heart can maintain life only under the most favorable possible conditions; and the result has abundantly justified our decision. In a few weeks' time, this girl was back to work. In the five

years that have intervened she has not lost a day because of her rheumatism or heart involvement. She gained over twenty pounds in a few months' time, and all the money in the world could not compensate her for the mistake that would have been made by a less intelligent program.

It is important to note that the very thing that we have indicated would be likely to happen, had already happened with this patient in question. Her brothers and sisters will tend to have the same type of defense as an ancestral legacy, and one brother and two sisters have also broken in the last five years since this patient presented, and with quite similar symptoms and marked benefit. However, we must, in these cases, remember that the prognosis must always be influenced by the nature and degree of this inherited susceptibility. These patients should plan their lives not only to prevent all overloads that are within reach of their planning; but so far as their dental infections are concerned, they are largely at the mercy of the dentist in whose hands they may either choose or be compelled by circumstance to place their lot. This, then, is fundamentally a responsibility of the dental profession; and while the members of that profession may be largely responsible for the carrying out of the teachings, the ultimate responsibility must go back to the dental colleges which furnish the ideals and the methods for their being carried out.

And again we stress how many of the one in ten funerals that go by your window because a heart has given out, have we as a dental profession either helped to produce or failed to prevent. As I dictate this paragraph, my memory goes back to patient after patient whose life has gone out prematurely at forty, fifty, and sixty years of age, from heart involvement and other complications, but particularly with heart, and in whose mouths there were teeth which, according to my information at that time (which was the teaching of dental practice) had not sufficient evidence of pathology to condemn. As I would now interpret those teeth, what I mistook to be insufficient evidence of pathology, was an inadequate local reaction; and the lack of rarefaction or evidence of condensation of bone were really evidences of that poor defense; and I have no doubt that many of those patients, some of whom had come to be very dear friends, might have lived for years had I known to put into practice what I am teaching in this book. While ignorance may be bliss, there is perhaps no pain or grief like that expressed in the following words:

"Of all sad words of tongue or pen,
The saddest are these: 'It might have been!'"

CHAPTER LX

CIRCULATORY SYSTEM.

DISCUSSION.

In this group we will study the various lesions of the circulatory system which may be influenced or produced by dental infections. These will include endocarditis, myocarditis, pericarditis, heart block, aortitis, angina pectoris, phlebitis, arteriosclerosis, hypotension and hypertension, anemia, leucopenia, leucocytosis, lymphopenia, lymphocytosis, bacteremia, and glycemia. In the past the emphasis in our thinking has been placed upon heart valve lesions probably, both because of their severity and frequency and also the fact that there has been very little known of other lesions', of the circulatory system, being produced or aggravated by dental infections. Since one in ten, and probably a little more, according to the data in both England and the United States, of the deaths of all ages reported from month to month, are caused by heart involvement, it becomes immediately apparent what a great responsibility falls upon the dental profession. If it fail to remove the causes of any of these heart involvements, and more particularly if it produce conditions which tend to develop them, if, as many believe, approximately 90 per cent of heart involvements are the result of streptococcal invasion, we see an immediate suspicion thrown upon the dental source. This suspicion is increased by the finding that practically all dental infections, apical or gingival, contain streptococci, and in the former, particularly, of types that may readily develop elective localization for heart tissues. The results of these researches throw a very important new meaning and importance on this whole problem for it has been found that in a group of 681 families there were more cases of heart involvement in 100 families than in the other 581, and in only 51 single cases were patients found to have developed a heart lesion where no other member of the family was recorded to have developed the same. In other words, in 92½ per cent of patients in whom heart lesions were found, at least some other members of that family were recorded to have had a heart lesion.

Since this presentation is a report of researches and not a treatise on pathology, it is not within its scope to do more than outline the main features involved. Since, as shown, such a large percentage, namely from 10 to 11 per cent, of the deaths of all ages which occur in our civilized communities of today is, according to statistics, from some form of heart failure, it becomes one of the most important problems in the health of the community to prevent, in so far as possible, heart lesions. While authorities differ as to the percentage of the various types of infection found in heart lesions, it is quite generally conceded that organisms of the streptococcal group produce a very large proportion of these involvements, some placing them as high as 95 per cent. It certainly is high, whatever the exact percentage may be in a given community. It is not within the range of this study, or at least we have not included it as such, to make estimations or determinations of the incidence of dental infections and heart lesions of focal origin. I am, however, convinced that there are very many such cases and many in which dental infection may not have been the first source of focal entrance. Indeed, many of our histories suggest that tonsil involvements in children have been followed by some heart disturbance from which the patients have apparently quite completely recovered. Since, however, they had an inherited susceptibility, or lowered defense, for that tissue, and since one streptococcal infection tends to predispose toward another, the presence of a dental infection has tended to re-establish acute involvements of the heart and circulatory tissues.

ENDOCARDITIS.

Endocarditis, with its involvements of the heart valves and lining membranes of the heart, constitutes one of the most serious affections of mankind. For years it has been recognized that it frequently appeared as a sequel to tonsilitis. It now seems very necessary to study carefully its possible relationship to dental infections. We have already discussed, in Chapter 17, the case of a boy, fifteen years of age, who was brought in by one of the district nurses because he had rheumatism. We very quickly discovered that he had a serious heart involvement with much enlargement and rotation outward of the apex. The history of his case showed that about four weeks previously he was afflicted with an acute attack of pulpitis or tooth-ache at school. This seemed definitely located in the mandible on the left side in the first permanent molar. About a week after his acute tooth-ache,

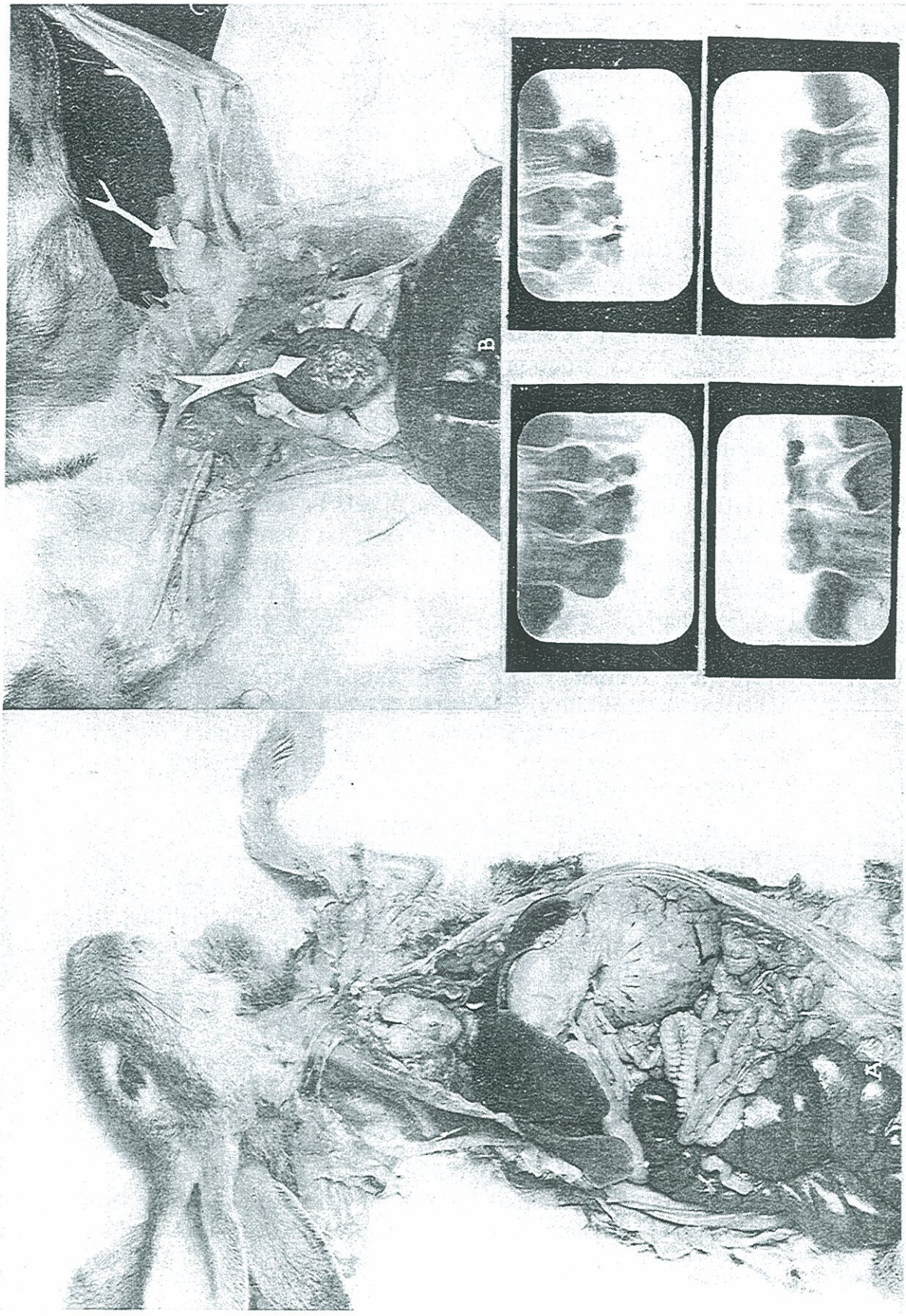


FIGURE 266. ACUTE ENDOCARDITIS IN TWO RABBITS FROM 1 CC. CULTURE FROM DECIDUOUS TEETH SHOWN, FROM CHILD WITH ENDOCARDITIS.

he developed acute rheumatism and myositis so severe that he could not get up from his seat in school, which necessitated his being carried home. The acute condition subsided in about a week and he returned to school. The teacher reported that he was very lazy. The suspected tooth was extracted; but before doing so, careful examination was made to determine the condition of the pulp. The tooth had very extensive caries in the crown, which, however, did not expose the pulp, though it had infected it. The tooth responded very sharply to changes of temperature and was sensitive to instrumentation within the cavity. On the removal of the tooth, the pulp was opened after sterilization of the dentin, cultures were taken from the pulp, which grew out pure streptococci, and this was inoculated into thirty rabbits. Ninety-three per cent developed acute endocarditis and 100 per cent acute rheumatism. In the chapter on tissue affinity qualities, characteristics of organisms, we have referred to the fact that subsequent inoculation of a second group of rabbits with this strain, after it had grown on artificial media for seventeen days, showed its elective localization very greatly changed. The percentage of hearts involved had fallen to 10 per cent. Incidentally, the boy died in about seven months from acute endocarditis.

In cases of acute endocarditis, the elective localization quality of the organisms seems particularly marked. In Figure 266 are shown two rabbits which were inoculated with the culture taken from the shown deciduous teeth, two of which had infected pulps, of a little girl nine years of age. (Case No. 1058.) She had been in bed five of these nine years. We do not know the nature and history of the early attacks or the probable source. The culture taken from the pulp chambers of the extracted deciduous teeth was injected into the ear veins of three rabbits and all developed acute endocarditis and myocarditis. The one shown to the left had the greatest enlargement of heart that we have ever seen in a rabbit on posting, and that shown to the right died on the thirteenth day from the acute endocarditis. The rabbit shown to the right also had rheumatism, with marked enlargement of the axillary lymphatics, as shown. These rabbits were inoculated with the washed culture of the organisms taken from the teeth.

It is very significant that in children suffering from endocarditis, rheumatism, or chorea, there is a marked tendency to delayed absorption of the roots of the deciduous teeth and delay in their

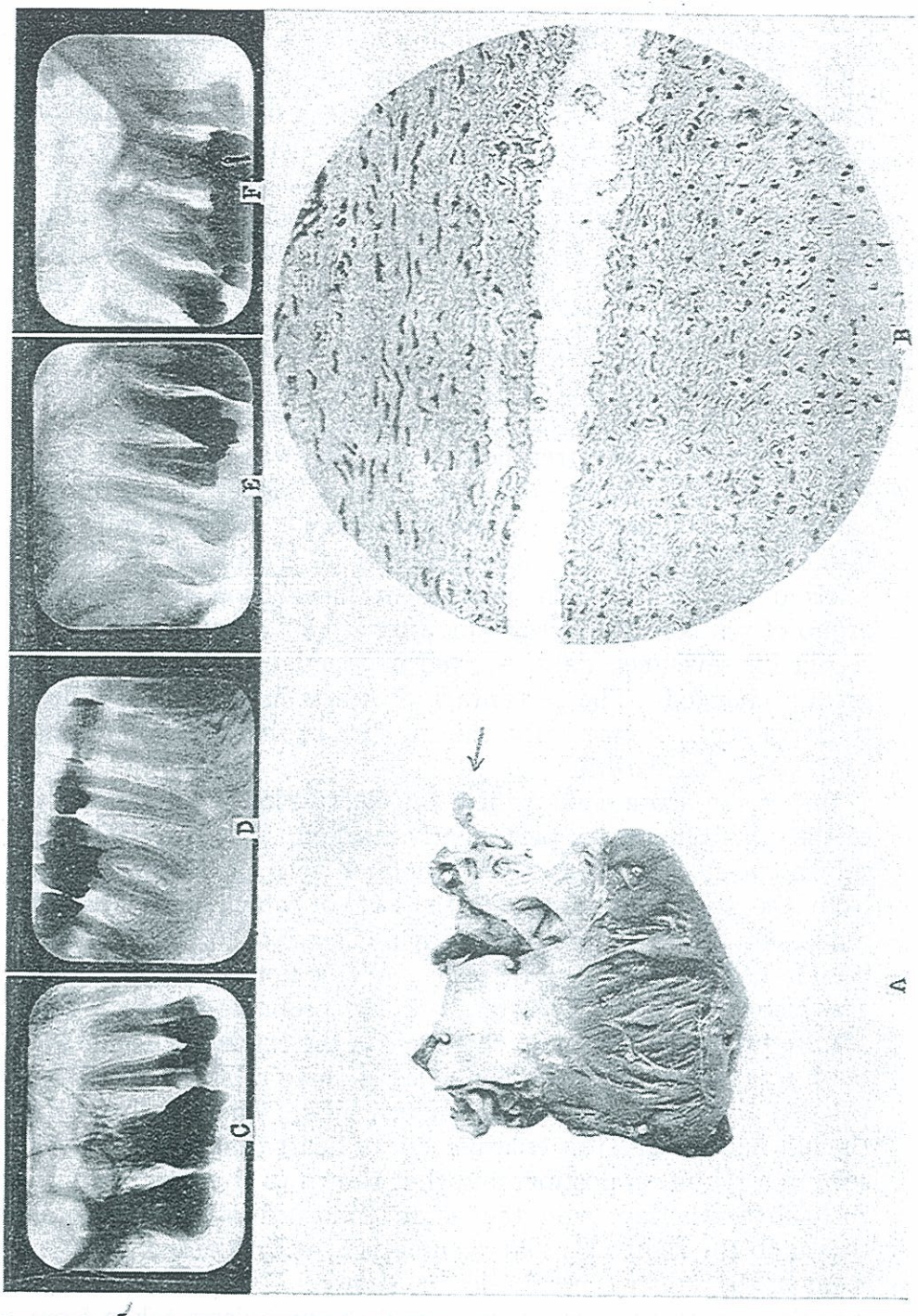


FIGURE 267. FATAL ENDOCARDITIS IN A RABBIT INOCULATED WITH ABOUT ONE-MILLIONTH OF A GRAM OF ORGANISMS FROM THE WASHINGS OF CRUSHED TEETH FROM A PATIENT WITH ENDOCARDITIS. HEART SHOWN IN A; THE TEETH IN C AND D; B, AN AORTIC ARCH INVOLVEMENT FROM ANOTHER RABBIT INOCULATED FROM TWO OTHER TEETH FROM SAME PATIENT, SHOWN IN E AND F.

exfoliation. This seems definitely to be related to depressed ionic calcium of the blood and disturbed calcium metabolism, which not only produce calcium hunger, but the very absence of the calcium ions directly disturbs, as I have shown, the metabolic processes and cell activities of practically all tissues and particularly those relating to morphological changes. This is an exceedingly important, and often serious, problem, for the very individuals who should be free from focal infection of deciduous teeth, are compelled to retain that infection because of disturbed metabolism relating to their exfoliation. I have no doubt that many a child has died from heart involvement who would have recovered had the infected deciduous teeth been removed. In these cases these infected deciduous teeth produced practically no discomfort to the individual; and we have been very often misled in presuming that because they were comfortable they were safe. Only those who have paid the price can know the seriousness of this mistake. I, myself, am one who was mistaken about the safety of my boy's deciduous teeth. Though they were roentgenographically in good condition, several of them having been treated and root-filled, they proved on extraction to be seriously infected and were being carried by an individual who had a heart involvement growing out of one severe attack of tonsilitis followed by acute rheumatism.

It is not necessary, however, that the quantity of organisms be large in strains having marked elective localization, which quality we have found only in acute processes. The heart shown in Figure 267-A is that of a rabbit which died in two weeks after being inoculated with the unfiltered washing from three teeth, two of which were root-filled, shown in Figure 267 in C and D. This rabbit developed both acute endocarditis and aortitis. We appreciate the impossibility of proving that these hearts were normal, and since aortic arch lesions have been reported in apparently normal rabbits, it makes an uncertainty as to whether this aortic arch lesion may not have been present previously, if not in its present aggravated form, in some form perhaps very much less severe. The fact, however, that the rabbit died with endocarditis from this small amount of infection is very important. The actual weight of the bacteria injected would probably be in the order of about a hundred millionth of one gram. Another rabbit inoculated with a culture from two other teeth from this patient, (Case No. 1113) shown in Figure 267 in E and F, developed aortic

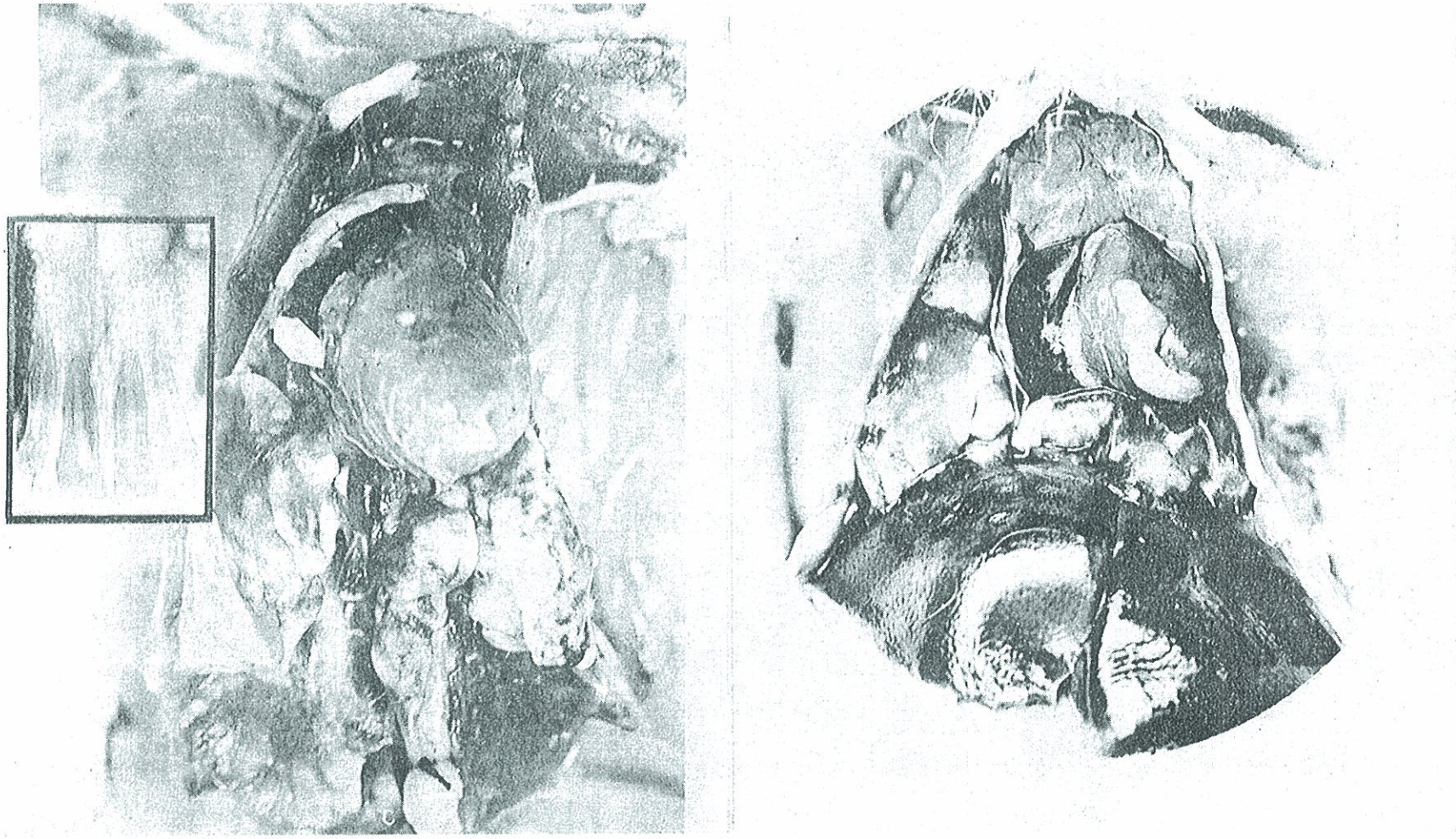


FIGURE 268. TWO RABBITS WITH ENDOCARDITIS FROM THE CULTURE OF THE APPARENTLY NORMAL TOOTH IN THE INSERT. PATIENT WAS PROSTRATED BY ACUTE ENDOCARDITIS.

ulcer with marked degenerative changes in the muscular coats and intima. The following is the pathological finding in this heart tissue:

"*Inverted Ocular* shows three small semicircular pieces of tissue from blood vessel, where the intima and media coats are well stained with a red-pinkish color; the adventitia with a light pink. In all the three sections there is an elevation at the center of the intima and media.

"*Low Power.* The section represents blood vessel wall (aorta). The intima is not well shown; only here and there can be seen remnants of the intimal endothelial lining. The media at the central part of the section shows distinct changes, namely for about 2 to 3 mm. it is swollen, and separated into two parts, which might be due to mechanical causes. The swollen portion shows many cells in degenerative processes; vacuoles can be seen surrounding the nuclei. There are practically no changes in the layer of adventitia surrounding that particular place of the media.

"*High Power.* The media at the central part shows fatty degeneration, the cell being filled up with small vacuoles which are pushing away the nuclei. The nuclei are taking good stain. There are no evidences of any cellular infiltration. This condition is found only at the central part of the section. The rest is in good condition.

"*Diagnosis.*—Atheromatous degeneration of the aortic arch."

In patients with a definitely developed susceptibility to streptococcal infection, expressing itself in heart irritation, there is a marked tendency to recurrence, particularly with the redevelopment of the focus as a source from which the infection may be developed. Figure 268 shows such a case. (Case No. 581.) About two years ago, she was brought in in a condition of extreme prostration from endocarditis and myocarditis, and was carried to our ward and operated upon in bed with the greatest possible care and consideration for her weakness. Her improvement was very rapid and pronounced. In a couple of weeks she was home about her house, and in six weeks her physician was permitting her to take light responsibilities about the home, and even walking up and down stairs. The heart enlargement had decreased and its irritability subsided. About two years later she suffered a recurrence of her endocarditis, with weakness and prostration and very marked dyspnea, which compelled her to gasp for breath about every half minute. Careful study of her mouth, roentgenographically, did not reveal a source of dental infection. However, the use of

the electrical and thermal tests for vitality revealed the presence of a non-vital pulp in the central incisor shown in the insert A. Note the absence of roentgenographic evidence. This tooth was extracted and its pulp cultured. Figures B and C show the hearts of two rabbits inoculated with this strain, both of which show marked endocarditis. In B, there are shown two large masses of coagulated exudate found within the pericardium. This patient's improvement was so marked that again in a few weeks' time she was at home doing most of her household duties, even walking up stairs.

BACTEREMIA.

Bacteremias are coming to be recognized as of frequent occurrence. Their symptoms may be very definite from the early stages, having much the appearance of an approaching febrile disturbance, the severity increasing progressively or intermittently, with or without evidences of heart involvement. The diagnosis seems to be most easily established by blood culture. The attacks may, however, come on violently and seem to be related to tonsilitis, surgical operation, an abscessed tooth, or some such acute process. It is, of course, always difficult, if not impossible, to tell with definiteness the source of the infection. The most significant thing is that they occur in individuals with an abnormally low defense for streptococcal infection, for the organism involved is very frequently the streptococcus. A close study of the history, morphology of the organisms, the biological characteristics of the strain, as established by fermentations, etc., together with the identification of the strain in some focus, will be an important procedure in determining the etiology of the disturbance. Such a case is shown in the following:

Case No. 926.—Figure 269 shows in B an area of radiolucency to the Roentgen-ray, about the apex of the lower left second molar. This tooth was extracted, and attached at its apex was a very large granuloma, shown with the tooth in A. The patient was suffering at the time from rheumatism and a mild fever. Her symptoms became rapidly worse after the extraction of the tooth and curettement of the socket. She was kept in bed in our private ward, and blood cultures showed organisms in abundance in the blood stream. The lymphatics showed marked involvement, and cellulitis developed, involving the neck. E, F, and G show organisms grown out by culture from the aspirated blood from the

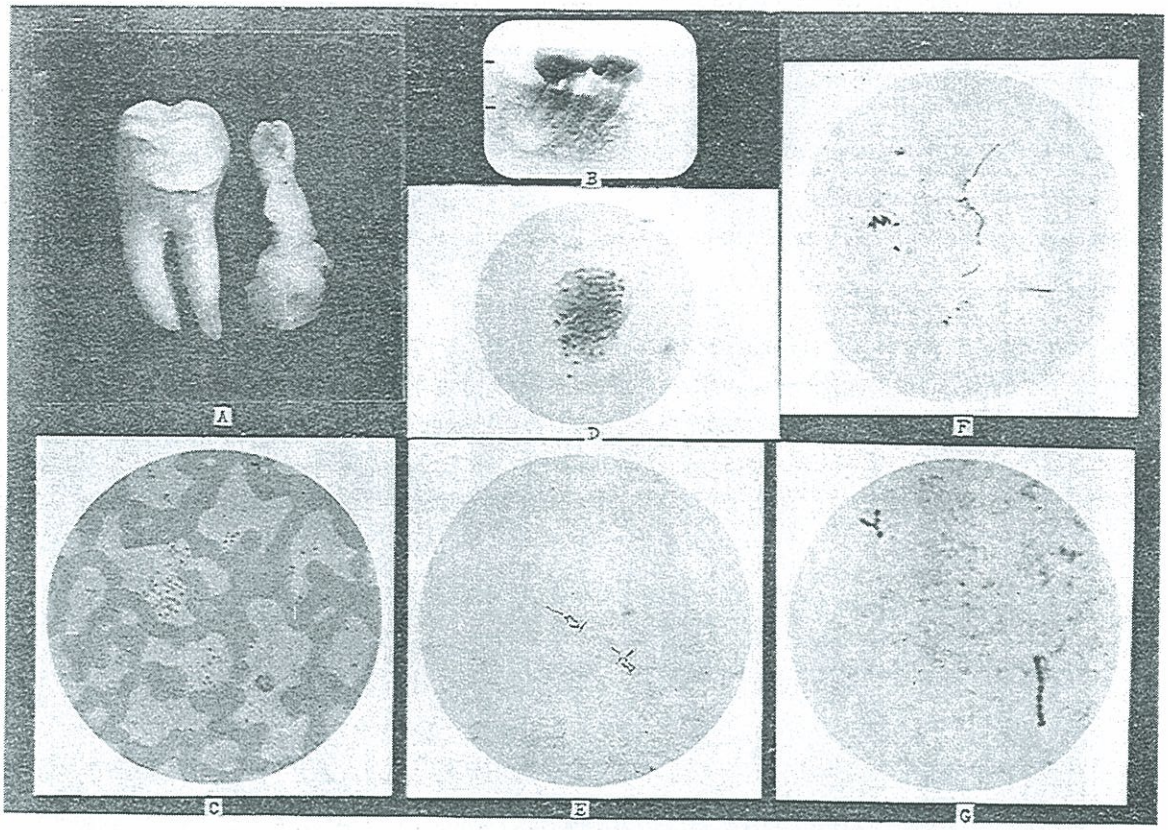


FIGURE 269. STREPTOCOCCAL BACTEREMIA: A, A DEGENERATING GRANULOMA OF UNUSUALLY LARGE SIZE, FROM THE SECOND MOLAR SHOWN IN B. E, F, AND G SHOW ORGANISMS GROWN FROM THE BLOOD TAKEN FROM THE MEDIAN BASILIC VEIN ON THREE DIFFERENT OCCASIONS. C, ORGANISMS IN THE BLOOD ASPIRATED FROM THE NECK; AND D, ORGANISMS IN A PHAGOCYTING LEUCOCYTE.

median basilic vein on three different occasions. C shows organisms in the blood aspirated from the neck tissue; and D, organisms in a phagocyting leucocyte. The culture grown from this tooth was inoculated into rabbits. Figure 270 shows one which developed acute rheumatism of the wrist joints and fore paws, which later developed into a typical deforming arthritis. The legs were bowed sideways and the rabbit walked on the sides of its fore feet, and for a long period was unable to hop, stubbing along with great difficulty like an old man nearly crippled from deforming arthritis. This rabbit lived, in apparently fair health, for twenty-five and one-half months after this inoculation of a single dose of the culture from this tooth (the amount of the dose being 1 cc. of a 24-hour growth of dextrose-ascites culture) and died finally of an acute or chronic peritonitis which, at post-mortem, within a few minutes after his death, showed in culture a streptococcus growing in diploid forms similar to that injected, in the multiple adhesions of the viscera and peritoneum. It is of interest that we never have found this type of infection or of le-

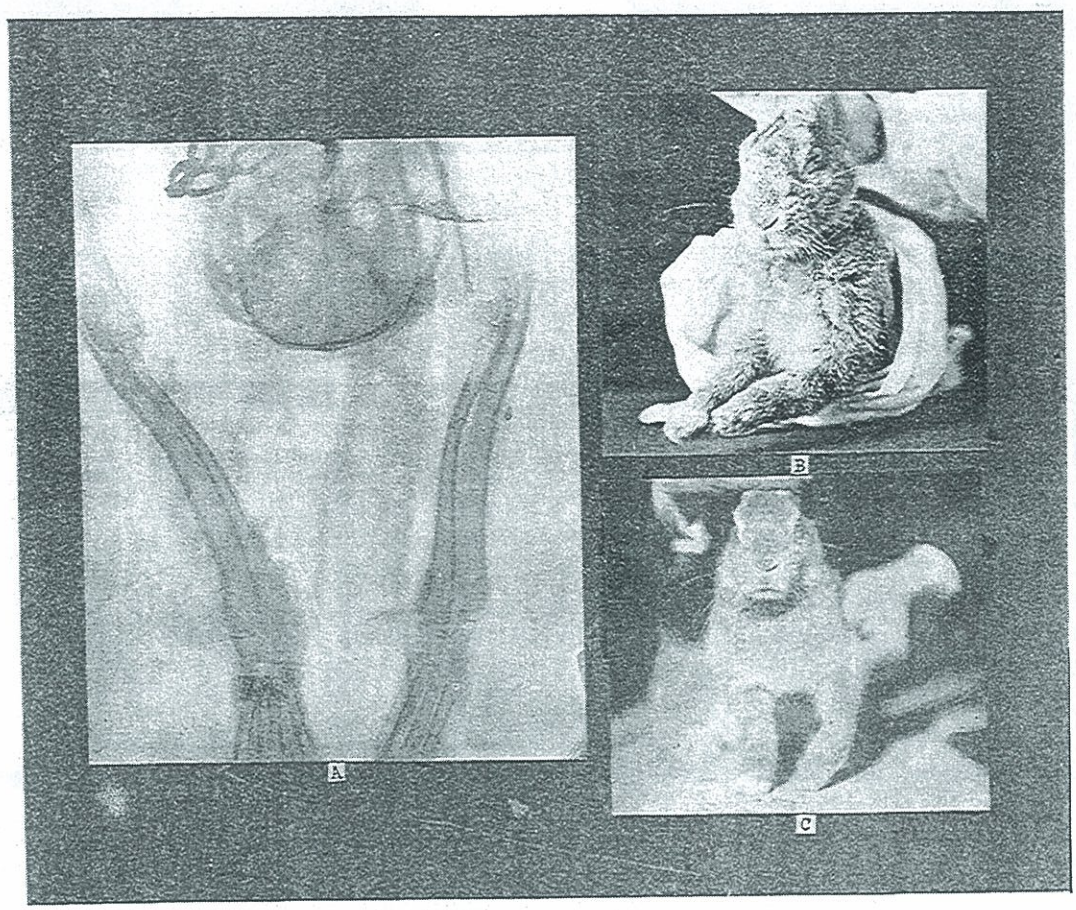


FIGURE 270. OLD PATRICK. THIS RABBIT LIVED FOR TWENTY-FIVE AND ONE-HALF MONTHS AFTER ONE INOCULATION FROM CULTURE OF TOOTH, FIGURE 269. HE DEVELOPED FIRST ACUTE RHEUMATISM, THEN DEFORMING ARTHRITIS, HAD BOWED LEGS, AND WALKED ON THE SIDES OF HIS FEET.

sion in the animals dying spontaneously that have not been previously inoculated with streptococcal strains. Figure 270 shows the roentgenograms of the bones of the forelegs. Note the deformity and enlargements. Figure 271 shows the rabbit as he was nineteen months after the inoculation. While he had grown large and heavy, he tended to be adipose and decrepit. As shown by the roentgenograms of different periods, there was a slow tendency to reduction of the arthritic deposits but never a restoration of function of the joints.

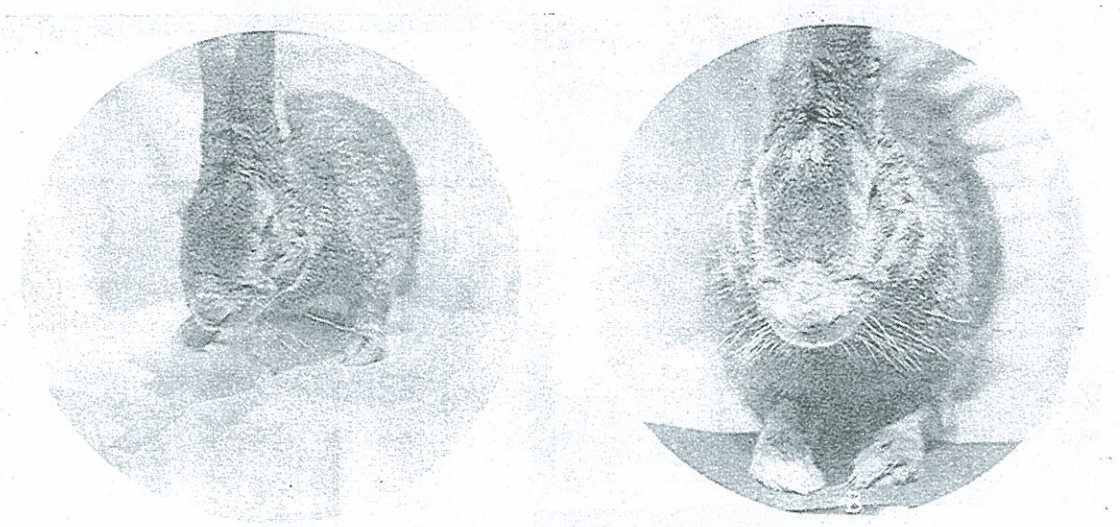


FIGURE 271. OTHER VIEWS OF OLD PATRICK WITH HIS DEFORMING ARTHRITIS. NOTWITHSTANDING HIS PERMANENT DEFORMITY, HE GREW VERY LARGE AND HEAVY.

Individuals with a very marked streptococcal susceptibility frequently have characteristic symptoms which are very suggestive. Their normal temperature is a subnormal of from one to four degrees. They may have a temperature which goes above this subnormal two or three, or even five or six degrees, usually a little above or a little below the true normal. This must be kept in mind; otherwise, it would not be recognized as a febrile disturbance. Their disturbances, however, are quite different from individuals with localizations without bacteremia.

Case No. 987.—Figures 272 and 273 show several views of rabbits inoculated with a culture from another such case. This patient's eyes were, frequently, both reddened. Their symptoms were very severe. During a period of about six years she has had severe recurring attacks; has never been entirely free for more than a short period of time, if at all; and her case represents a type for which the prognosis must always be extremely guarded. The symptoms have tended to develop in a somewhat definite order, one of the earliest of which was the eye involvement which would go through progressive stages of severity and become very painful and sensitive to light, after which, there would be considerable dimness of vision, so severe on several occasions that for days or weeks it would be difficult for her to make her way alone across the street. The use of an autog-

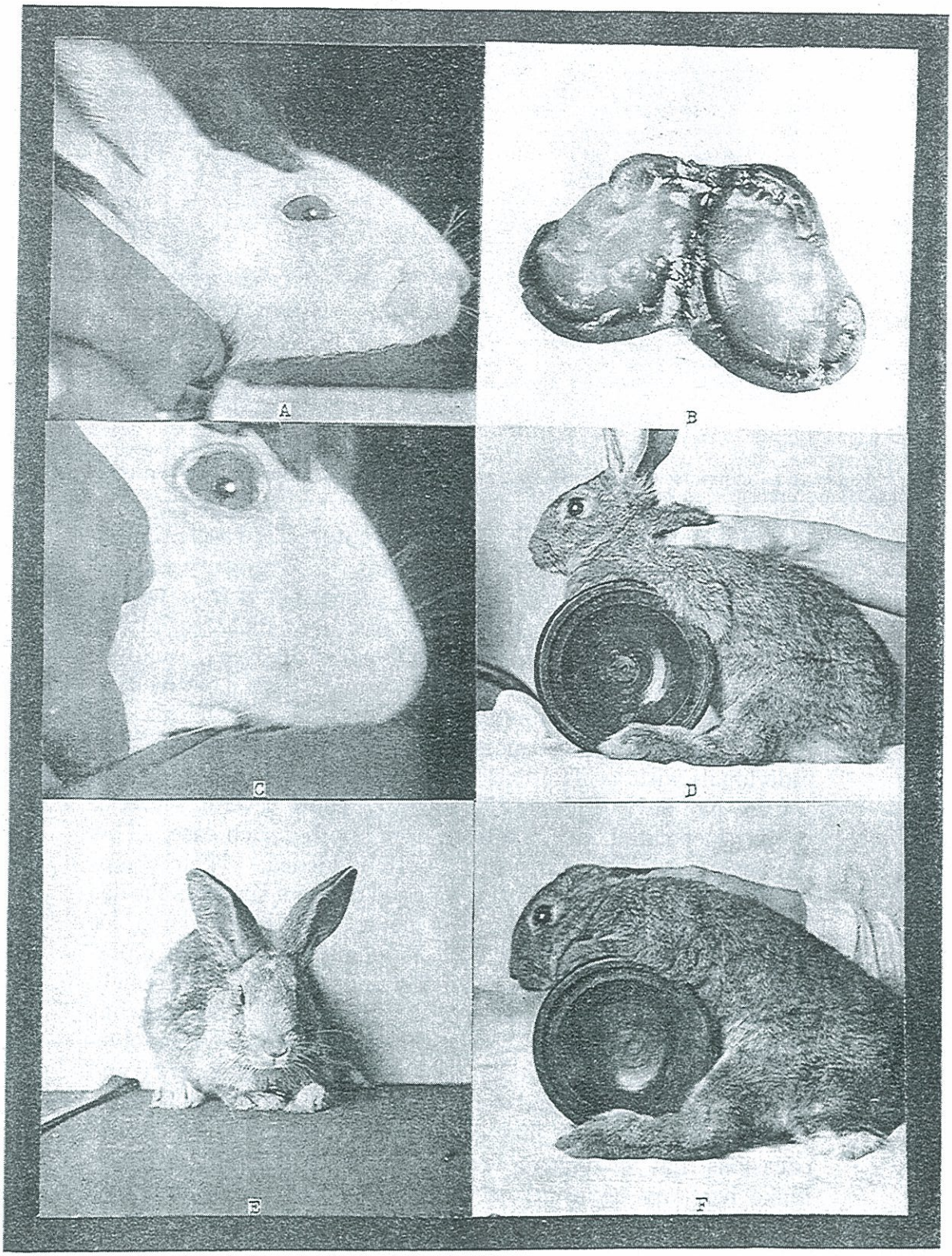


FIGURE 272. MULTIPLE LESIONS PRODUCED IN RABBITS FROM A CASE OF RECURRING STREPTOCOCCAL BACTEREMIA, CASE 987.

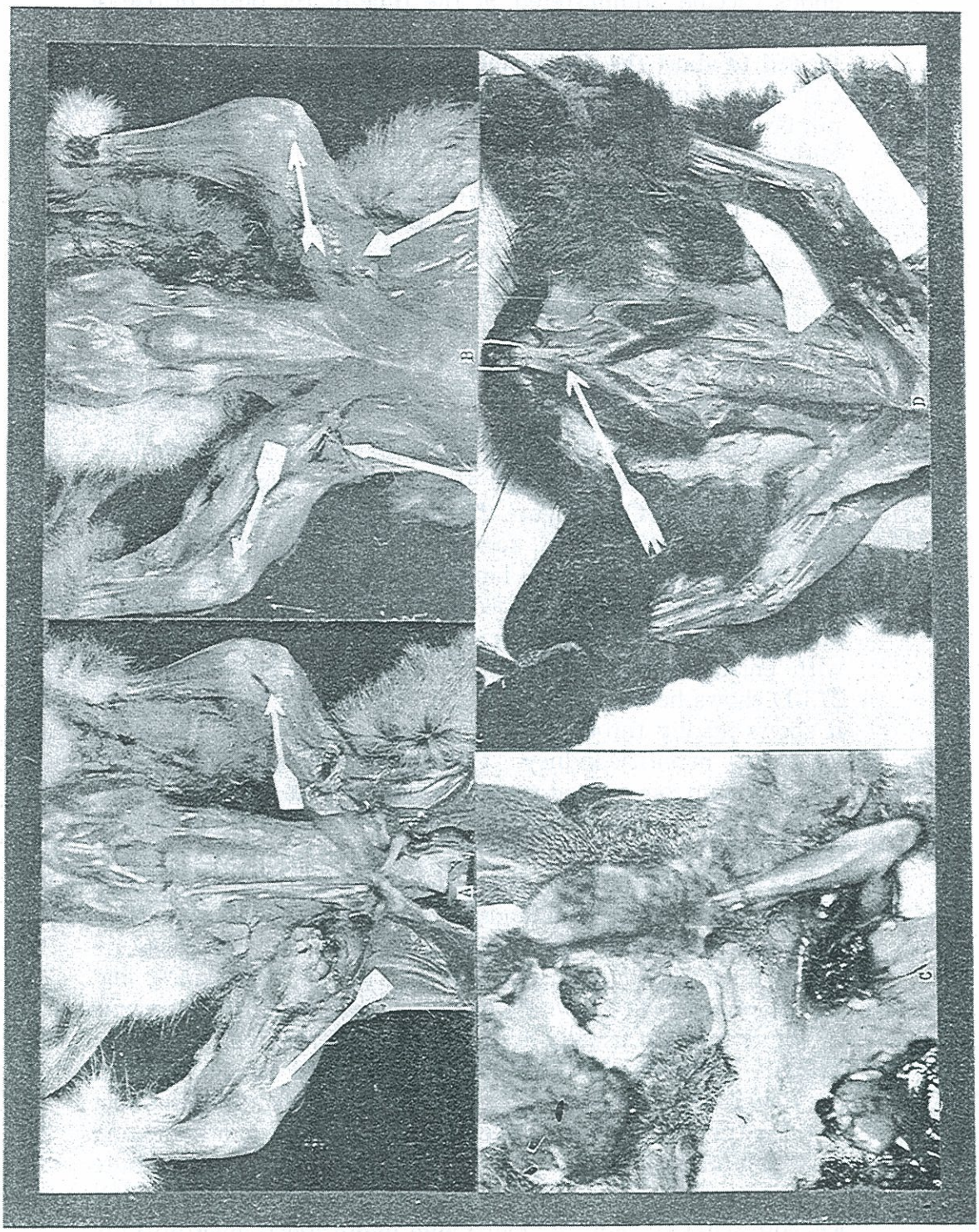


FIGURE 273. OTHERS OF THE MULTIPLE LESIONS PRODUCED BY THE DENTAL CULTURES FROM CASE 987 WITH STREPTOCOCCAL BACTEREMIA.

enous vaccine administered at the time of the onset of one of these attacks (or the earliest symptoms of one of these cycles) tended to abort the development of the cycle. The eyes would clear up without the customary pain, congestion, etc., and would not be followed by the acute rheumatism, though occasionally with mild symptoms of it.

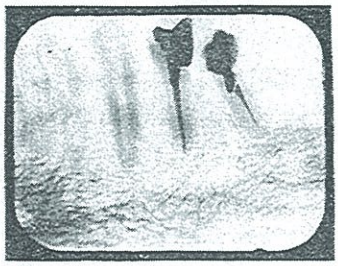


FIGURE 274. SOURCE OF CULTURE FOR INOCULATIONS FROM CASE 987.

The culture from the tooth, shown in Figure 274, when inoculated into rabbits, produced expressions in many and varied tissues. A and C of Figure 272 show the progressive involvement of a rabbit's eye; E, acute rheumatism; D and F, views, on different days, of the left hind leg of a rabbit showing a very marked edema which subsided without joint changes. A, B, and C of Figure 273 show extensive rheumatic involvements with enlargement of the axillary lymphatic glands. Figure 273-D shows hemorrhagic infection of the pulp, so marked that it shows readily through the tooth *in situ*. Figure 272-B shows an acutely nephritic kidney. Cultures from this woman's tooth, blood stream on several occasions, and eye at the time of the acute inflammatory processes of it, gave the same organism and same type.

It is important to note that this patient's symptoms were very general and diffuse, which tends to be true of the systemic expressions of bacteremias. She had involvements of her eyes, acute rheumatism, heart irritations, frequent febrile disturbance, and edema, any or all of which symptoms would tend to become rapidly worse, but usually in succession. Cultures inoculated into animals from the dental infection, the blood stream, and the eyes, similarly tended to produce very diffuse disturbances. Just as this patient's wrists would be swollen in twenty-four hours and very painful with edema, which condition would subside quite as rapidly, just so the animals tended to be affected. The hind leg, shown in two views of twenty-four hours apart, illustrates the rapid reduction of the edema. Within twenty-four hours after inoculation this rabbit was carrying this hind leg, with the edema and swelling of its foot. The swelling disappeared. Another in-

oculation was given and again in twenty-four hours it was carrying the foot. It will be noted that the infection in these rabbits is more generalized than is usually found, as I have shown in other chapters.

It would seem probable that this streptococcal invasion of the blood stream, in so abundant a form as we have found it, would make possible the securing of this organism in almost any tissue of the body during these periods; and if any tissue were capable of becoming, because of degeneration, a pabulum for the growth of the organisms, it would readily be inoculated from the blood stream; and if such a patient should develop a non-vital pulp, it would seem very certain that it would become immediately infected with this strain. In this sense, it may probably be said that, the systemic infection, or bacteremia, has caused the dental infection rather than that, the dental infection has caused the bacteremia. It should be kept in mind, however, that all Nature's normal tissues lend themselves to Nature's mechanisms of repair and defense so readily that in normal tissue Nature is able, generally, completely to eliminate the systemic infection. If, however, any tissues such as dentin and pulp tissue have become non-vital, Nature has no mechanism again to place that tissue in a sterile condition, and it immediately becomes a focus, and permanently so, so far as Nature is concerned, and, notwithstanding the violent opposition of many members of our dental profession, such infected tooth structure is, in effect, if not literally, an infected sequestrum.

RAYNAUD'S DISEASE.

Raynaud's disease is a vasomotor neurosis which is supposed to affect chiefly children and young adults, but which has been present in a number of cases studied in this clinic. Its etiology is very obscure. In the severe cases it is marked by capillary congestion and livid swelling which may eventually result in gangrene. It not infrequently happens that individuals afflicted with this disease will have one after another of the fingers or toes amputated as the disease progresses. The affection is very little affected by local or systemic treatments which are designed to affect the capillary circulation. One of the cases of particular interest in this connection is as follows:

The patient, male, about fifty, had a severe affection of the toes of one foot, one of which had been amputated about three years previously. A second toe became acutely involved and proceeded to a gangrenous necrosis and required an amputation about

one year before. When he presented to me, a third toe was seriously affected and there seemed every indication that it would suffer the same fate as the other two. He had several dental infections which were removed, which resulted in a very marked improvement in his Raynaud's disease which did not manifest itself again for a year, after which time I lost connection with him and do not know his later history. It seems very probable that this disturbance was largely a sensitization process in its early stages.

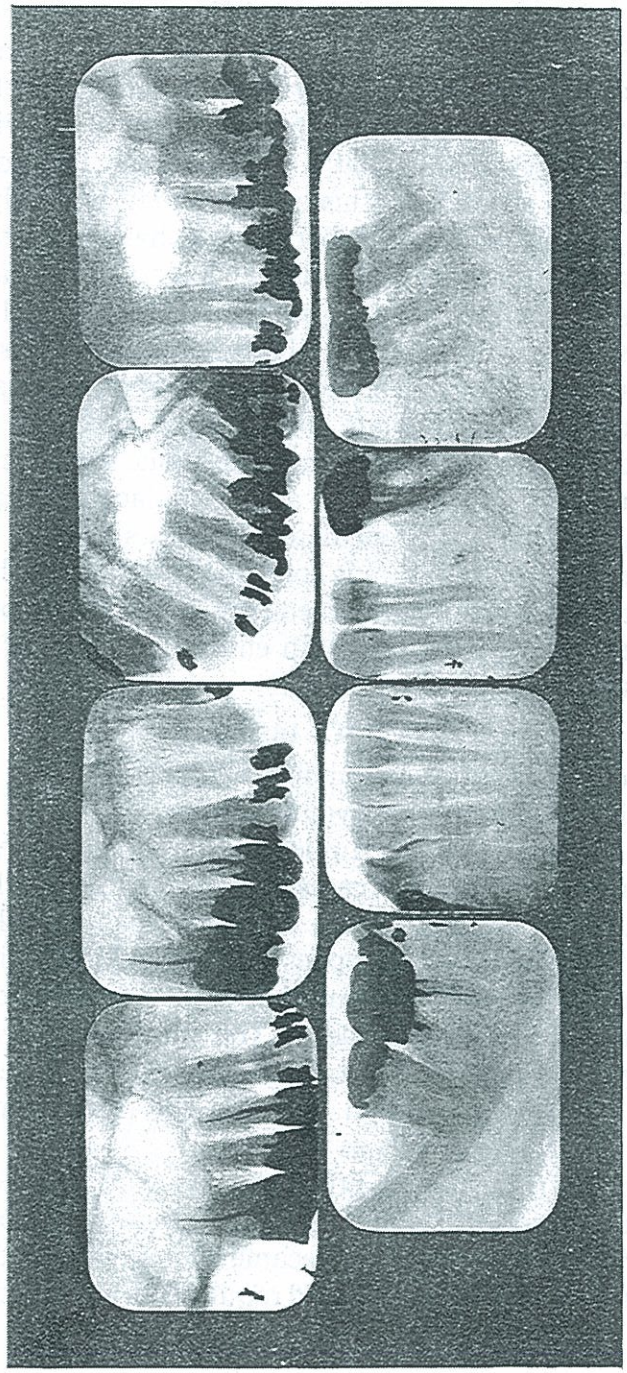


FIGURE 275. ROENTGENOGRAPHIC APPEARANCE OF TEETH, CASE 1241 WITH ANGINA PECTORIS. PATIENT APPARENTLY IMPROVED.

ANGINA PECTORIS.

It is uncertain to what extent dental infections contribute to angina pectoris. We have, however, records of several cases in which the disturbance disappeared promptly and for sufficient periods of time to warrant the belief that the relief was produced by the removal of the dental infection. To illustrate:

Case No. 1241.—A patient presented with obscure disturbance in the vicinity of the chest and heart. Sometimes he could walk many miles without any discomfort, and on other occasions would be almost prostrated from pain and exhaustion. The dental examination revealed conditions that were considered border-line. They would readily be interpreted, as shown in Figure 275, as having slight pathology. In order to strengthen our basis for our diagnosis as greatly as possible, he was carefully examined by the internist of my staff, and we decided to send him to a heart specialist for confirmation or correction of our diagnosis. That report strongly strengthened the basis of our suspicion, and these border-line teeth were extracted, with the result that his angina symptoms entirely disappeared and have not returned, even for a moment, for nine months. This was particularly important, as will be seen by referring to the roentgenograms in Figure 275. There is so little evidence of dental pathology. These teeth, when cultured, showed definite internal infection with streptococci which, when inoculated into rabbits, produced both heart and kidney lesions.

One of the teeth of his case was placed beneath the skin of a rabbit, after having covered with celloidin its entire surface except the root apex. (Note: Our previous experiments have shown that celloidin is but slightly irritating when planted in the tissue of rabbits.) The rabbit proceeded to build an encapsulation about the tooth. A photograph of the encapsulated tooth is shown in Figure 276-B. A local abscess, however, developed and it died in twelve days, having lost 25 per cent. This rabbit's heart appeared congested on posting. On the anterior surface there were two triangular whitish patches about three-fourths of an inch in extension. On cutting transversely over the same, the whiteness extended into the muscle tissue for about one-half millimeter. A photograph of the heart is shown in C, and a section of the heart muscle showing the fatty degeneration is shown in D. The kidneys of the rabbit showed parenchymatous nephritis and local hemorrhages, a section of which is shown in A. This patient died suddenly about one year later.

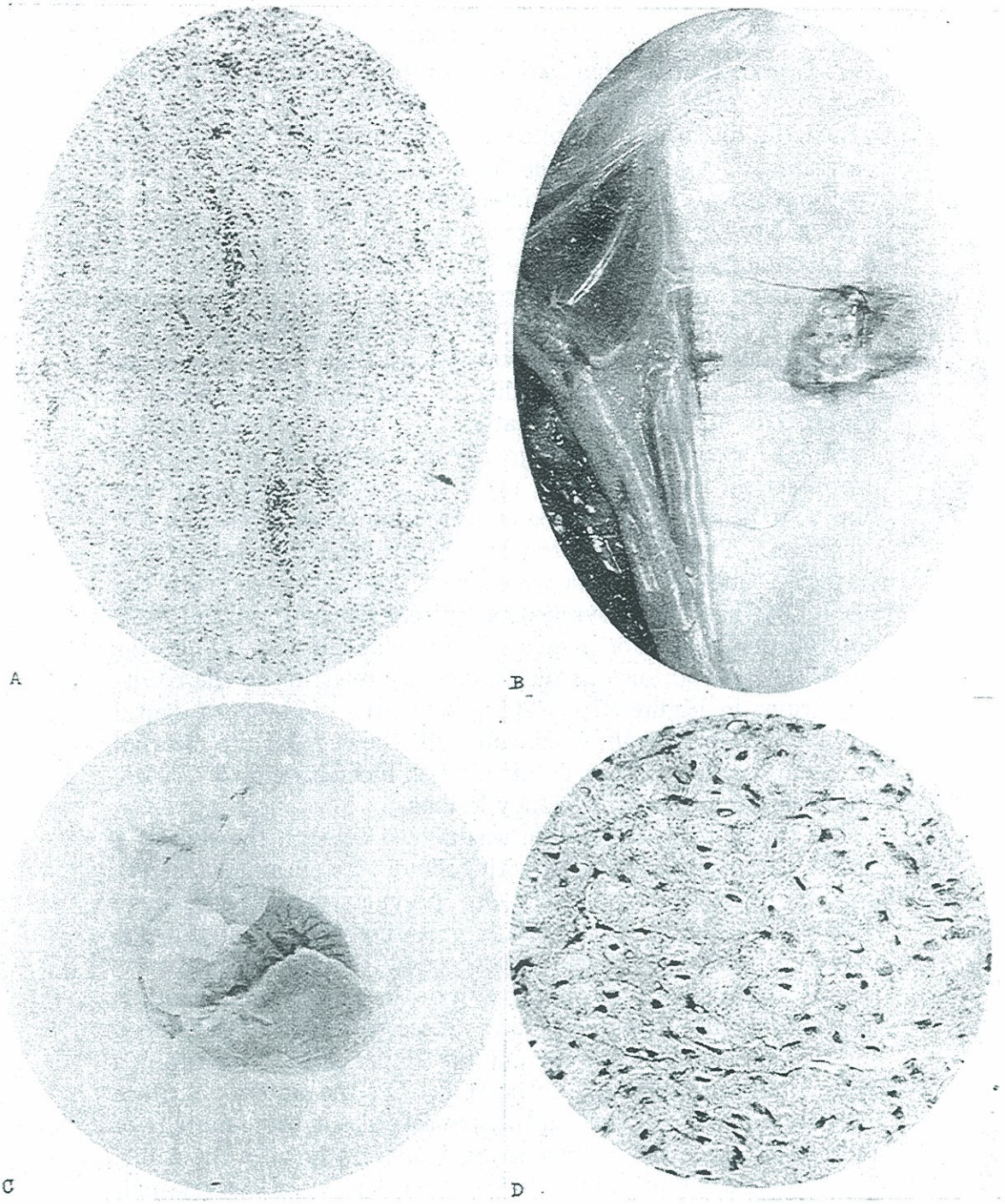


FIGURE 276. EFFECT OF IMPLANTING A TOOTH FROM CASE 1241 BENEATH THE SKIN OF A RABBIT. B, PHOTOGRAPH OF THE ENCAPSULATED TOOTH. C, A PHOTOGRAPH OF THIS RABBIT'S HEART. D, SECTION OF THE HEART MUSCLE SHOWING FATTY DEGENERATION. A, A SECTION OF THE KIDNEY, PARENCHYMATOUS NEPHRITIS.

HEART BLOCK.

Case No. 900.—In the chapter on dental cysts, I discuss a case of a very extensive invasion with absorption of root apices. This patient seventy-six years of age, was brought to us suffering from a very severe central nervous system disturbance and extreme hypotension, which varied sometimes quite rapidly. He had, on several occasions, given evidence of symptoms which his physician had diagnosed as heart-block. After the surgical treatment of his cyst, this symptom entirely disappeared so that he could walk for miles at seventy-six years of age as rapidly and comfortably as most men of thirty; and after two years, he is still free from those symptoms which had so nearly taken his life on several occasions. When brought by the physician, he was considered to be in such a critical condition that we were advised to be extremely careful or he might go out at any moment. The hypotension was quite completely relieved and it, also, for two years has remained nearly normal. Roentgenograms of his case are shown in a figure of Chapter 69.

HEMOPHILIA.

Few, if any, of the effects of dental infection are so marked as the chemical changes in the blood, conspicuous of which are the anemias and hemophilia. A typical case of the latter is as follows:

Case No. 1024.—A man of thirty-eight years of age was referred by a physician with the following history: For three months there had been almost constant seepage of blood from the mucous membranes of the mouth, chiefly about the necks of teeth, with occasional bleeding of the nose and throat. He had been very near death on several occasions. A few weeks prior to his being referred, he had had two blood transfusions which gave exceedingly little and temporary relief. The socket of a tooth extracted three months previously was still bleeding. The roentgenograms revealed the condition shown in Figure 277. Careful examination showed that the hemorrhage was greatest around the non-vital teeth. On the presumption that these teeth were furnishing a toxic substance which was contributing to this condition, we deemed it wise to remove one of these for study and observation of the effect, notwithstanding the great danger and difficulty attending the control of the hemorrhage following the extraction. Extreme care was taken and immediate packing of the socket and retaining of pressure to prevent hemorrhage was

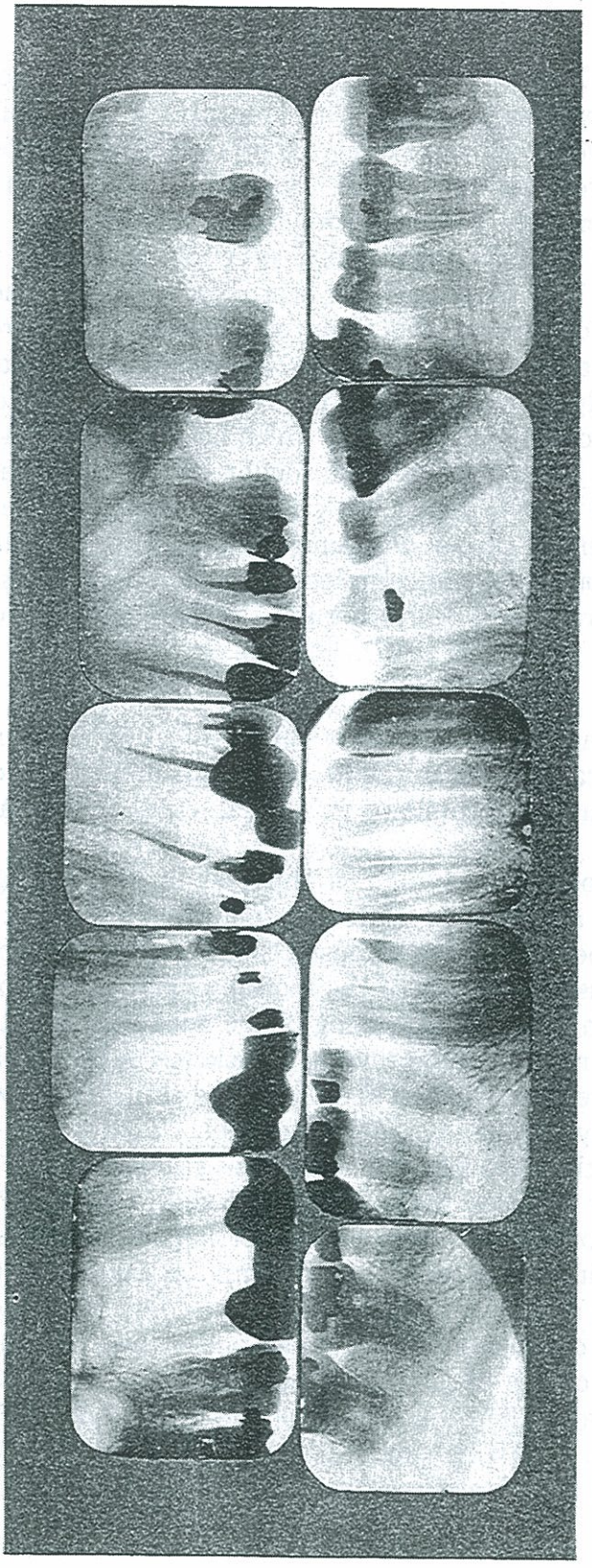


FIGURE 277. HEMOPHILIA. CASE NO. 1024. ROENTGENOGRAPHIC APPPEARANCE OF THE TEETH. NOTE THE ABSENCE OF LOCAL REACTION. PATIENT NEARLY DEAD FROM SPONTANEOUS HEMORRHAGE, CHIEFLY FROM GUMS, FOR THREE MONTHS, AND MOST SEVERE ABOUT ROOT-FILLED TEETH. SEE TEXT.

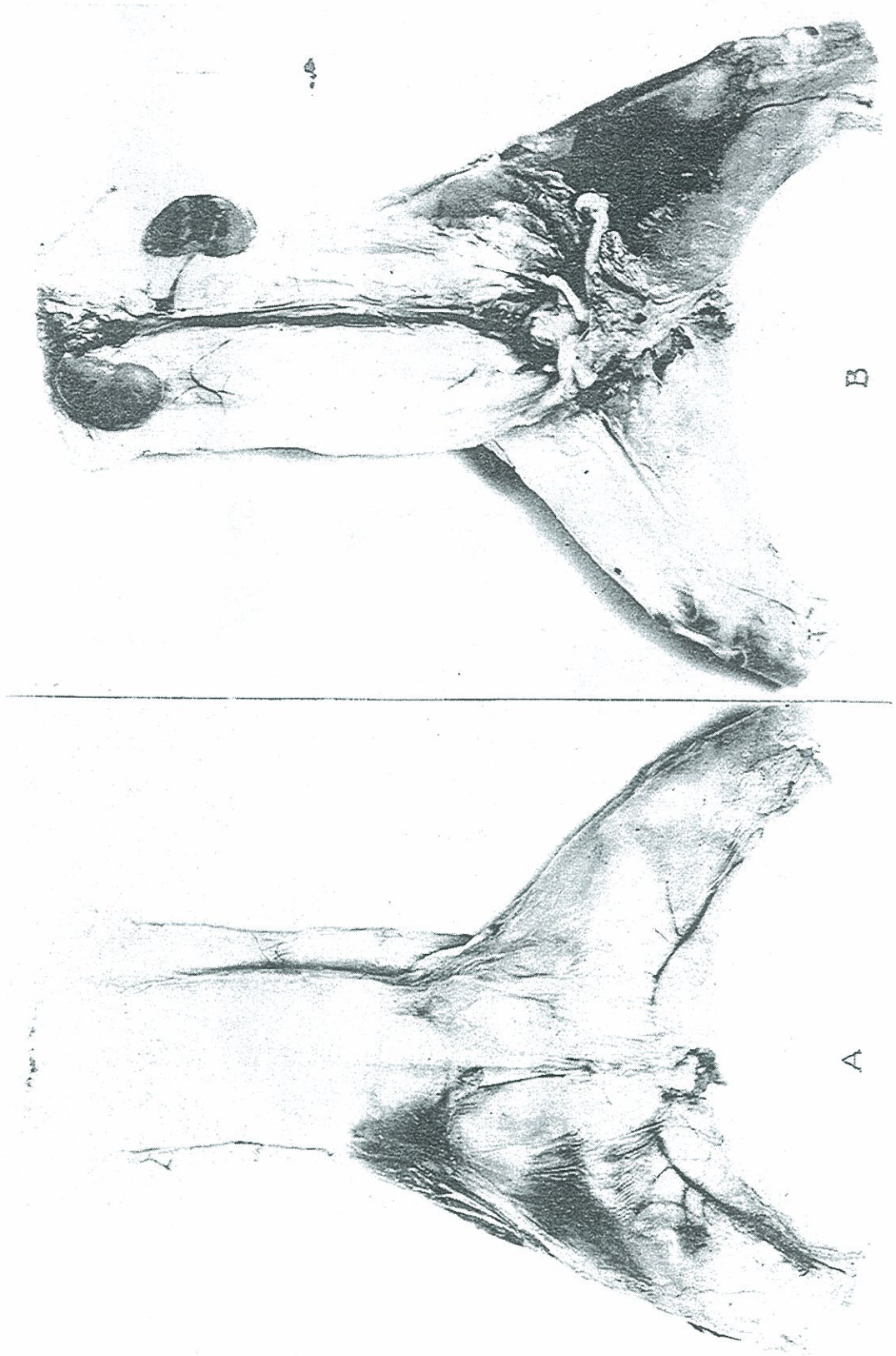


FIGURE 278. SPONTANEOUS HEMORRHAGE IN RABBIT, CAUSING DEATH IN TWENTY HOURS, FROM CULTURE FROM TOOTH, UPPER RIGHT THIRD MOLAR.
SEE FIGURE 277.

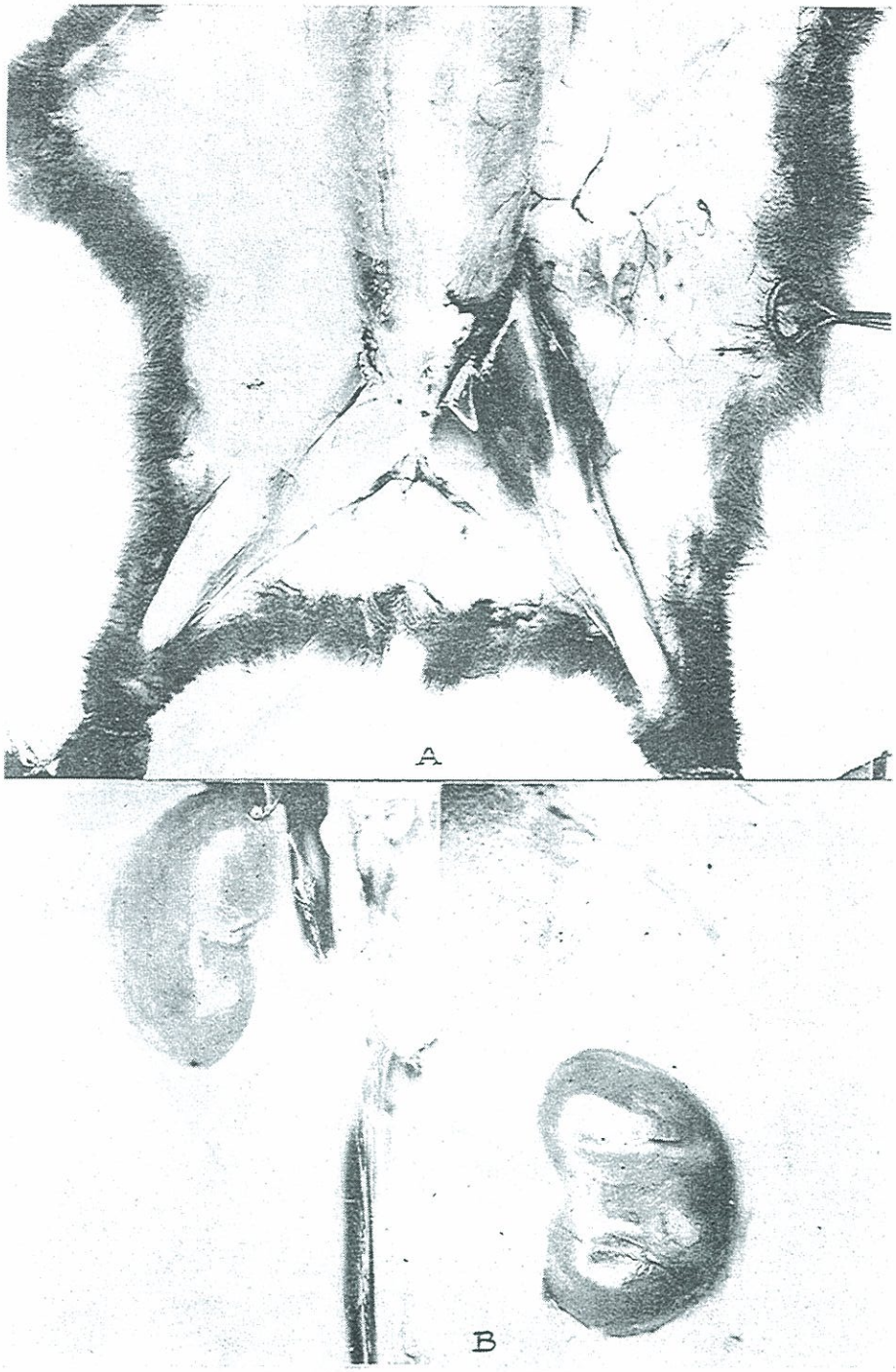


FIGURE 279. SPONTANEOUS HEMORRHAGES IN RABBIT'S KIDNEY AND THIGH. CASE 1024. MANY RABBITS DEVELOPED DELAYED CLOTTING OF BLOOD FROM THIS CULTURE. PATIENT GREATLY IMPROVED.

done. Notwithstanding this precaution and the close attention of a skilled nurse, a few ounces of blood were lost in a few hours. The tooth was used to make a vaccine from its culture; the organisms grown from it were also used for animal inoculation. These lengthened the clotting time of the blood of rabbits, which had been found to be normal at a half minute to a minute, to three and four, and in extreme cases to six and ten minutes, which is very unusual for rabbits, it being extremely rare that severe spontaneous hemorrhages occur. In the last thousand rabbits inoculated in the last two years, only a few rabbits have died from spontaneous hemorrhage, one of which is shown in Figures 278 and 279, which was inoculated with the culture from the tooth of this case. It died in twenty hours from extensive hemorrhages into the thighs, legs, viscera, kidneys, etc., and there was so little blood left in the circulatory system that it was impossible even to get a small amount for blood chemistry, which is frequently made in such conditions, by aspirating blood from the heart and larger blood vessels. This rabbit was posted immediately upon its death, which death process was being watched, and there was not time for any clotting of the blood within the vessels, which process was very slow in this rabbit.

With the extraction of this tooth and the use of the vaccine made from it, this patient's condition very rapidly and markedly improved. Three other teeth were extracted with intervening periods of a few days, and in one week's time spontaneous hemorrhage had almost entirely ceased from the mucous membranes of his body, and in four weeks' time he was back at his business with his clotting time reduced from eight and one-half minutes to three and one-half minutes. He had completely lost the hearing of his left ear at the time he came to us, as a result of a spontaneous hemorrhage in his internal ear, which deafness persisted. He continued at his business with but slight interruptions for seven months when he had a hemorrhage in one of his eyes. This laid him up for a couple of weeks, after which he went back on the road. After a very hearty meal, while being entertained at a friend's home, he was taken with distress in his stomach. He came home and had a severe hemorrhage from his nose. This was followed by a distress in his abdomen which was diagnosed as peritonitis. He was taken to a hospital in a critical condition for surgical assistance and, according to the report of his wife, died in a few hours from a complication as an extensive hemorrhage in both the abdomen and thorax. It seems probable that

Private Records of Weston A. Price, M.S., D.D.S., 8926 Euclid Avenue, Cleveland, Ohio

Form No. 13 - Serial No. 1118

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT I. W. D. Case No. 1118 AGE 45

ADDRESS DATE 6-14-21

CHIEF COMPLAINT Fatigue. Heart. Neuritis. Rheumatism

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf	Father's Side: Father	Father's Side: Grandfthr	Father's Side: Grndmothr	Father's Side: Uncles	Father's Side: Aunts	Mother's Side: Mother	Mother's Side: Grandfthr	Mother's Side: Grndmothr	Mother's Side: Uncles	Mother's Side: Aunts
		No.	5	1							5	2				4	2
##	#	Tonsillitis	#2														
#	#	Rheumatism	#	#				#									
		Swollen or Deformed Joints															
#	#	Neck-back or Shoulders		#													
		Lumbago						#									
#	#	Neuritis	#														
		Sensitizations															
		Sciatica	#														
		Chorea or St. Vitus's Dance															
	#	Nervous Breakdown	#	+													
		Mental Cloud															
	#	Persistent Headache															
##	##	Heart Lesions						⊕			⊕	+	+		⊕	#	⊕
		Dropsy													⊕		
		Kidney Lesions, Brights	#														
+?	+?	Liver or Gall Lesions		✳									#				
		Appendicitis															
#	#	Stomach pain or Ulcer											⊕				
#	#	Eye, Ear, Skin, Shingles						#									
		Pneumonia															
+	+	Anemia															
	+	Goiter															
##	##	Lassitude, Chilliness															
		Hardening of Arteries											##				
		Stroke															
		Age if Living															
		Age at Death						84	80	70			81	65	75		
	#	Flu with Complications															
#	#	Flu without Complications															
#	#	Persistent Constipation															
	#	Overload															
	+	Extensive Tooth Decay															
?	+	Abscessed Teeth															
		Loosening Teeth															

Years — Duration of Dental Infection — Duration of chief Affection

KEY FOR CHART: + HAD LESION; # FREQUENTLY; #VERY SEVERELY; +? PROBABLY; ✳ OPERATION; ⊕ FATAL ATTACK

D. INFCTN TYPES: CARIES + | LOKD CONDSNG + | SL. HG. | SYST. RELF. | COMP. | PART. | RECR. | NONE

PYRRH | OPEN | REVING | RA.HG. | SUSC. TBLT. ### | INHT. | ACQD. | ABST. | SC.NO

FACTOR OF SAFETY: V.HG. | HIGH | FAIR | LOW | V.LW. ###

FIGURE 280. SUSCEPTIBILITY HISTORY OF PATIENT AND FAMILY. CASE NO. 1118.

he died in a condition strikingly similar to that developed in some of the rabbits inoculated with the culture from his teeth. This patient's hemoglobin was 70 and increased to 80. His erythrocytes increased from 3,250,000 to 4,700,000. The total calcium of his blood, ionic and combined, was only 8 mgs.

Some of these dental strains have very marked effect upon the various cells of the blood. It is very frequently found that in patients with a streptococcal susceptibility, whether inherited or acquired, the secondary anemias exist. There may be an erythropenia, two or three million, very often three and three and one-half million, which condition rapidly improves with the elimination of the dental infection. There may also be a very marked leucopenia. This condition is so frequently found that its presence is a very important diagnostic symptom. These patients tend to have a leucocyte count of four or five thousand per cubic centimeter. A differential count may show a polynuclear count of forty to fifty-five per cent. These patients are in very poor condition for defense. They tend readily to systemic complications. With removal of their dental infections, this condition frequently very rapidly improves. In Chapters 19 and 20, I have shown that just as these patients have these typical changes in their blood morphology, the rabbits inoculated with the strains from dental infections very frequently develop similar changes, which is also true of the chemical changes in the blood. For more detailed reference to these blood changes, see all the charts in Chapters 19, 20, 43, and 44.

CHRONIC CARDITIS.

There are many striking illustrations of the potential handicap of individuals born of an ancestry having a marked susceptibility to heart involvements. Such a case is strikingly illustrated in Case No. 412, a married man, aged forty-six, who has been suffering from acute heart involvement. There has been a history of heart involvement since seven years of age. He is a semi-invalid. A history of the family and ancestry reveals that his father died of a heart lesion at forty-eight. His father also had rheumatism; four of his father's brothers had rheumatism and one had heart and kidney involvements. His mother had heart involvement, and her mother died of heart trouble. One of her sisters is an invalid with heart involvement. The patient's mother and her mother and one sister all have had rheumatism. He has had acute digestive disturbance not accounted for by food, as have

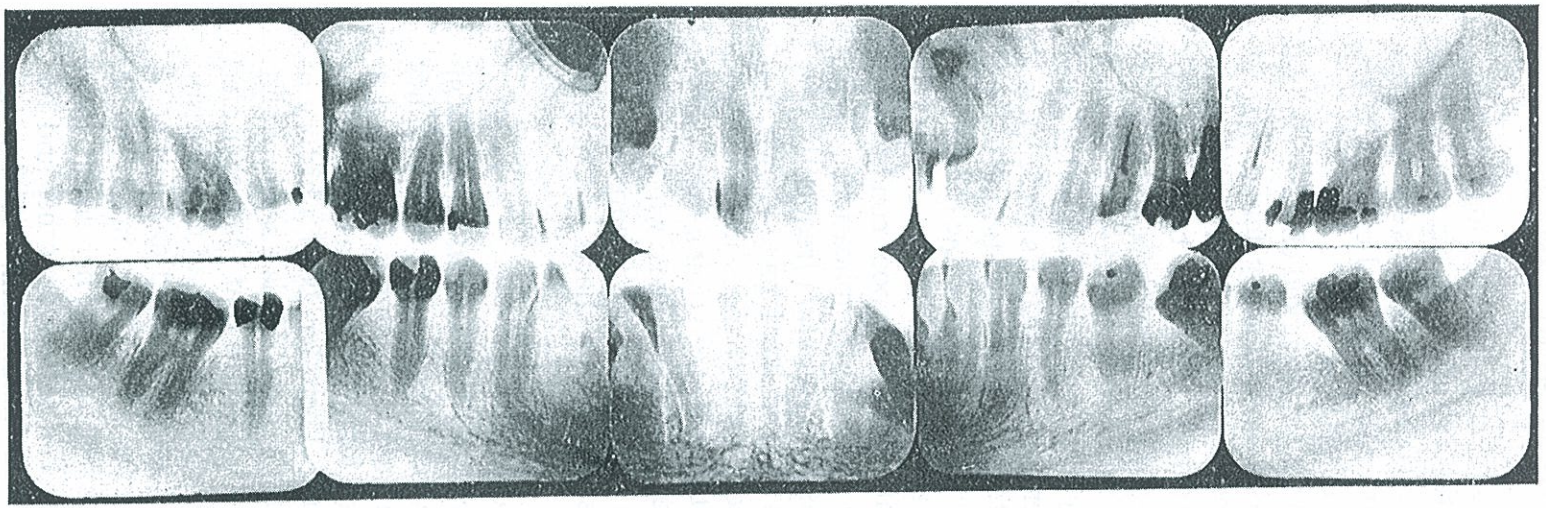


FIGURE 281. ROENTGENOGRAPHIC VIEW OF TEETH OF CASE NO. 1118 WITH RECURRING HEART INVOLVEMENT.

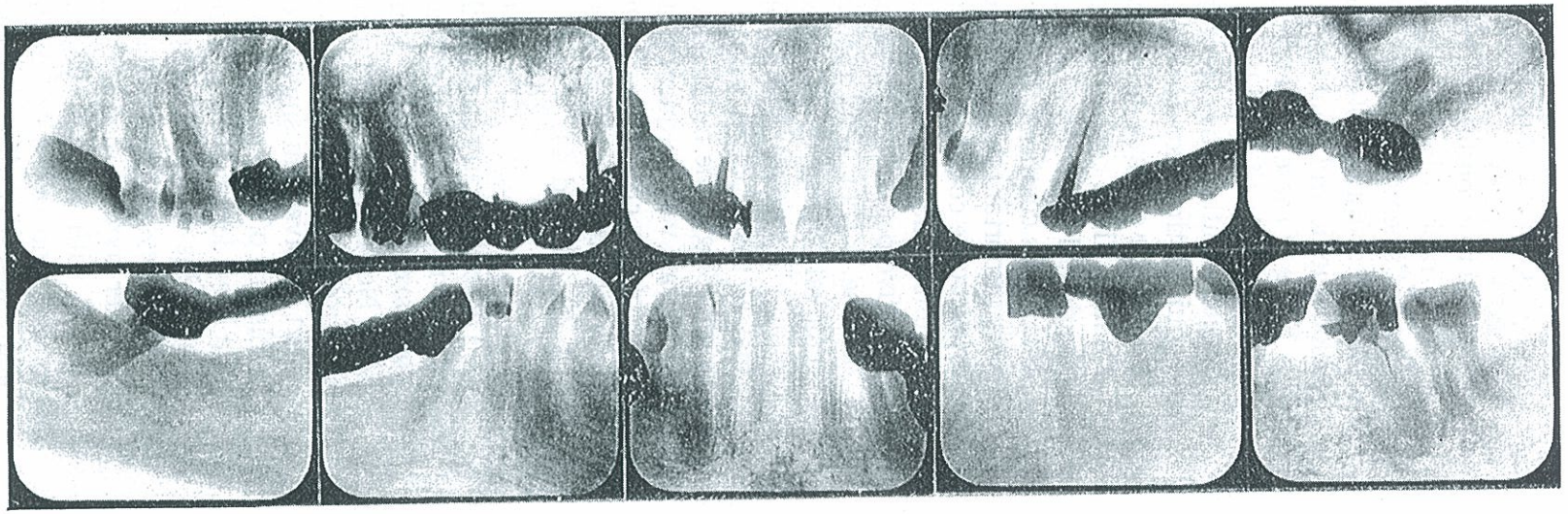


FIGURE 282. ROENTGENOGRAPHIC APPEARANCE OF TEETH OF PATIENT WITH MYOCARDITIS. CASE NO. 1346.

also two brothers. This has been a serious affliction with the patient's mother, and involved her mother, her brother, and sister. There has been left a very marked inherited susceptibility.

Such a case history can only be considered unfavorably and the prognosis not good. If this patient has a locked area of dental infection, it will be almost certain to aggravate his heart condition. Since it is so nearly impossible, if not entirely so, to maintain the sterility of a tooth, no matter how well sterilized and how well root-filled, in the mouth of this type of patient having a lowered defense, we would say with confidence that this patient has no right to have a root-filled tooth in his mouth. His prognosis will always be bad. The removal of dental infection or any other source of focal infection will be very important as removing that much overload. Absorption of toxic substances from the alimentary tract, nasal sinuses, or any other source, would tend to be a serious overload. Streptococci will grow in this man's body with very much greater ease than in the normal, and the proportion of streptococci in the bacterial flora of the mouth will be much greater than in individuals with a high defense for streptococcal infection.

We have stated elsewhere that the seriousness of the patient's lesion together with the factor of safety, as interpreted from the susceptibility chart, will largely determine whether so-called border-line teeth will be left or extracted. If, for example, the patient is entirely well, but is young, and has had no serious overloads, and the history shows that he or she might be expected to have a strongly inherited susceptibility for heart or kidney or some such vital tissue, it is my judgment that such a person should not be permitted to carry a condition which might some day produce the only other element required—namely, a source of streptococcal infection—to make possible a break in the heart tissue when the normal defenses become lowered. Sometimes, however, the break is already beginning if we have the foresight to recognize it. Such a condition is illustrated in the following case.

Case No. 1118.—The patient at forty-five years of age was suffering from fatigue, heart, neuritis, and rheumatism, and for some time had been practically incapacitated for her work. The roentgenographic study of her teeth, as shown in Figure 281, revealed only one non-vital tooth: namely, the upper right bicuspid. This did not have roentgenographic evidence of much local

structural change. We would consider this tooth border-line.

Her susceptibility revealed, as shown in Figure 280, that her chief lesion is heart, that it has been progressively developing, but most important of all that her father and one of his brothers died of heart involvement, and that one of her father's sisters was afflicted with a heart involvement. Her mother's mother died of heart and kidney involvement. Her brother had a heart involvement and her sister died of heart involvement. In other words, she has a strong susceptibility to heart involvement from both sides of the ancestry.

We, accordingly, would expect that with a source of streptococcal infection and an overload, physically or nervously, she would tend to develop a heart lesion. We would not expect that the removal of such a tooth as shown in the upper right bicuspid would produce sufficient physical change in her body to make great change in the condition of her heart. We would, however, expect, and that with confidence growing out of our experience, that this tooth would be infected in its dentin with streptococcal infection. It was extracted and cultured internally and found to be infected with a Gram-positive diplococcus.

An important procedure in this and all such cases is, we believe, the use of such means as may be possible to elevate the patient's attacking power for streptococcal infection, which is chronically low in this type of individual. For this we would recommend, and used in this case, an autogenous vaccine made from the organisms grown from the tooth. Results were very gratifying and her improvement marked, so that she was able to return to her profession of school teaching. I desire this case to be considered as an emphasis of the need for making a susceptibility study, to ascertain the patient's probable inherited factor of safety, together with the patient's own record of such.

As an additional precaution, we recommended that this patient see a throat specialist regarding the tonsils, which he recommended should be removed, on account of her general history rather than the positive tonsillar history. Her health has been excellent for two and one-half years up to the present, and she is again carrying full load, and that very comfortably.

Our later study of these cases reveals that an inherent lowered defense is expressing itself primarily in a decreased bactericidal content of the blood. Their best is never high or adequate for combating an overload. With the reduction of overloads to the

minimum, most important of which for them is a focal streptococcal infection, they may have quite comfortable and efficient lives; and this is the type of patient—namely, one having a low normal bactericidal content of the blood—whom we may greatly assist with a properly dosed and properly prepared vaccine, which was demonstrated in this case.

MYOCARDITIS.

These researches seem to be throwing an important new light on the probable etiology of many cases of myocarditis. Some of the most striking and gratifying improvements that we have ever seen have been in this type of patient. We have always considered heart involvements of all types as being very serious and, indeed, we do still. We do not, however, look with such alarm upon this condition as we did formerly, having seen so many individuals take up again very vigorous life work and carry it without break for many years with both comfort and efficiency.

In the next chapter under Respiratory System we discuss a case in which, with the suspected tuberculosis, there was severe tachycardia with lassitude and dyspnea on exertion, which has been entirely relieved by the removal of his dental infections, the patient having gained in weight from 122 to 176 pounds and has since taken large life insurance policies notwithstanding that he had been refused previously on account of his heart. In five years he has retained practically perfect health, carrying on an active business, and looks like an athlete.

In Chapter 59 on the Application of Preceding Experimental Data in Clinical Practice, I have used as an illustration a patient who at twenty-three years of age was suffering from a very acute heart involvement and rheumatism, the former so severe that she could scarcely walk about. Within a few weeks, she gained from 131 pounds to 146, and for five years has retained her perfect health notwithstanding the fact of a very marked hereditary susceptibility, both her father and mother having died of heart involvement between fifty and sixty years of age, as did others of the ancestry.

It is very difficult in classifying cases, to prevent overlapping because of the frequent, if not general, tendency to complications; that is, several organs or tissues will be involved at the same time in the one patient. The following is such a case.

Case No. 1346.—The patient was forty-nine years of age and had been suffering what threatened to be a complete break in his health for the last three years. His chief distress has been in and

about his heart. Physical examination indicated that the heart was enlarged and the apex rotated nearly to the nipple line. His disturbance had been previously diagnosed as myocarditis. The blood pressure was 180. He had a sensation of extreme tension in his head and symptoms which had been diagnosed as stomach involvement. He had had several thorough physical examinations including his mouth, and it had on each occasion been decided that the teeth were not involved, roentgenograms of which are shown in Figure 282. Our first impression from the roentgenograms was that his teeth were not sufficiently involved to be a serious contributing factor, if judged exclusively from a casual study of the roentgenograms. A more thorough study, however, revealed that the pulps were putrescent in both the second and third upper left molars, and exposed by caries and infected in the upper left first molar, none of which teeth showed apical involvement in the roentgenogram, but which conditions were evident upon careful physical examination of the teeth. The low angle of the upper right cuspid did not reveal clear evidence of apical involvement which, however, the high angle

FIGURE 283. HIGH ANGLE VIEW OF UPPER RIGHT CUSPID SHOWN IN FIGURE 282. NOTE DIFFERENCE IN PERIAPICAL APPEARANCE.

view, shown in Figure 283, clearly reveals.

The ionic calcium of his blood was much below normal. His blood sugar was 108; non-protein-nitrogen 49; urea 12.5; erythrocytes 5,450,000; polymorphonuclear leucocytes 47.5; small lymphocytes 47.5 per cent. His features were drawn and expressive of great nervous strain and tension. A culture was made, anaerobically, from the pulp of the upper left first molar and from the contents of the putrescent pulp of the upper left second

molar and inoculated into two rabbits. One died in about twelve hours with hundreds of small hemorrhages throughout the musculature of the body. These were found in both striated and non-striated muscles. These are shown in the chapter on Elective Localization in Figures 152, 153, and 154. Figure 152 shows four views of this rabbit with its spontaneous hemorrhages in various parts of the body. Figures 153 and 154 show spontaneous tissue hemorrhages in several different rabbits, with the characteristic, that the specific quality which expressed itself as spontaneous hemorrhages, reduced as the culture increased in age. In the rabbit dying in twelve hours, and which received the earliest generations of the culture grown from his teeth, and which had hundreds of hemorrhages in various parts of its body, the heart was large and flabby and showed evidence of dilatation. The heart muscle showed a very remarkable condition. In addition to the macroscopic hemorrhages visible in the heart and corresponding with the macroscopic hemorrhages in other tissues of the body, the heart muscle showed, when sectioned, exceedingly profuse interstitial hemorrhages. These had been so violent as to rupture the connective tissue. This is shown in Figure 284. The upper left molar was planted beneath the skins of several rabbits in succession, the first five of which produced definite lesions, the first with hemorrhagic myositis, with spontaneous hemorrhages; the second, hyperemia of the myocardium, muscle atrophy, and edema of the kidney; the third, acute appendicitis, minute hemorrhages of the wall of the large intestines, and hyperemia of the myocardium, liver, and kidneys; the fourth, hyperemia of the heart and liver, and muscle atrophy; and the fifth, hyperemia of the myocardium and kidneys.

The patient was placed on the following program: A diet rich in calcium, consisting of from three pints to two quarts of buttermilk or sweet milk per day, calcium lactate in tablet form, parathyroid one-tenth grain daily, reduced later to one-twentieth grain daily.

The postoperative condition following the extraction of the three upper left molars was that a secondary hemorrhage set in a few hours after the extraction, which persisted for hours and was very obstinate, requiring the patient to be kept in the ward with nurse's attendance for the night. This is particularly important in connection with the effect of the culture on the inoculated rabbits which developed spontaneous hemorrhages in the muscles.

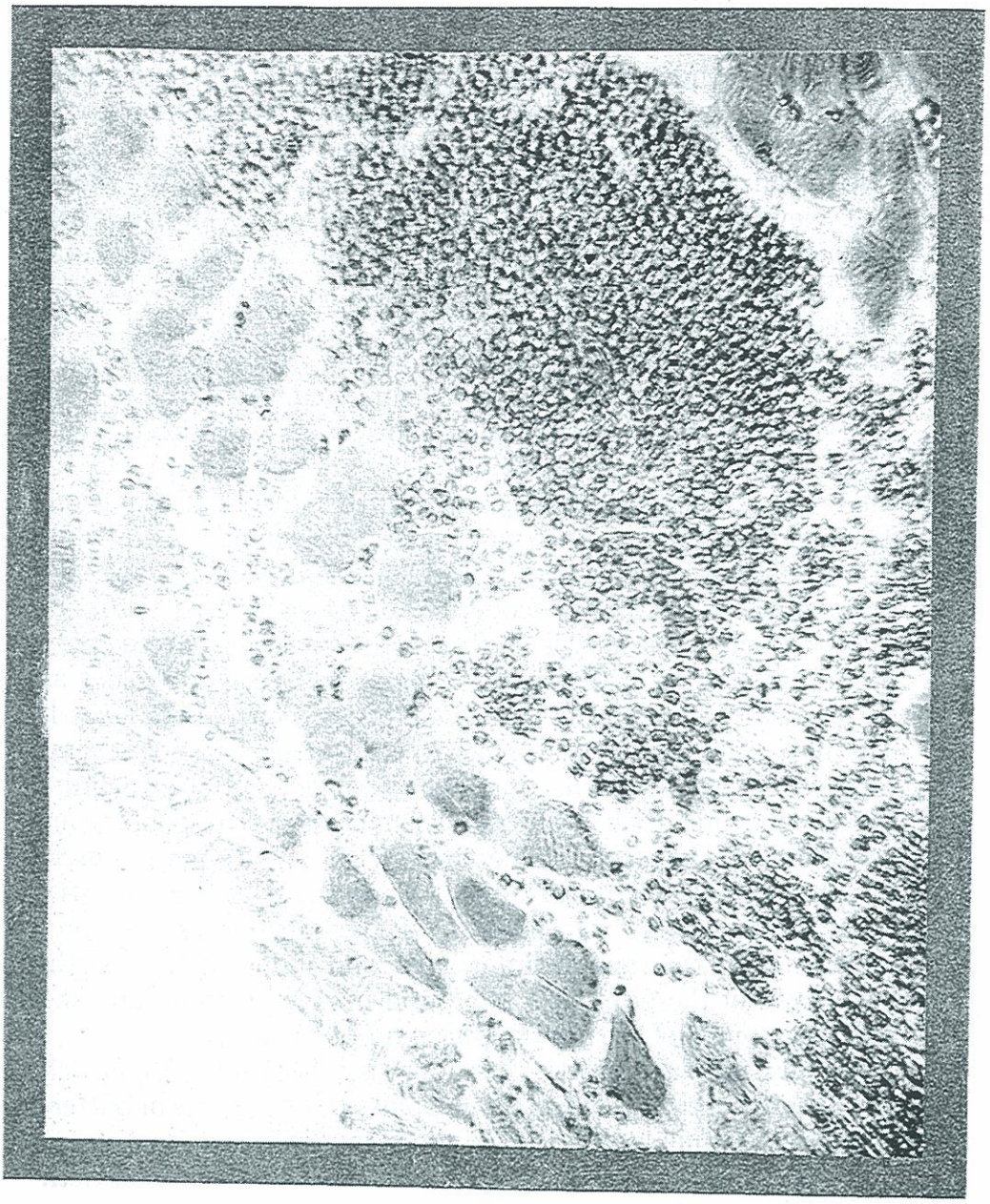


FIGURE 284. SECTION OF HEART WALL OF A RABBIT WHICH DIED IN TWELVE HOURS FROM SPONTANEOUS HEMORRHAGE FROM TOOTH CULTURE OF CASE NO. 1346. SEE ALSO FRONTISPIECE C.

After the extraction of the first three teeth and the treatment that was instituted, no further hemorrhages were experienced. The other extractions followed in a few days. The general result

was that in ten days' time the patient's ionic calcium of the blood was back to normal. His general physical state had improved so greatly that he stated that he had not felt so well for three years. His appetite was excellent and he slept well. The vital index of the polymorphonuclears showed marked improvement. The relation between the ionic calcium and the general condition of the patient was characteristic of this type. When the ionic calcium was low, he had to drive himself with a whip, being in a state of intense lassitude and nervous irritability. He expressed the former condition as one in which the feeling of his head was as though he had been struck over the head with a club, and it was almost continually sore or under sense of severe tension for months. This sensation completely disappeared. He stated that he had not felt as well at any time for three years as he did within ten days after these first extractions and the starting of the special treatment.

A piece of the root of the upper left second molar was placed in some of this patient's blood serum to determine its effect upon the blood calcium. This piece of root furnished enough toxin to combine with approximately one-tenth of the available ionic calcium of this serum in 1 cc. in one-half hour's time, or a total of approximately 30 per cent, when added to the already combined calcium.

Whereas, before the removal of his dental infections and his treatment, he was in such serious condition that he could not carry on business and at times could scarcely carry on a conversation because of the sense of distress produced by having to think, which symptoms were more aggravated for an hour after eating, at which times he would not dare to walk a block because of the distress about his heart, since the removal of the dental infections and treatment, and beginning within a few days and rapidly improving, the heart irritation has entirely disappeared, as also the distress related to eating, and he is entirely free from the nervous disturbances and mental irritability. Within a few days he was walking several blocks, and in a few weeks was carrying on business practically without limitation. He has gained in weight and a feeling of well-being and joy was clearly expressed in all his features in place of the haunted nerve tension that clearly demonstrated that he was just at the point of nervous crisis.

FIGURE 285. SPONTANEOUS HEMORRHAGES IN THIGH OF ONE RABBIT AND PSOAS MUSCLES OF ANOTHER RABBIT. TOOTH CULTURE FROM CASE NO. 1346.

Illustrations of the spontaneous hemorrhages produced by both culture and the implantation of his infected teeth in other muscles than the heart are shown in Figure 285, in which A shows hemorrhages into the hind leg of a rabbit, and B, hemorrhages into the psoas muscles of the back. This case is discussed also in the chapter on Digestive Tract in relation to the type of lesion expressed in the stomach.

For those who are interested directly in the elective localization quality of the organism found in this case, we would state that in ten rabbits inoculated, nine showed spontaneous hemorrhages and the tenth showed hyperemia of the myocardium. This should be thought of in connection with the fact, that the patient not only had the heart involvement, which had been interpreted as a myositis, and which condition was apparently quite perfectly relieved, but also had an exceedingly severe secondary hemorrhage following the removal of his dental infections. This elective localization quality tended definitely and rapidly to diminish with time. Only the first generation of organisms produced the sufficiently severe spontaneous hemorrhages to cause death. In this connection it should also be noted that even the implanted tooth produced spontaneous hemorrhages.

FIGURE 286. SMEAR FROM THE URINE OF CASE NO. 1346, SHOWING MANY PUS CELLS WHICH ENTIRELY DISAPPEARED AFTER THE REMOVAL OF DENTAL INFECTIONS.

The urinalysis before the removal of the dental infections showed both hyaline and granular casts and pus cells in large numbers, arranged largely in shreds as if formed into such in the glomeruli. Figure 286 shows a smear from his urine with polymorphonuclear leucocytes and diplococci. This condition entirely disappeared with the removal of his dental infections.

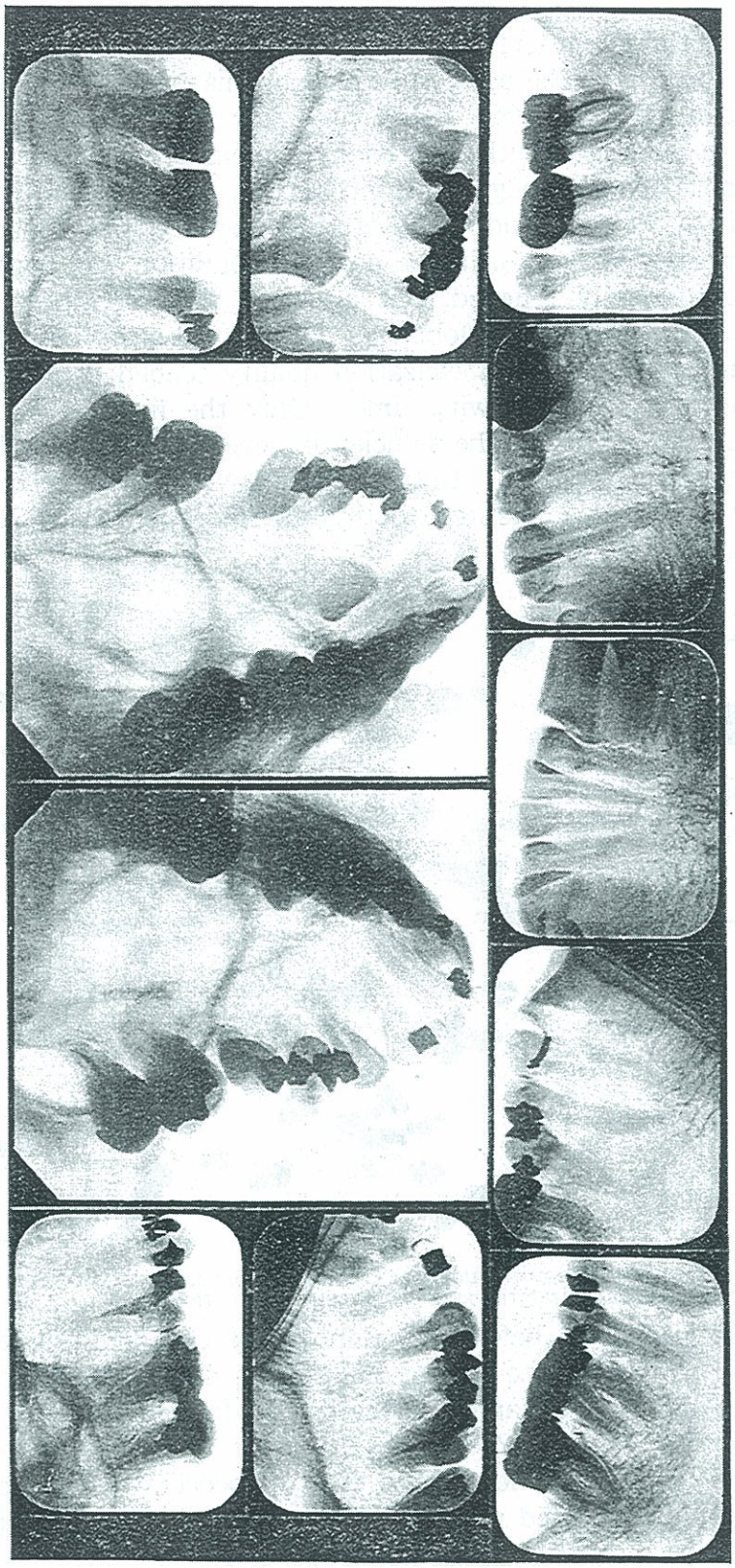


FIGURE 287. ROENTGENOGRAPHIC APPEARANCE OF TEETH OF CASE 1335 WITH HISTORY OF SEVERE HEART INVOLVEMENT.

Form No. 13 Serial No. 1335

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT I. W. R. Case No. 1335 AGE 30

ADDRESS DATE Nov. 17, '22

CHIEF COMPLAINT None

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf	Fathers Side: Father	Fathers Side: Grndfthr	Fathers Side: Grndmthr	Fathers Side: Uncles	Fathers Side: Aunts	Mothers Side: Mother	Mothers Side: Grndfthr	Mothers Side: Grndmthr	Mothers Side: Uncles	Mothers Side: Aunts
		No.	1	1							5	2				1	½
	X	Tonsillitis															
		Rheumatism						+									
		Swollen or Deformed Joints															
	+	Neck-back or Shoulders															
		Lumbago															
		Neuritis															
		Sensitizations															
		Sciatica															
		Chorea or St. Vitus's Dance															
	#	Nervous Breakdown											#				
		Mental Cloud															
		Persistent Headache															
+	#	Heart Lesions						⊕⊕			⊕	⊕					
		Dropsy															
		Kidney Lesions, Brights															
		Liver or Gall Lesions															
		Appendicitis		*													
		Stomach pain or Ulcer						#									
		Eye, Ear, Skin, Shingles															
	#	Pneumonia															
		Anemia															
		Goiter															
		Lassitude, Chilliness															
		Hardening of Arteries															
		Stroke															
		Age if Living	31	25									53				
		Age at Death						58	50					72	84		
	#	Flu with Complications															
		Flu without Complications															
		Gout													#		
		Croup														⊕	
		Extensive Tooth Decay															
#	#	Abscessed Teeth															
		Loosening Teeth															

Years | Duration of Chief Affection | Duration of Dental Infection

KEY FOR CHART: + HAD LESION; # FREQUENTLY; #? PROBABLY; * OPERATION; ⊕ FATAL ATTACK

PATIENT SEES	CARIES	LOKD	CONDSNG	SL. HG.	SYST. RELF.	COMP.	PART.	RECR.	NONE	FACTOR OF SAFETY				
	+	+								V.HG.	HIGH	FAIR	LOW	V.LW.
	PYRRH	OPEN	REVING	RA.HG.	SUSC. TBLT.	INHT.	ACQD.	ABST.	SC. NO					
			# #		#									

FIGURE 288. RESISTANCE AND SUSCEPTIBILITY RECORD OF FAMILY AND PATIENT OF CASE NO. 1335. NOTE FIVE DEATHS ON FATHER'S SIDE.

Many individuals present for dental operations with every evidence of having excellent health and of high defense, who have as a matter of fact a very serious handicap in the form of a marked susceptibility which cannot safely be ignored. Such a case is the following, whose roentgenograms are shown in Figure 287. (Case No. 1335). She looks well and at the time of presenting says she is well. A study of her case would readily, of course, condemn the lower right second molar. Since her health is reported so good, it would be very natural for some of the other root-filled teeth to be passed without suspicion. This is the type of case where very great harm might be done if the operator either through ignorance, carelessness, or lack of time, neglects to take the history. Notwithstanding that the girl is apparently in splendid health now, her history shows that she was laid up with enlargement of the heart for one and one-half years following the Flu in 1918. Her susceptibility chart is shown in Figure 288. It will be seen at a glance that her father died at fifty-eight of heart involvement, her father's father at fifty with heart involvement, two of her father's brothers and one of the father's sisters all dying of heart involvement; in other words, five members of her father's family, including her father. This shows an inherited susceptibility of so great a strength, that, even though she had never broken, we would be very fearful for fear she would. The fact that she has done so, following the Flu, throws very great responsibility upon the dental infections which she carried at the time of her Flu, for as we have shown in the chapter on Overloads, more than twice as many people were found to have developed complications with the Flu in a group having dental infections as in the group without the dental infections. It is clearly our duty in this case to remove all root-filled teeth. With this evidence of streptococcal susceptibility I would say that the chances are more than 999 out of 1,000 that every root-filled tooth in her head carries streptococcal infection, for in the thousands of teeth that we have cultured, we have practically always found the root-filled teeth, which have been under suspicion, to be infected within the tooth structure.

There was one item in this case which should arouse suspicion, at least to the extent of making inquiry: namely, that this patient was apparently and actually decidedly underweight. In another chapter we have discussed the frequency of underweight in streptococcal susceptibility.

While dictating this part of the text of this chapter, there has

come in the mail a typical communication from a member of the profession of another state, who stands far above the average, and in the best ten per cent, so far as judgment, training, and experience would be expected to place him. His inquiry is so typical of the plight of the profession in general that I would use his case as an illustration. He presents the roentgenograms that had been made for his patient with the recommendation that certain root-filled teeth be extracted, and expresses the wish that, if possible, they may be saved. He desires an expression of my judgment before deciding. Incidentally, he gives this information about the patient. He is suffering from enlargement of the heart and from angina pectoris.

This is just such a communication as I am receiving frequently except that the symptoms of the patient will vary, but similar in the very little detail that is given, such as the age of the patient, how long he has been suffering, etc., etc. In the first place, it is impossible correctly to read the roentgenograms without a physical examination of the patient's mouth, or to make such tests and direct examinations as will disclose non-vital teeth whose pulps have not been removed, etc. The roentgenograms show evidence of apical involvement with condensing osteitis; and, notwithstanding evidence of considerable deficiency in root fillings, there is not a considerable periapical alveolar absorption. The fact that there is not as much as the physical conditions of the roots would suggest might be expected, together with the brief statement regarding the patient's condition, that he has an enlarged heart, (for these latter immediately suggest a low systemic defense for streptococcal infection,) suggests that we should expect in such a case, as we have shown, very little apical alveolar absorption. In other words, this patient would, in all probability, fail to establish an adequate quarantine immediately about the tooth, and because of the absence of this the bacteria and their toxins could pass beyond that quarantine and would have to be dealt with throughout the body, and would tend to attack the most susceptible tissue. His case resolves itself then, since we are dealing with an organ that is vital to health, into a choice between taking the chance of his living a longer time with fewer of his own teeth and dependent upon artificial substitutes, or a probable shorter life without artificial substitutes. If I were a betting man, my research experience would justify me in betting a thousand to one that every

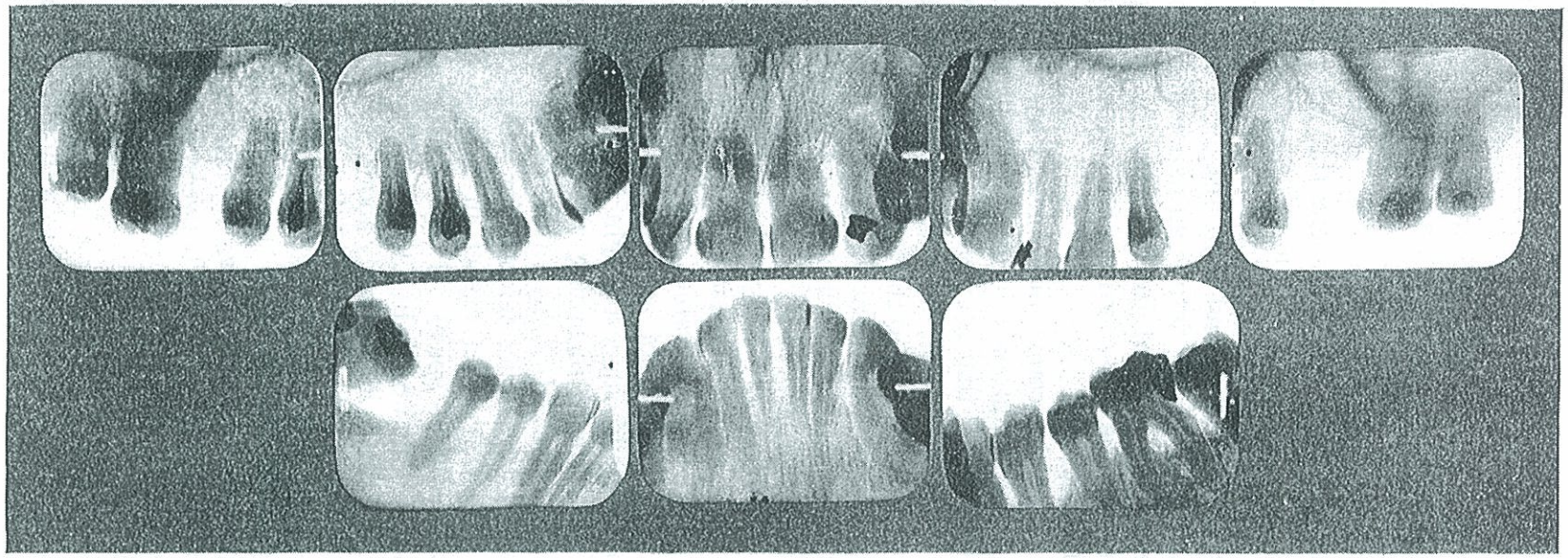


FIGURE 289. ROENTGENOGRAPHIC APPEARANCE OF TEETH OF CASE 1009, A SEVERELY SUFFERING INVALID WITH DEGENERATIVE ARTHRITIS. NOTE DIFFERENCE IN LOCAL STRUCTURAL CHANGE.

one of the root-filled teeth in question in this patient's mouth is infected in the dentin. This would not necessarily be a serious situation for a constitution that was so organized that it could adequately defend itself against the invasion of infections and toxins immediately at the portal of their entry into the system—namely, the vicinity of the root apex—but it is a profoundly serious matter for a man with so much evidence that he is failing in that very defensive process, both as revealed by the condensing osteitis and his carditis. His enlarged heart, in all probability, is the direct result of streptococcal invasions, first as petechial hemorrhages followed by their subsequent fibrosis with, or without direct bacterial infection.

Two things, in particular, must be kept in mind regarding this type of invasion: First, that one streptococcal invasion predisposes to another; and second, that the dominant characteristic of the organisms with which we are involved is their ability to accommodate themselves to the environment and culture medium that any particular patient may tend to furnish, which quality must dominate in the absence of that similar quality, which constitutes the efficient mechanism of defense of the patient whereby the patient as a multicellular organism readjusts itself to every counter move of the bacteria and maintains without a moment's failure the adequate quarantine by a chemical process of combating the organism and its toxin as far as it comes within its reach about the hiding place—namely, the patient's infected tooth—for these chemical substances of defense cannot enter, as we have shown, an infected tooth and stamp out the source of supply. Yellow fever has been almost completely banished from the face of the earth in a very few decades by the stamping out of the source of infection and the carriers, the mosquitoes. Our human bodies can do this with, practically, every other infected structure of the body except the tooth.

In Chapter 21 we have discussed the relation of overload of several closely consecutive pregnancies and illustrated with patients, one of which group is illustrated in the following:

Case No. 1009.—She was brought to us, in a wheel chair, so severely weakened from heart involvement and deformed from arthritis that she could only stand a moment, and that with great difficulty, taking very few steps. Her weight was 78 pounds and her height was about 5 feet 4 inches. At three years of age she had infantile paralysis, but as a girl had nearly normal

strength, had been engaged in business, and when married had good health. The roentgenograms of her teeth are shown in Figure 289. The family history on the father's side was excellent; not so on her mother's side. Her mother and grandmother and two of the mother's sisters, all died of heart involvement. This girl had three miscarriages in two and one-half years, all closely following a full term birth. The result of this overload was to bring on an acute rheumatism and deforming arthritis and heart involvement. We would expect from the type of early reaction around the necks of her teeth that she had normally a high defense, since, as we have shown, a capacity for a good reaction is evidenced by the destruction of alveolar bone and gingival tissues in the presence of irritants. Cultures taken from her teeth were inoculated into five rabbits, every one of which developed carditis, four as endocarditis, and one as myocarditis and aortitis. This patient's weakness was very marked and she was a very great sufferer, frequently not being able to sleep a moment during an entire night, from the pain. She had never been able to regain her strength after the depression of her frequent pregnancies. The use of an autogenous vaccine made from the culture of her infected teeth, together with the removal of the infected teeth, produced so great a change that she was able to go about the city alone in a few months' time and was practically free from pain and has progressively improved to the enjoyment of very comfortable health and few serious physical limitations.

We would interpret her case as follows: She inherited a good defense from her father's side and a susceptibility to heart infection from her mother's side. Under normal conditions she had normal health. In the presence of her unusual overload she became a prey to streptococcal infections (to which she was, by inheritance, susceptible,) from all available sources, important among which were the teeth. She was not able to regain control of this handicap without the removal of the principal source of infection—namely, her teeth—and the boosting of her defenses by means of a vaccine. Her margin of safety is low, at best, and now always will be lower than before, because of the carditis, and infantile muscle atrophy, even though she seems quite well. With a recurrence of overload, which may be Flu, or, as before, she may be expected to break and particularly so, if there be present at the time within her system, a focus of infection to furnish the type of organisms to which she is so sensitive. The knowledge of the inherited susceptibility for heart involvement so

strong from her mother's side places an entirely new and important responsibility upon her dentist, upon herself, and her husband. This is the type of case that will likely break with another pregnancy, unless very great care be taken to keep her calcium reserve as high as possible.

A striking illustration of inherited susceptibility to disturbances in particular tissues or organs of the body will often be found associated with this most important organ of the body, the heart, and, no doubt, constitutes one of the major afflictions of mankind. Previously in this chapter I have discussed as Case 1346, a condition that had been diagnosed as myocarditis which was apparently entirely relieved by the removal of dental infections. Cultures taken from the tooth of that patient produced profuse hemorrhages into the muscular tissue of the heart, when injected into a rabbit, as shown in Figure 284. This individual's daughter (Case No. 1414) presented later with symptoms of nervous break, much lassitude, and a pain about her heart. Two things are very important in this connection: The first is that with the removal of her dental infections her heart disturbance was entirely relieved, as were also her nervous symptoms, and she, like her father, made very important and rapid improvement. The other important thing is that when a culture from her tooth was inoculated into a rabbit, there was a very marked disturbance of the heart, both as endocarditis and myocarditis. Figure 290-A shows a section of the heart muscle with multiple areas of infection, some of which involved zones are large. The heart wall was thickened and there was distinct evidence of fibrosis; and even though the heart lesion was so severe, the heart was still functioning splendidly when the rabbit was chloroformed for posting. B shows a higher magnification of one of these zones, which shows a profuse round cell infiltration and a beginning of degeneration. In some of these zones, however, degeneration had gone on to a process of necrosis and vacuolization, as shown in Figure 291.

It is important in this connection to emphasize again the type of dental pathology that was expressed in this individual. In Chapter 42 of Volume One I have shown for comparison the roentgenographic and blood chemical analysis studies of two patients presenting the same day, one with a high, and the other with a low defense, and I have discussed there some fundamental factors involved. The patient with high defense furnished a

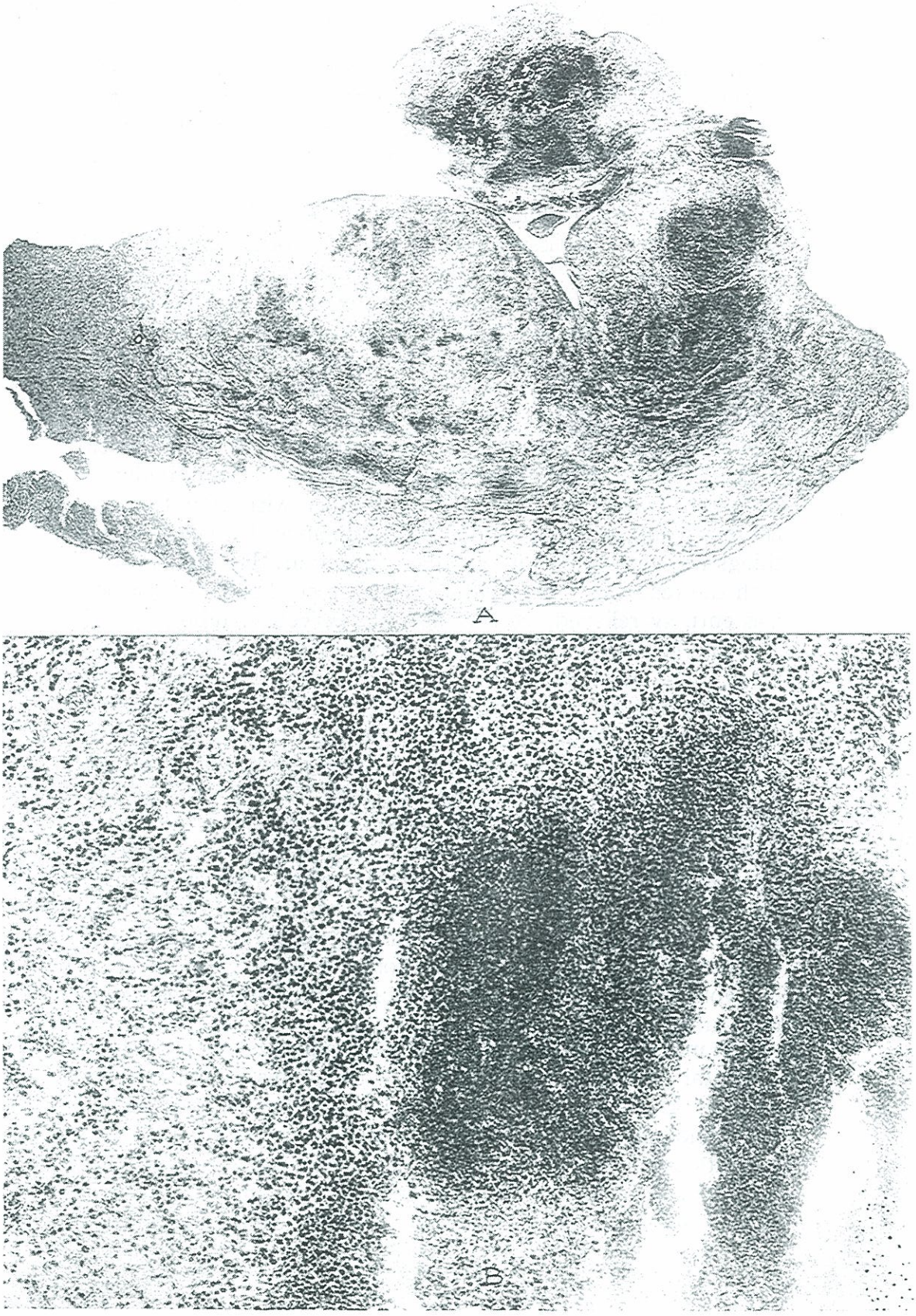


FIGURE 290. A VERY SEVERE MYOCARDITIS PRODUCED IN THE HEART OF A RABBIT INOCULATED WITH CULTURE FROM CASE NO. 1414. A, LOW POWER; B, MEDIUM POWER OF FOCALIZATION.

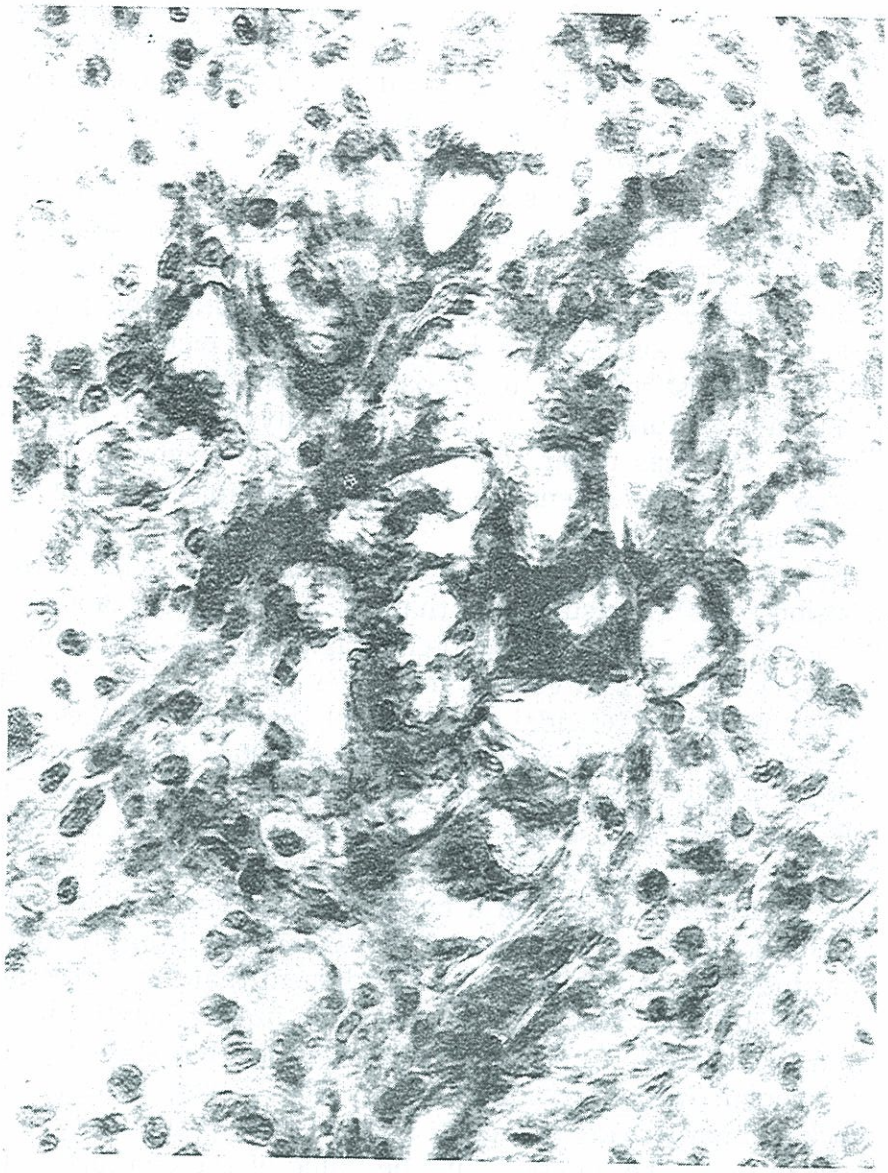


FIGURE 291. HIGH POWER OF SEVERE MYCCARDITIS PRODUCED IN THE HEART OF A RABBIT INOCULATED WITH CULTURE FROM CASE 1414. SHOWS EXTENSIVE NECROSIS, FIBROSIS, AND VACUOLIZATION, WHICH WAS NOT YET FATAL WHEN CHLOROFORMED.

blood that was very efficient in bactericidal property, besides which it had a capacity, when vaccinated, to have this high efficiency exalted, whereas this patient, Case No. 1414, furnished a blood with exceedingly low bactericidal property and which, when vaccinated *in vitro*, showed no capacity for an increase of that function. I have also shown in that chapter the typical

difference in the roentgenographic expressions of irritations about the teeth; and since there is so much to be learned from a careful study of that great truth, I deem it of sufficient importance to show in this connection the roentgenograms of the teeth of both of these patients, which are presented in Figures 292 and 3. The teeth of this patient are shown in 293, and it will be noted that three pulpless teeth—the lower right first molar, the lower left second molar, and the upper right second bicuspid—show very little evidence of periapical reaction, notwithstanding there is much occasion for it, particularly in the upper bicuspid and the lower right first molar. In comparison with this, note that the companion picture of the teeth of the individual with the high defense, who has never suffered any of the rheumatic group lesions, shows very extensive gingival and periapical change from irritation.

For those dentists and physicians who are want to make their decisions on the presumption that the extent of the apical involvement, as expressed roentgenographically, is a measure of the danger, I would urge that they refer occasionally to the difference in the bactericidal capacities of the bloods of these two patients, as shown in Figure 248 of Volume One. Since the other volume of this book may not be conveniently near for immediate reference, and because of the great importance of this matter, I am presenting that illustration again here in Figure 294. If that condition obtained in a child of mine, I would not for a million dollars permit those teeth to remain, for from my intensive study of this problem, it is my judgment that the probability of this girl's going through life without further serious injury from these teeth, is not one in ten, granting that she will have the average overload of a normal life. She is a chip off of the old block and has already proven it; and, after all, is that not true of most of us? The difference in the value of the comfort of life without the injuries which these teeth can produce, when compared with the possible discomforts of living and eating with artificial restorations, is so great as to make an effort at comparative values a mockery. We do well to remember that the cracked china cup may last longer than any cup in the cupboard, but only because it is better taken care of. We should also always keep before us the fact that approximately one in ten of all deaths is a life gone out years too soon because of a secondary involvement which has injured the heart.

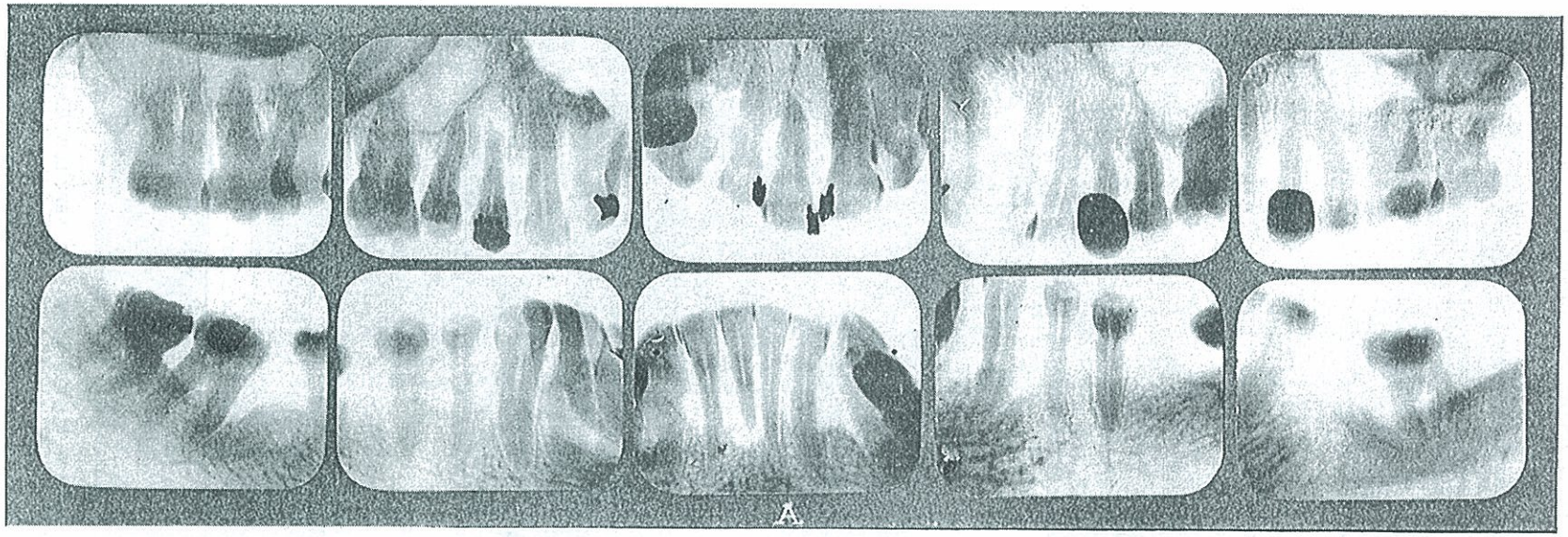


FIGURE 292. DENTAL CONDITIONS OF CASE NO. 1415 WITH HIGH DEFENSE SHOWN IN FIGURE 294.

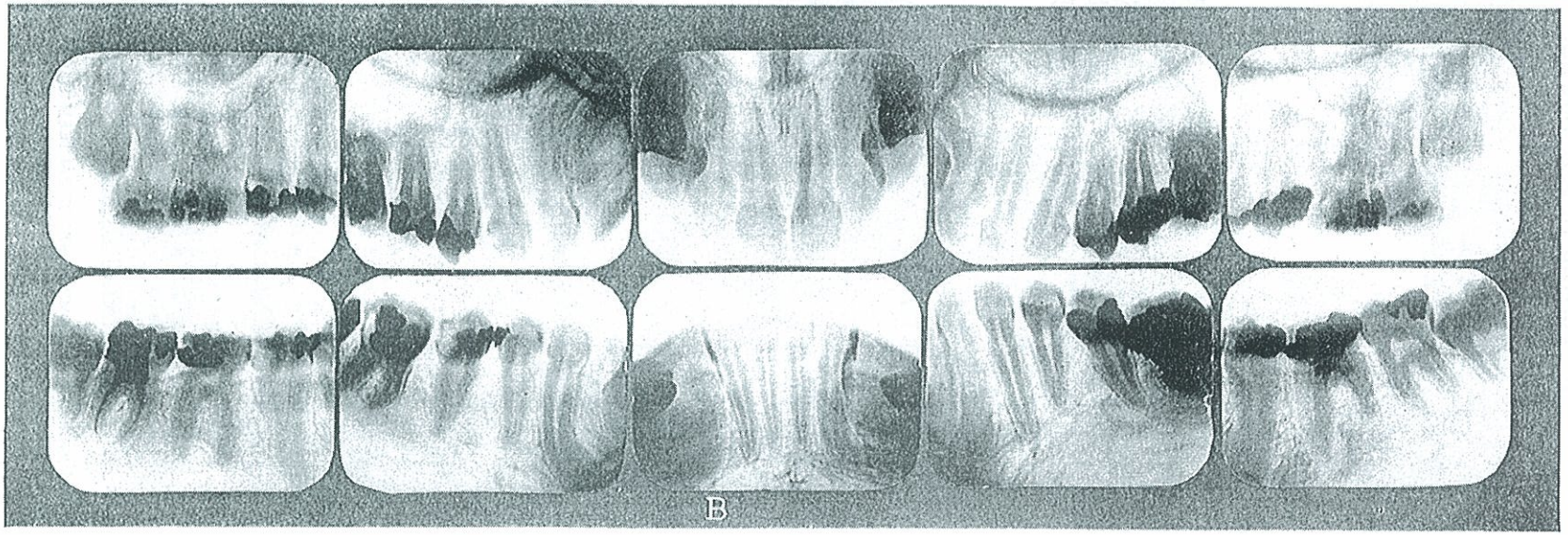


FIGURE 293. DENTAL CONDITIONS OF CASE NO. 1414 WITH LOW DEFENSE SHOWN IN FIGURE 294.

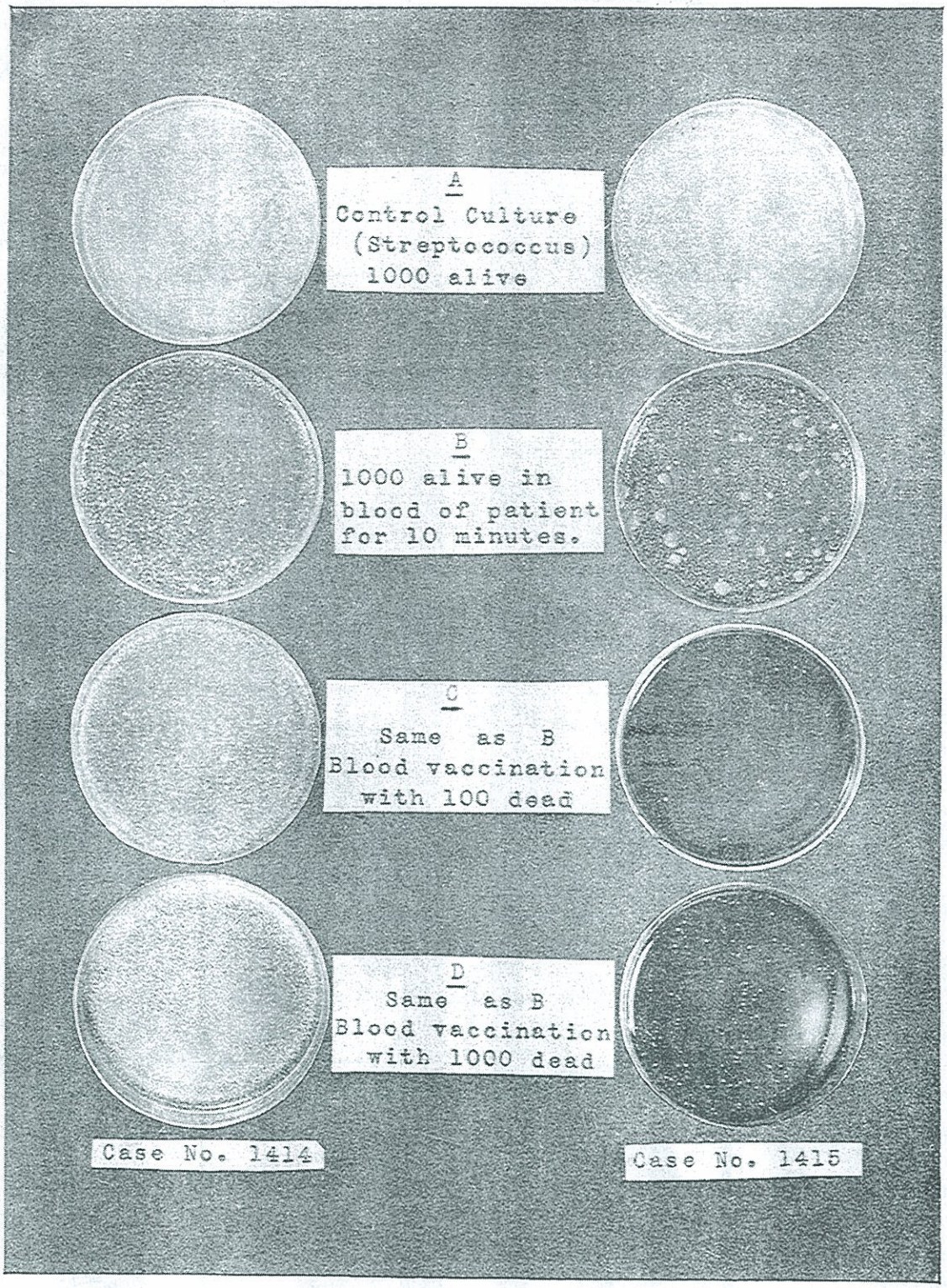


FIGURE 294. COMPARISON OF BACTERICIDAL PROPERTIES OF TWO BLOODS: CASE 1414, VERY LOW; CASE 1415, VERY HIGH. SEE DIFFERENCE IN DENTAL PATHOLOGY IN FIGURES 292 AND 293.

Another phase of myocarditis has to do with those degenerative heart conditions which are the result of long standing irritations. It not infrequently happens that patients who are making a supreme struggle in every tissue of their bodies to carry on, go down with a crash with a disturbance of dental infections in the presence of a heart overload that is already involving the capacity of the powers of adaptation. Probably I hear of more of them than I would in general practice and were I not engaged in research, but it does seem that scarcely a month goes by that I do not hear of a death following dental operations. Unfortunately, the public mind does not know that the individual whose life has gone out, took to the dentist a condition that was almost, if not entirely too late for repair, and the dentist is generally too severely criticized. The time must come, however, when methods will be developed whereby the average practitioner can determine what cases constitute legitimate risks and what do not.

It is not only the patients with acute heart involvement that should have this consideration, for many other individuals have extremely grave conditions from the standpoint of surgical procedure. This is true particularly of those individuals suffering from a marked depletion of their alkali reserve. Even though the organs of their bodies are functioning with relative efficiency, they are entirely incapable of taking care of the additional toxic products which will be provided by the breaking down of tissues as well as by the setting free of both bacteria and toxin from the infection in the area. Many of these patients look fairly well, but their appearance is very deceiving. In the chapter on Osteomyelitis in Skeletal Diseases I have discussed a case which shows in quite considerable detail the relation of defense to alkalinity index of the blood. It is most gratifying that since we have developed the information presented in these two volumes, we have not had a single serious or grave sequence following surgical procedure, and I think entirely because we have a basis for judgment in determining what operation may be considered safe for a given patient before any operations are undertaken.

It has long been known that diabetics constitute exceedingly poor risks for surgical procedures. While this is general knowledge, it probably is not generally understood that probably the most important factor in diabetes, contributing to making those individuals a poor risk, is the greatly depressed alkali reserve; in other words, they are in a chronic state of acidosis. At this point

it is well for me to make an important distinction. I have frequently referred to the fact, that patients with a marked susceptibility to periodontoclasia make a splendid repair after extractions, and I have also stated that diabetics tend to have periodontoclasia, and *vice versa*. It is therefore most natural to make the conclusion that diabetics make a good repair after surgical procedure. The facts are that diabetics constitute a distinct divergence from the general group which would be susceptible to periodontoclasia. This is evidenced in many ways, only one of which is this lack of readiness to healing, another being the lack of response of pyorrhetic conditions to treatment and both for the same reason. This condition, too, is true of all individuals with marked acidosis, or distinctly depressed alkalinity index.

All of this is preface to the presentation of a case which illustrates the need for an adequate examination of the patient before beginning extensive dental procedures. The case is that of a man thirty-four years of age, Case No. 1057, whose chief disturbances were heart, rheumatism, and digestive tract, with extreme nervous irritability. There was a history of attacks of rheumatism at five years of age, twenty-five years of age, and twenty-eight years of age. His heart trouble was first recognized about four years ago; he fatigued in walking a few blocks with much shortage of breath, which began about four or five months prior to examination. He was brought by a physician who greatly desired that we hasten our operations as rapidly as possible. As he had recently been to a sanitarium and had pretty complete studies made, we accepted their reports as a basis. We, however, took the precaution to insist that he stay in the ward for a day for observation before making extractions. The first two attempts to make surgical procedures were abandoned because of the patient's condition. His physician was present and urged that we proceed, since he was going from bad to worse and since he had so much dental infection that probably was an important contributing factor. With extraordinary precautions, one or two teeth at a time were extracted on three occasions. He was kept under careful observation in the ward with our pathologist watching his heart condition which was not the most disturbing symptom. While there was evidence of improvement in some of his conditions, his general condition grew progressively worse, and in twenty-eight days from the time of our first opera-

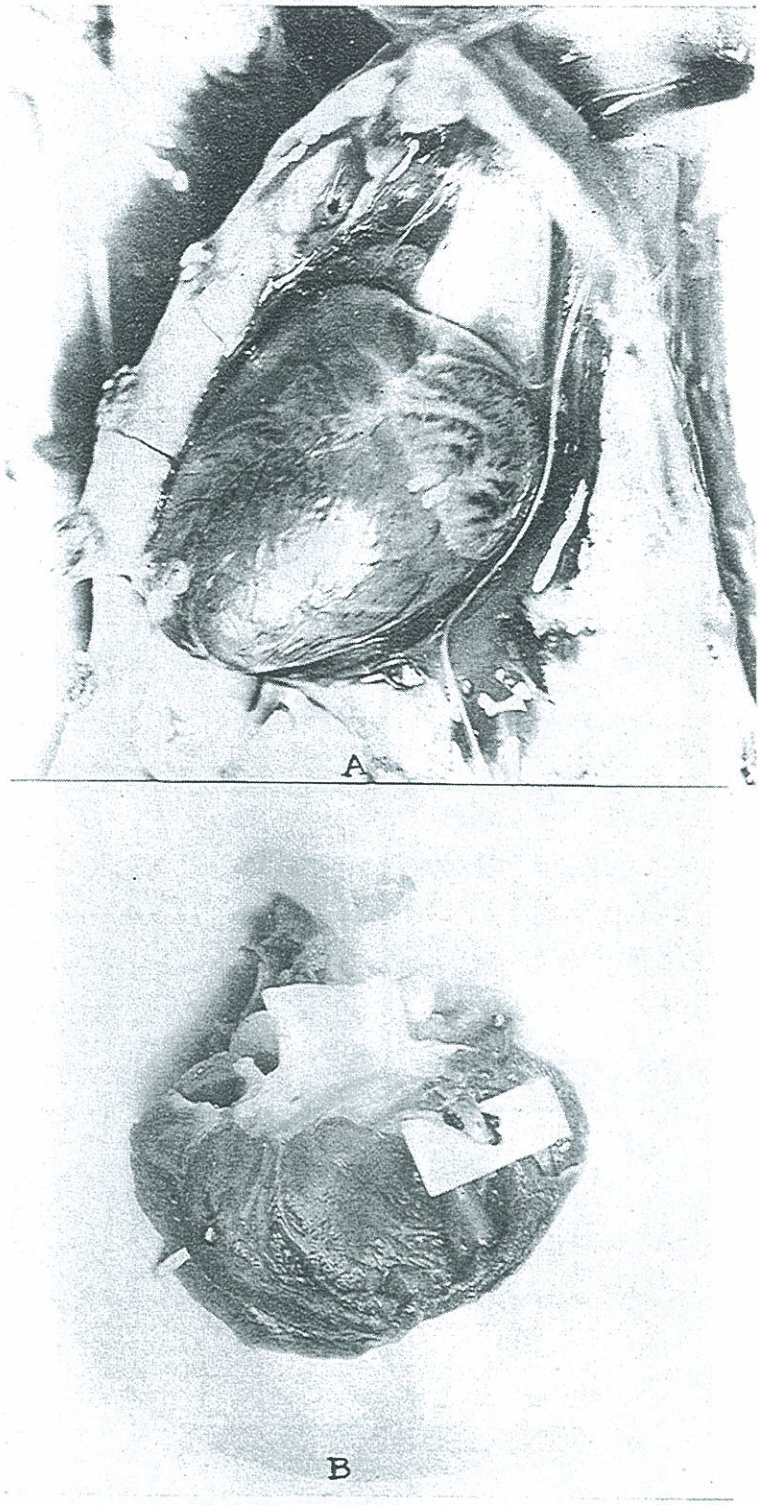


FIGURE 295. TWO SEVERE HEART LESIONS PRODUCED IN RABBITS INOCULATED WITH CULTURE FROM CASE NO. 1057: A, MYOCARDITIS WITH HYPERTROPHY; B, ENDOCARDITIS.

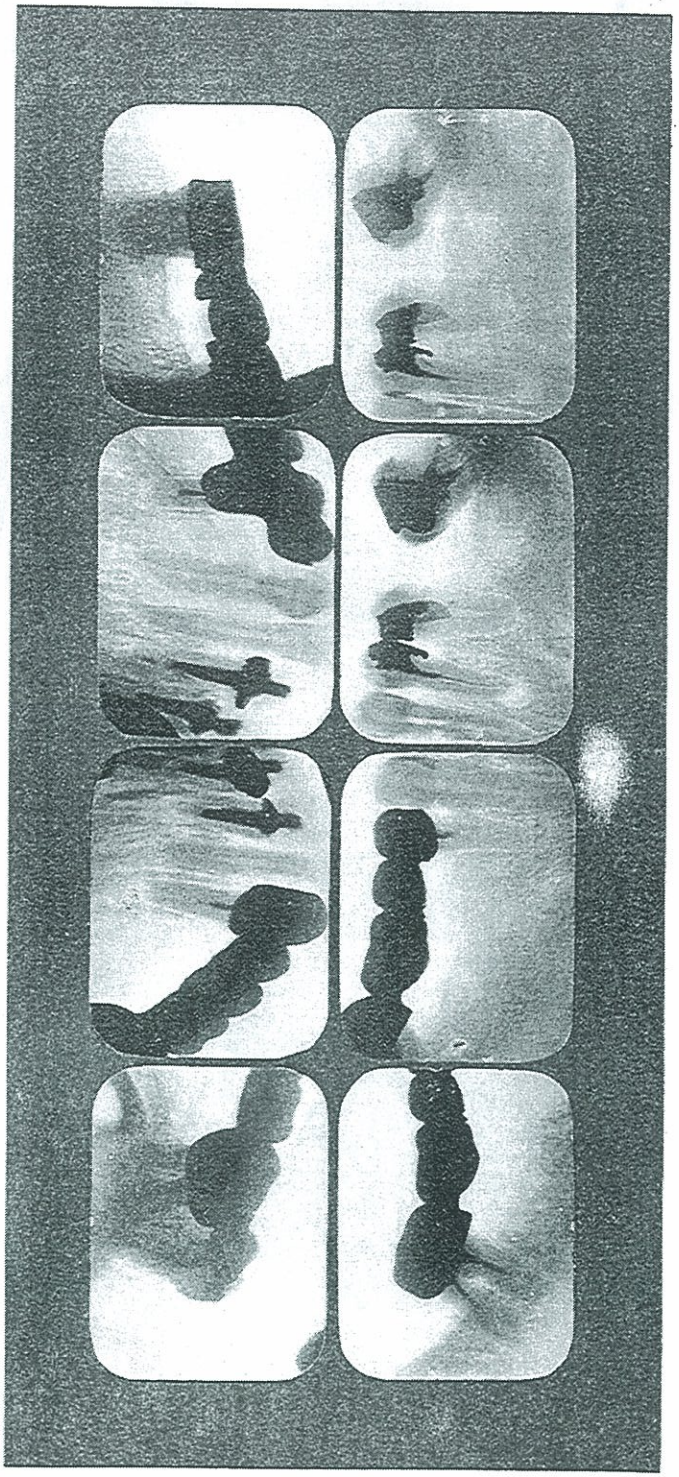


FIGURE 296. ROENTGENOGRAPHIC APPEARANCE OF DENTAL CONDITIONS OF CASE NO. 1057, SUFFERING FROM SEVERE ACIDOSIS, WITH HEART, STOMACH, AND RHEUMATIC INVOLVEMENTS.

tion he deceased with symptoms of extreme acidosis.

I do not know of any procedure which would have made this grave condition a safe one for surgical operation. In the first place, the removal of the dental infections was much too greatly delayed. I feel quite sure, however, that had we at that time been making determinations of the alkalinity index as we do now in all questionable cases, that we would not have undertaken an operation until he was in better condition, which probably could have been obtained by antiacidosis treatment. Cultures were taken from his teeth and were inoculated into rabbits, the hearts of two of which are shown in Figure 295. The one in A shows a very great hypertrophy, and the one in B vegetations on the heart valve. Some of his dental conditions are shown in Figure 296.

In several chapters of Volume One and in this and the preceding chapter of this volume I have stressed the fact that the difference between relative safety and danger from focal dental infection is largely a matter of defensive capacity of the host rather than the attacking power of the bacterium involved. In individuals with a high defense the mechanisms of attack upon the invading organisms are sufficiently active not only to destroy the organisms in the territory adjacent to their source but will tend to destroy them at every point where they are accessible to those defensive forces. I have also demonstrated that the mechanical structure of the tooth with its approximately three miles of closed channels in a single-rooted tooth, constituting the tubuli of the dentin, constitutes a protected zone into which the forces of defense cannot enter. In individuals with an adequately high defense, therefore, there is a solution process established by the host, which slowly but progressively takes down the fortress by absorption of the infected tooth, thereby ultimately making accessible all of the organisms for annihilation. I have also shown in Chapter 42 that part of the protective mechanism is the building of so efficient a barricade between the source of infection and toxin and the host that the products of the warfare may by their mechanical pressure break a channel to an external surface and there escape, and in so doing start an exit for the exfoliation of the infected sequestrum. It is very unfortunate that so many of the members of our profession find themselves in antagonism to the thought that root-filled teeth may be to a greater or less extent an infected sequestrum, without having sufficient experimental data to justify their conviction that the

same is not true, which conviction I fear is largely based upon clinical symptoms, all of which are in their more nearly correct analysis evidences of an adequate defense, which latter makes that tooth relatively safe only so long as that relatively high defense is maintained.

In order to assist in the visualization of what is involved in this process of defense I wish to call attention again to the fact that an important part of the defense against bacteremias from focal infections is the capacity of the host to build a protecting membrane around the infected sequestrum and so to vitalize it with defensive fluids, including the defensive cells of the blood, that for all practical purposes an adequate quarantine is established and maintained. In Figure 297 I show in A such a cystic membrane organized around the broken up chips of an infected tooth, which were sufficiently fine to pass through a medium sized hypodermic needle. The rabbit was later chloroformed and this encysted material removed for sectioning and further study. C shows a cross section, and it will be noted that a dense fibrous capsule has been built around the pieces of infected tooth structure. It is very highly vascularized and there is evidence of a very efficient mechanism of defense, both from the local structural conditions and from the clinical, for the rabbit gained in weight from 1185 to 1539 grams, amounting to 30 per cent in sixty-nine days, at which time it was chloroformed for study. On posting no systemic pathology was found. Locally a cyst had been formed and was removed for study.

PHLEBITIS.

It seems probable that we have not given due consideration to focal infections as playing an important role in the etiology of phlebitis. In so far as I know, it has not been suggested that dental infections are involved in the etiology of these processes. While there are many types of inflammation, certain general conditions are usually present, such as infiltration of the coats of the vein with the formation of a thrombus of coagulated blood. The swelling, stiffness, and edema, frequently produce a great deal of pain, and with these it is very troublesome in its more severe forms in which there is the breaking down of tissue with the development of local necrotic processes. In its simpler forms the chief symptoms are the swelling, edema, and pain. One of our patients (Case No. 1048) had been suffering severely from this disturbance and after her recovery presented for the study of her

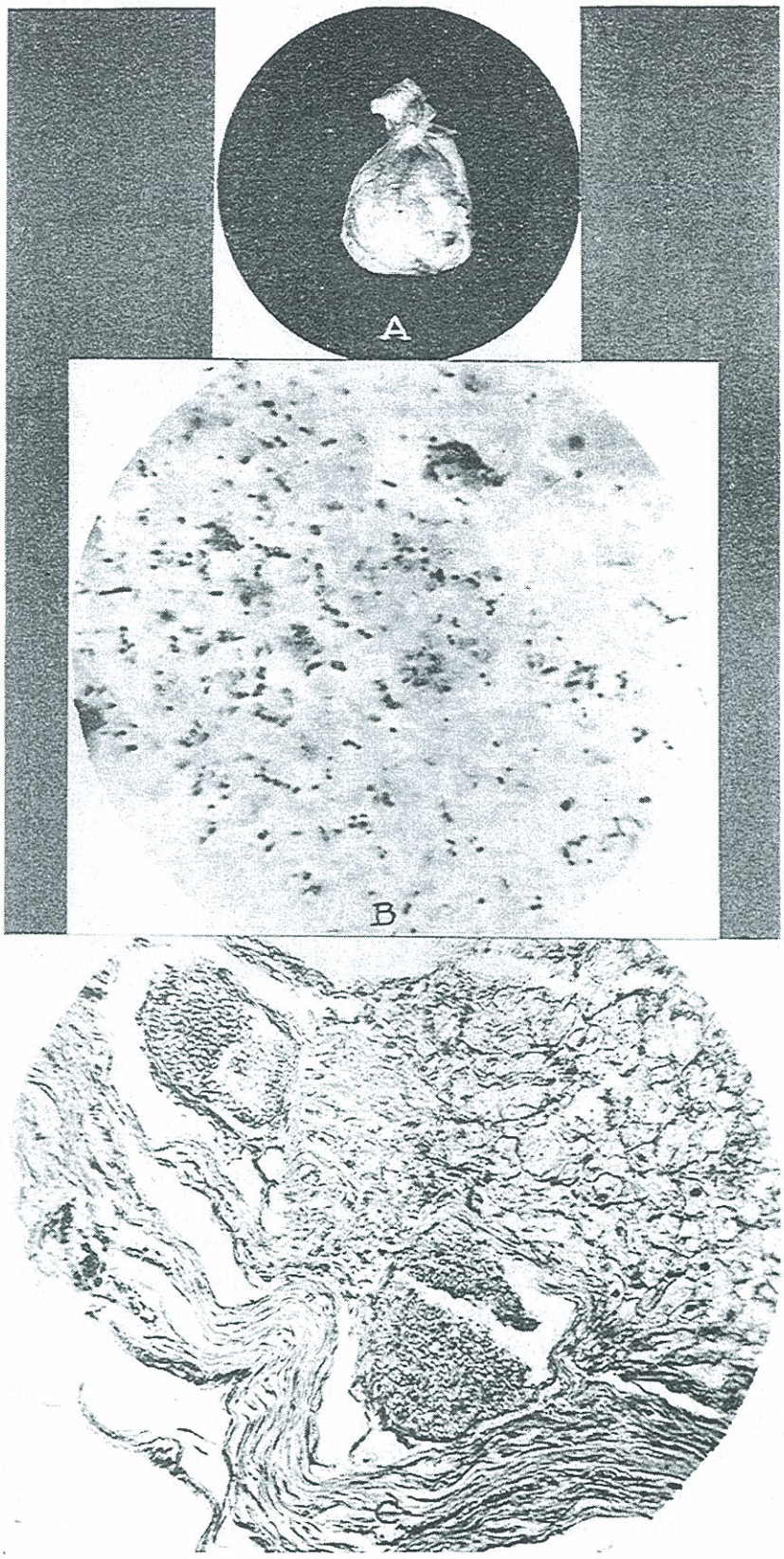


FIGURE 297. DEFENSIVE REACTION: A, ENCAPSULATED TOOTH CHIPS; B, ORGANISMS IN SAME; C, FIBROUS ENCAPSULATION TISSUE, VERY VASCULAR.

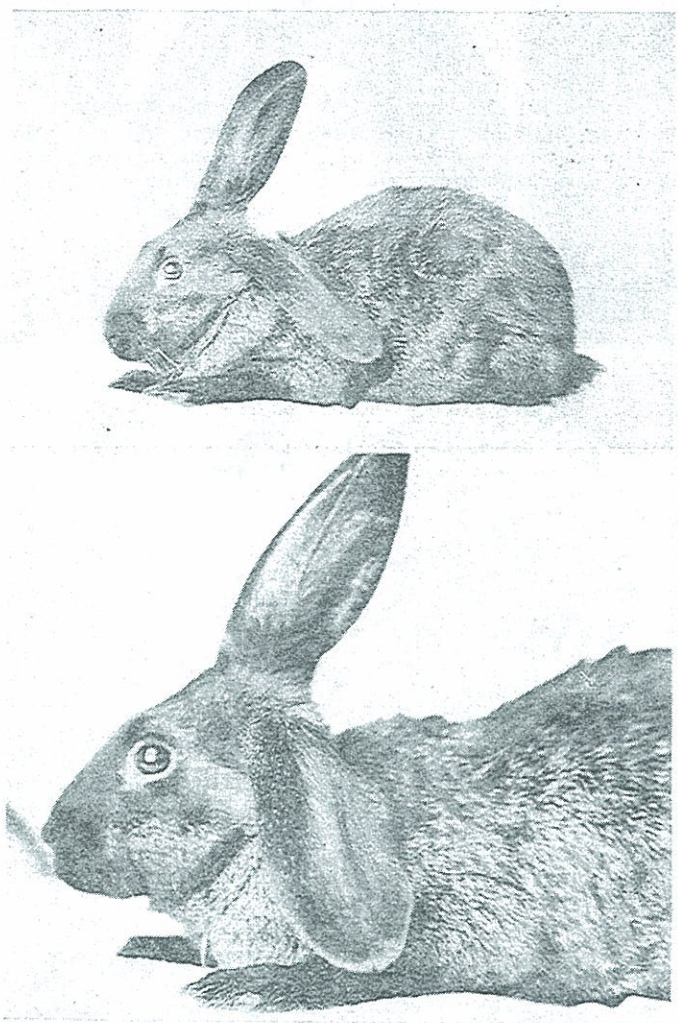


FIGURE 298. A SEVERE CASE OF PHLEBITIS, PRODUCED IN A RABBIT'S EAR BY INOCULATION WITH A CULTURE FROM A TOOTH OF A PATIENT WHO HAD RECENTLY SUFFERED FROM A SEVERE ATTACK.

dental infections in connection with her digestive tract disturbance, localizing particularly in the liver and gall-bladder. The cultures taken from her tooth not only showed the acute infective involvement of the gall-bladder, with multiple ulcers as shown, but also localized in the blood vessel walls of the rabbit. In Figure 298 we show this rabbit's ear which is swollen ten to twenty times its normal thickness, very red, edematous, and painful to touch. This, of course, does not prove that this patient's phlebitis was in any way connected with her infected tooth. The fact, however, that this lesion is very rare in our experimental animals leads me to suspect that there was some connection, which would be entirely in keeping with our knowledge to date

regarding elective localization qualities and the conditions under which they express themselves as such.

HIGH BLOOD PRESSURE.

The etiology of hypertension and hypotension is exceedingly difficult to determine. High blood pressure tends to be associated very often with renal disease and tends to develop, in many cases, carditis. It, therefore, is a relatively serious manifestation. I am coming to associate certain types of dental infections very frequently with a type of abnormal blood pressure, which tends to fluctuate in a marked degree. In the case referred to under heart block, that gentleman, seventy-five years of age, had a blood pressure, varying from day to day, from 125 to 175. In other cases the blood pressure tends to remain abnormally high. Such a case is the following, and this also, like the one just referred to, is related to a dental cyst.

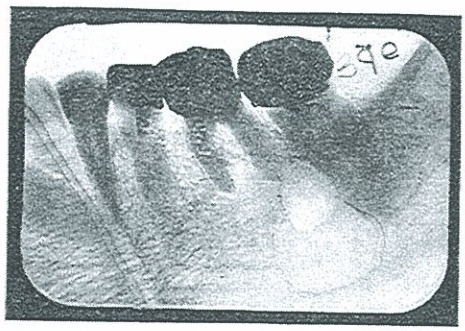


FIGURE 299. A DENTAL CYST WHICH PRODUCED A HIGH BLOOD PRESSURE REACHING ABOVE 220, COMPLETELY RELIEVED BY ITS REMOVAL.

Case No. 796.—This woman, aged forty-seven, had a blood pressure in the vicinity of 220, above and below. She had very marked distress in her head, was almost incapacitated, and the symptoms were quite alarming. The prognosis had been given by her medical attendant as very bad. In the roentgenogram shown in Figure 299, there will be seen a bone cyst in the mandible, beginning at the apices of the roots of the first permanent molar and reaching nearly to the lower border, but encased in the structure of the mandible. With the removal of this and the two adjoining teeth and curettement of the cyst chamber, her blood pressure, which had been high for over a year, rapidly descended to 125 and has remained in the vicinity of normal ever since. Her physical condition has returned completely to normal; she has again taken up her duties, and for several years has had no tendency to reinvolvement. It is also of interest to note that a few years prior to the development of her high blood pressure she had

an operation for the removal of an exceedingly large ovarian cyst. In the light of our studies recorded in Chapter 62, it is particularly suggestive that her dental infection may readily have been the origin of this ovarian cyst.

CHAPTER LXI.

RESPIRATORY SYSTEM.

DISCUSSION.

There are two distinct ways in which dental infections very directly contribute to, or become confused with, tubercular and pneumococcal infections of the lungs and respiratory tract: namely, they may be additive to these other infections, or may be confused and mistaken for them. There is need for a great deal of very careful research work in this field, for, it not infrequently happens, that the interference with dental infections of patients suffering from lung involvements, very greatly aggravates that condition rather than relieving or correcting it. We have seen lives go out very rapidly after the breaking up of dental infections where there was involvement of the respiratory tract. Also, as we shall illustrate, we have seen cases of exceedingly marked improvement and apparent complete recovery as a result of the removal of dental infections.

While we may, in a general way, be able to visualize the differences between these groups, the information available does not justify presentation at this time of a set of rules. In a number of instances where patients with a marked susceptibility to streptococcal infections have developed pneumonias, our examination of the sputum has revealed a practically pure culture of streptococci, usually in diploid form; and, indeed, I have come to believe that the pneumonias of this type of patient are either complicated with streptococcal infection, or the result, primarily, of invasion by that organism. Of the tubercular complications and cases interpreted as tubercular, which are not, but are streptococcal, while there is quite a large number in each group, it would be very difficult to prove conclusively the presence or absence, with certainty, of the tubercle bacillus since that organism is so easily overlooked.

One of the symptoms of streptococcal infection which adds very greatly to the confusion with the tubercular infection, is the fact of a recurring afternoon temperature. The streptococcal curve with its weakness and cough would cause many to class

that symptom group with tubercular infection. One of the frequently present differentiating symptoms, although only suggestive, is the fact that tubercular patients do not suffer from mental cloud as a direct effect of the toxin of that organism, which reaction is very likely to be present in patients suffering from streptococcal infection. While the tubercular patient is always going to get well, and hopeful, and confident to the day of death, the streptococcal patient tends, on the contrary, to be discouraged and fearful of an impending doom, which may take any phase from hysteria, or even insanity, to an extreme nervous activity, even expressing itself in an exalted mental efficiency. Indeed, some of the best products of the human brain have been done under the stimulation of this whip.

We would present as an illustration of the role of dental infection in a case of so-called tubercular infection of the two above types, the following: Case No. 345.—This patient, aged fifty-one, presented with the following history. He had been sent away from the city to die or get better from tubercular involvement of his lungs. He was running a typical lung temperature, had a persistent and very aggravated cough and rales, and these symptoms were aggravated by a definite heart lesion which expressed itself in tachycardia with skipping a beat. He was advised that he probably would not live over six months when sent to a sanitarium in the eastern mountains. After waiting to die for about two years and with his condition changing but little, he returned to the city and was referred to me by his physician. The dental conditions are revealed by the roentgenograms shown in Figure 300. It will be seen not only that there was a very great quantity of infection in his mouth, but that his reaction had formerly been very considerable to this infection locally, so that there were extensive areas of absorption surrounded by zones of condensation, indicating a break in that defense.

As he presented, his weight was 122 pounds; his height, about 5 feet, 11 inches; a man of large frame but greatly emaciated. His cough was very distressing and his heart enlarged, rapid, and missing beats. When asked how long he had had this heart irritation, he stated for several years. This he knew because he had been refused life insurance on account of his heart.

Our program was quite radical. We removed all of the questionable teeth. The results were so remarkable that they were spectacular. His cough disappeared; his heart irritation disap-

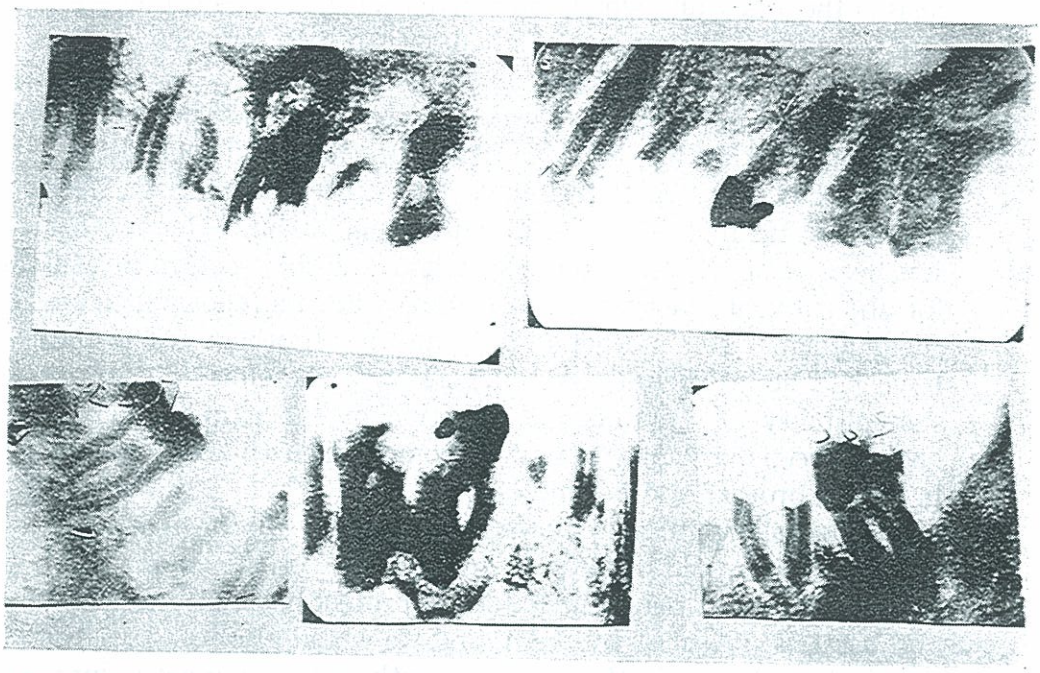


FIGURE 300. DENTAL INFECTIONS WHICH PRODUCED A CONDITION DIAGNOSED AS PULMONARY TUBERCULOSIS. AFTER THEIR REMOVAL THE PATIENT GAINED FIFTY-FOUR POUNDS.

peared; and in a few months' time he had gained from 122 to 176 pounds. He has since taken out three life insurance policies; and it is interesting to note that the insurance companies, knowing of his former record, refused to accept the result of his physical examination on the ground that it was impossible with the history of such a heart lesion as he had had. They wrote to me to find out what I had done to make so great a change in his heart. The fact that he has taken $50,000 of life insurance, and that he has had no recurrence of his trouble in five years, and is carrying on his business, apparently in perfectly normal health, is sufficient evidence that his dental infections were the principal cause of both his lung and cardiac disturbances.

Another case is quite as significant though not so spectacular. Case No. 1153.—This patient at the age of thirty-eight was brought to me by her brother in an invalid carriage a year ago. Knowing of his personal experiences, he desired to know whether this sister, who was in a hospital with acute lung involvement, might not have her condition either aggravated by dental infection or be otherwise involved. She had been confined to her bed in a hospital for months because of daily temperature, bad cough, and raising of sputum, all of which was interpreted as tubercu-

losis of the lungs, and which may have been true. She, however, had occasional symptoms of rheumatism with lameness in the neck and shoulders and hips.

A study of her history reveals that she has had rheumatism frequently during her life. Of seven brothers and four sisters, one brother and two sisters have had acute rheumatism. Her father and his mother had had acute rheumatism. Her mother has been until her death recently a bed- and chair-ridden invalid for about twenty years with deforming arthritis following acute rheumatism. Her mother's father and her brothers and sisters have had acute rheumatism. There was, therefore, a marked susceptibility to streptococcal infection by inheritance. There had also been marked nervous symptoms as neuritis and neuralgia in both a brother and her mother.

Her dental condition is shown in Figure 301. In the light of our experience we would not expect this patient to make an adequate reaction about her dental infections to protect her from the toxins and bacteria furnished by them; and we would also interpret the physical conditions in the involved teeth as furnishing a volume of infected material, such as should in a normal person produce a much greater reaction than is apparent in her case. (See non-vital upper left first biscupid.) We, accordingly, condemned the upper right first molar, second bicuspid, upper left first bicuspid, and first, second, and third molars. The other teeth responded normally to testing.

The result has been most gratifying. She very rapidly gained in weight; her cough and fever disappeared; and for the past six months, she has been, practically, in perfectly normal health. She has gained in weight approximately to her normal, gaining a pound a week for about seventeen weeks.

In different chapters I have discussed streptococcal infections as complications with other disturbances. For example, in a study of overloads, I found that in patients suffering from Influenza, as found in the various city hospitals of Cleveland and Columbus at the time of the 1918 epidemic, the incidence of serious complications such as pneumonia, heart, empyema, was approximately two and one-third times as great in the groups with focal dental infection, as it was in the groups without dental infection, in which cases the complication was, practically, always a streptococcal involvement of the lungs as pneumonia, the pleura as empyema, or the circulatory system with carditis. I also found many cases of acute neuritis with extensive dental infections.

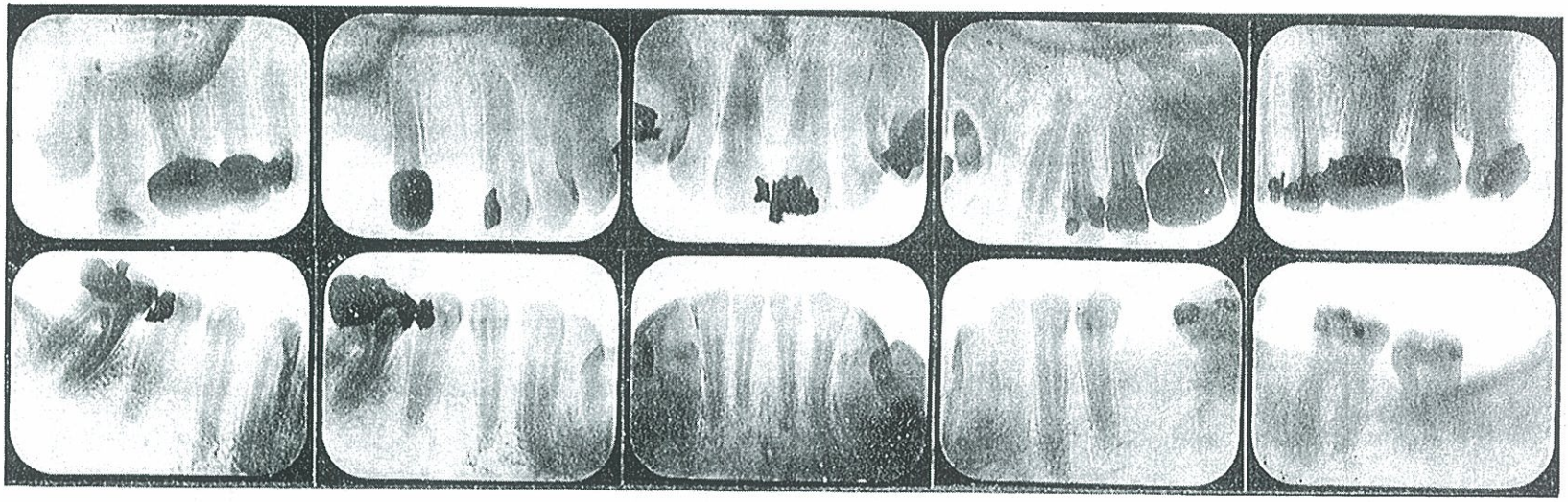


FIGURE 301. ROENTGENOGRAPHIC APPEARANCE OF TEETH OF CASE 1153. NOTE ABSENCE OF PERIAPICAL ABSORPTION.

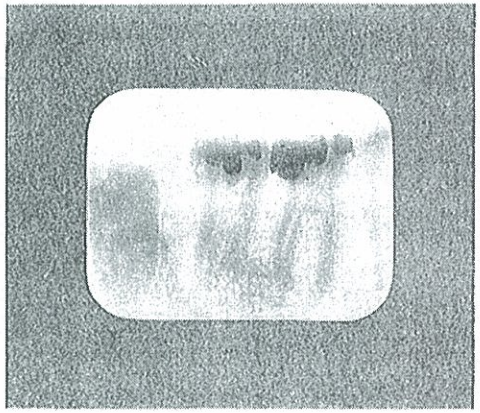


FIGURE 302. ROENTGENOGRAPHIC APPEARANCE OF THE DENTAL INFECTION PRODUCING A SEVERE NEURITIS. CASE 1120. SECOND MOLAR HAS PUTRESCENT PULP.

These cases all gave a history of no trouble from their dental infections either before the attack of Influenza or since its onset. These individuals clearly became a prey to an infection already focal in their system, but for which under normal conditions they had an ample defense. Similarly, we found in the chapter on Pregnancy as an Overload, that a lower defense from that cause made individuals and animals susceptible to infections which under previous conditions they had carried without apparent involvement.

DENTAL INFECTIONS AND TUBERCULOSIS.

In the preceding paragraphs I have discussed the relation of dental infection to lung involvements simulating pulmonary tuberculosis but which are streptococcal lesions or streptococcal infections superimposed upon tubercular. There is a phase of the relation of dental infection to tuberculosis, which I believe is quite new and which has developed from these researches and is presented here for the first time.

In our studies of the physical and clinical histories of many hundreds of patients and their families, in my effort to establish some fundamental characteristics constituting the presence or absence of susceptibility to streptococcal involvements, I have included many other susceptibilities for comparison, such as susceptibility to typhoid, tuberculosis, influenza, cancer, etc. In Chapter 31 of Volume I, I have discussed some phases of the role of dental infections in precancerous conditions, and in the chapter on Overloads, the relation of dental infections to influenza. I wish here to discuss my studies on some phases of the relation of the presence and absence of susceptibility to streptococcal infection, to the presence and absence of the susceptibility to tubercular infection.

We are all quite familiar with the evidence of an inherited susceptibility to tuberculosis as a unit characteristic and similarly to an inherited susceptibility to streptococcal infections, as endocarditis and rheumatism, etc. In these studies I have been primarily concerned to establish in considerable detail the presence or absence of streptococcal susceptibility and the group characteristics of each class. In Chapter 4, Volume I, I have presented in consolidated form, various data characterizing the inheritance and acquirement of streptococcal susceptibility. I have not included in the figures presented there, other data which was secured at the same time. It early became evident that a predisposition to streptococcal infection did not necessarily con-

stitute a predisposition to tuberculosis, notwithstanding the fact, that dental infections, which are primarily streptococcal, constitute a distinct overload and handicap in the warfare of the patient against tubercular involvements. An analysis of the individuals making up the list of those developing tuberculosis, has revealed the important fact, that when dividing individuals into two groups, those with a distinct susceptibility to periodontoclasia and those without, the former group has much the larger percentage of individuals developing tuberculosis. But I have said elsewhere and frequently in these chapters that individuals with a marked susceptibility to rheumatic group lesions —in other words, streptococcal involvements—do not as a group tend to develop periodontoclasia, and, conversely, those with marked susceptibility to periodontoclasia do not as a group tend readily to develop rheumatic group lesions, and when they do so it is usually an acquired susceptibility. I have also shown that tendency to alveolar absorption relates similarly to a physical state, whether apical or gingival, and hence and accordingly individuals with a high defense for streptococcal infections tend to have the more extensive rarefaction about an apical involvement from a putrescent pulp or infected tooth structure than do those individuals with a distinct streptococcal susceptibility. What I am now saying is that those individuals, who, as a group, tend to have a high defense for streptococcal infections, are as a group more susceptible to tubercular infections. This grouping is not sufficiently clear cut and constant to make it a universal rule.

There are several phases of this relationship which have great importance, and an understanding of them, when it shall be obtained, must assist in an understanding of the tubercular infection and therefore with developing means for combating it. Doubtless all who have had the responsibility of caring for tubercular patients, have seen all too frequently, the temperature rise, perhaps with a bound, following the extraction of an infected tooth and, occasionally, seems to mark the development of progressive decline, terminating fatally. This type of reaction will not infrequently be seen associated with the removal of teeth with marked gingival infections rather than periapical. For the present, let us think of these individuals as carrying a capacity overload, in which state the stirring up of an infected process or the liberation of toxic materials will constitute overloads. We will also think of these individuals as having a lowered capacity

for both defensive reaction and repair. These, however, probably do not constitute the whole or chief contributing factors.

In order further to study these relationships, I have in addition to my contact in my clinical practice, endeavored to study this problem both by going to sanitariums where various types could be seen, and by correspondence. I have made one of these studies at the tubercular sanitarium at the Cleveland City Farm, a municipal enterprise for the care of not only the indigent tubercular patients with well developed or advanced tubercular conditions, but also for those contact cases, who, because of environment and heredity, would be considered susceptible. I wish to take this opportunity to express my appreciation of the splendid coöperation and assistance of Dr. Rockwood, Director of Public Health, and Dr. Horrigan, Dental Surgeon in charge of oral hygiene and oral surgery. I asked Dr. Horrigan what, if any, oral or dental pathological lesions he found to be sufficiently frequently associated with tuberculosis to make it a characteristic lesion, to which he replied in substance, a predisposition to gingival infections and alveolar recessions.

A study of the patients from bed to bed, while revealing a majority with periodontoclasia, disclosed several without this lesion in a marked degree. A more careful examination disclosed, however, that some of these individuals had been very faithful in prophylactic procedure. In a comparative study of periodontoclasia and dental caries in Chapters 7 and 8, it was demonstrated that individuals with a marked susceptibility to periodontoclasia had a less susceptibility to dental caries. It was accordingly of much interest to note that in the individuals herewith studied, the percentage with all of the teeth intact, or only one or two fillings or cavities in the entire denture, was large, which is quite the opposite characteristic of the group with a marked susceptibility to rheumatic group lesions.

If conditions obtain, as these data suggest, (the evidence available is not adequate yet for making extended conclusions) several important questions are suggested, one of which is: What are the constitutional qualities involved in a defense for streptococcal infection and a lessened defense or susceptibility to tubercular infection? I have shown in other chapters that there is a distinct relationship between the degenerative inflammatory reactions, with the taking down of organized bone as in osteomalacia and periodontoclasia on one hand, and proliferative deform-

ing arthritis and calcification processes on the other. This immediately suggests that those individuals in which osteoclastic activities are dominant over osteoblastic activities, there would be a distinct difference in the capacity for calcification of fibrocytic tissues. In other words, if two individuals, one representing each of these two groups, would be considered as having a lung tubercle, the data presented in many of these chapters would suggest, if not justify, the conclusion that the individual with the marked tendency to periodontoclasia and such osteoclastic processes, would in a very much lesser degree calcify the tubercle and fibrocytic capsule than would the individual of the other group with a marked tendency to osteoblastic activity. If this line of reasoning should be based on fact, it should be possible to find data in a chemical analysis of the blood of tubercular patients that would throw light upon this process. In Chapter 20 of Volume I, I have shown in the first chart a series of one hundred successive blood analyses related to both the physical condition of the individuals and the type of dental pathology existing. In that and succeeding chapters, particularly 43 and 44, I have shown a direct relationship between the ionic calcium of the blood and the factors of defense and susceptibility. These have shown that a lowered ionic calcium of the blood tends to accompany a proliferative arthritic reaction and an exalted ionic calcium tends to accompany, if not produce, a degenerative type with osteoclastic tendencies predominating. To illustrate, patients with active periodontoclasia practically always have an exalted ionic calcium of the blood as do patients with osteomalacia. However, individuals with either of these (though the latter can scarcely exist without the former) may develop in a few months' time a quite divergent physical state, in which the gingival pockets would not have been obliterated or conspicuously changed, and therefore lead to gross misinterpretation through not distinguishing between an active and a passive process. I have not been able to find in the literature, data showing in comparison the ionic calcium of the blood of individuals making a successful warfare against the tubercular parasite, with the ionic calcium of the blood of those making an unsuccessful warfare.

Another factor entering directly into this phase of the problem has to do with the acid-base balance of the individual making a defensive reaction. I find in the literature, data calling attention

to the fact, that in the terminal stages of tuberculosis severe degrees of acidosis have been noted. My studies to date do not include a large enough number of determinations to warrant conclusions; they do indicate, however, that these individuals in the early stages of their tuberculosis tend to have an ionic calcium of the blood at and above normal, and an alkalinity index below normal. The following are some typical analyses, and it will be noted that, in general, they correspond with those of advanced stages of periodontoclasia.

Case No. 1427. Blood from vein. 3 P. M.	
Alkalinity index	25.90
Calcium plus thrombin	23.00
Calcium ionic	8.46
Calcium ionic plus combined	11.976
Calcium in combination	3.516
Thrombin content	14.54
Non-protein-nitrogen	41.40
Blood sugar	84.00
Uric acid	2.00

Case No. 1428. Blood from vein. 3 P. M.	
Alkalinity index	24.20
Calcium plus thrombin	25.00
Calcium ionic	9.943
Calcium ionic plus combined	12.162
Calcium in combination	2.219
Thrombin content	16.057
Non-protein-nitrogen	34.00
Blood sugar	78.00
Uric acid	2.05

Note: These are advanced stages of tuberculosis and therefore the ionic calcium has gone down, but the pathologically combined is very high in both, making the total calcium seem high: namely, 11.9 in the first Case 1427 and 12.1 in the second Case 1428. The most striking pathological condition is seen in the alkalinity index, amounting to a severe acidosis, 25.90 in Case 1427 and 24.20 in Case 1428.

By analogy we may be justified in making some observations. Since active periodontoclasia reactions tend to develop an exaggeration of the associating complications, such as acidosis, osteomalacia, and pancreatic insulin insufficiency, all of which

conditions are lessened in severity and often markedly so by the correction of the periodontal infection, it should be expected that the development of periodontoclasia might aggravate tubercular infection by lessening the defense against it, and this is not without support from clinical observation, for we have noted a direct improvement in many cases by the instituting of adequate prophylactic and therapeutic procedures. These should, however, be considered as imperative accompaniments with the protective and preventive procedures of the early stages, rather than means for restoring a defensive mechanism after it is overwhelmed and broken. Maver and Wells [2] have shown that calcifications tend to develop and calcium tends to enter tubercles even in the early stages of necrosis. Their experiments on guinea-pigs indicated "that tuberculous organs regularly show much more calcium than normal lesions."

If, as seems indicated, defense and susceptibility are factors which are closely related to calcium metabolism, whether for the streptococcal group of organisms or the tubercle bacillus, and if it be true that that physical state which tends to the development of periodontoclasia and odontoclastic reactions, predisposes to tuberculosis, we may have here a new approach to the study of the etiology and pathology of tubercular processes, and thereby to new means for combating this malady which is man's greatest single scourge.

In the extensive analyses of case histories in connection with dental and general pathology in Chapter 4 of Volume One I have shown that certain affections tend to group in certain individuals. In the subsequent chapters, especially 20, I have shown evidence of a chemical basis for these groupings, or at least a parallel group of associated serological conditions. If my above suggestion be true that there is an association between lowered defense for tubercular infection and a tendency for osteoclastic activity with decalcification processes, as in periodontoclasia, through calcification and decalcification activities, it should be possible for other associations to be made of tubercular susceptibles. I have shown, for example, that individuals with definite tendency to periodontoclasia do not tend to have the rheumatic group lesions while in that physical state. This has suggested observing the association of rheumatic group lesions with tuberculosis, since tuberculosis tends to be less successfully resisted by individuals with a marked susceptibility to periodontoclasia. I am gathering data on this point which will be presented in further

[2] See Bibliography.

detail later, but it is important that in about two hundred cases now studied in this regard, it has been found that a very large majority of the progressive cases support this interpretation. I have shown that, in general, individuals with an acquired susceptibility, that is a broken defense from overload plus infection, behave very similarly to those with an inherited susceptibility; and hence a history of rheumatism or other rheumatic group lesion would not necessarily contraindicate the above interpretation since individuals may change from their normal type of reaction during such a break. In checking this factor it will be necessary, therefore, to make this observation. The apparent exceptions may prove to be those with a broken streptococcal defense due to overload. *The evidence to date strongly indicates a definite relation between normal osteoblastic activity, or calcium deposition, on the part of those with high defense for tuberculosis, and osteoclastic activity, or calcium depletion or suspension, on the part of those with a low power for fighting a tubercular infection.*

If this be true, we should expect that cases progressing favorably would show more extensive calcifications of lung tubercles than those progressing unfavorably, which, according to many observers, corresponds with the basis roentgenographic observations.

STREPTOCOCCAL PNEUMONIA.

With regard to the streptococcal pneumonias, there are two types in particular of frequent occurrence. One of these is related to influenza in patients carrying streptococcal foci of infection. Since dental infections are practically always streptococcal, this is a matter of great importance. In Chapter 21 on Overloads, I have shown that patients suffering from influenza tend more definitely to develop complications if they have dental infections than if they do not. To review that research briefly, I found by examining patients in five hospitals during two severe Flu epidemics, that the percentage of individuals having serious complications in the group of individuals without dental infection was 32, and in the group with focal dental infections it increased to 72, which is two and one-half times the percentage in the first group. This strongly suggested that dental infections may be carried by the patient without apparent injury while that patient has his normal defensive mechanisms. Influenza

infection, however, destroys the normal defense in a very few hours after its onset, which is shown in the blood morphology and blood chemistry. In this state of broken defense the individual becomes a prey to that infection for which he previously had an adequate protecting mechanism.

In Chapter 41 of Volume One I have shown that the defense of the blood is very largely dependent upon bactericidins which are carried by the leucocytes, and which substances are set free from the leucocytes by the antigen of the invading infection. In the individual with his normal defense the reaction is so efficient that the organisms are destroyed almost immediately that they pass beyond their protection within the infected tooth, and that this battleground of the first line defense about the apex of the tooth constitutes a local quarantine station. Structurally, the tissue is highly vascular and designed particularly to combat and neutralize the toxic substances and destroy the bacteria. The lymphatic circulation carries away a large part of the overflow from the chemical processes of neutralization. If the quantity to be carried away is too great, a fistula forms to the surface and there may be a continuous discharge of the neutralized products. Contrary to the general conception, such a fistula discharges a substance which is harmless compared with the toxins before they are neutralized. It is not uncommon to see these fistulæ close with the onset of disease, such as influenza and other fevers, in which state the products are not being properly neutralized, there is not so much of the overflow of waste product, and instead of the battle being a fight to the finish close by the tooth, these products may then go to other parts of the body. This is approximately what happens in a case of influenza when a patient is carrying a dental infection. That warfare, which formerly was waged with the complete destruction of invading organisms and toxin in the immediate vicinity of the source—namely, the infected tooth—becomes much less active and efficient, with the result that these products pass beyond that first zone. That patient's body has suddenly become like a village without its fire department, all right so long as there was no fire, but in the presence of a conflagration and high wind the hamlet is doomed.

In order to determine the effect of dental infections when superimposed upon influenza infection, I have made studies during two

epidemics by inoculating animals with influenza virus by using the washings from the nasopharynges of patients during the first twelve hours of an attack, and injecting this material into the tracheæ of the rabbits. This produces a typical disturbance, characterized by a change in blood morphology, lassitude, and an acute congestion of the lungs, with some emphysema, which, however, is practically never fatal. Using the method suggested by Olitsky and Gates[3], I have macerated the lung of such a rabbit and inoculated other rabbits. Those workers have shown that an extended series of animals may be inoculated in succession by this method and have the typical influenza lesions produced by this process of animal passage. By taking cultures from infected teeth and inoculating a small amount of a streptococcal strain into the ear vein of a rabbit carrying influenza infection, there is a very marked tendency to the development of terminal streptococcal pneumonia. This is illustrated in Figure 303, in which A shows an influenza lung, which is not fatal to rabbits, and B the lung of a rabbit dying with pneumonia by superimposing a small quantity of dental infection upon the influenza.

It is common knowledge that a very large percentage of the deaths from influenza are streptococcal pneumonias. Since so many individuals carry streptococcal focal infection about the teeth, these individuals are living in the presence of a real danger since they cannot know when their influenza attack may come. It is, therefore, a matter of very great importance in connection with the degenerative diseases, which constitute so large a part of the fatalities of a modern civilization which has rid itself of the infectious fevers, to see to it that focal dental infections are not permitted to develop or remain. If space permitted, it would be of interest to present here, data from the reports from the various army camps at the time of the outbreak of the epidemic of 1918, which not only showed a very high percentage of fatalities being caused by pneumonia, but also that they were streptococcal. We must therefore think of these as being blood-born rather than air-born with the influenza virus.

There is another group of pneumonias which have direct relation to oral infections, and these are the result of the aspiration into the lung of infected material from the mouth. This will involve, particularly, cases of advanced pyorrhetic infection, in which case there is much streptococcal infection with the spiro-

[3] See bibliography

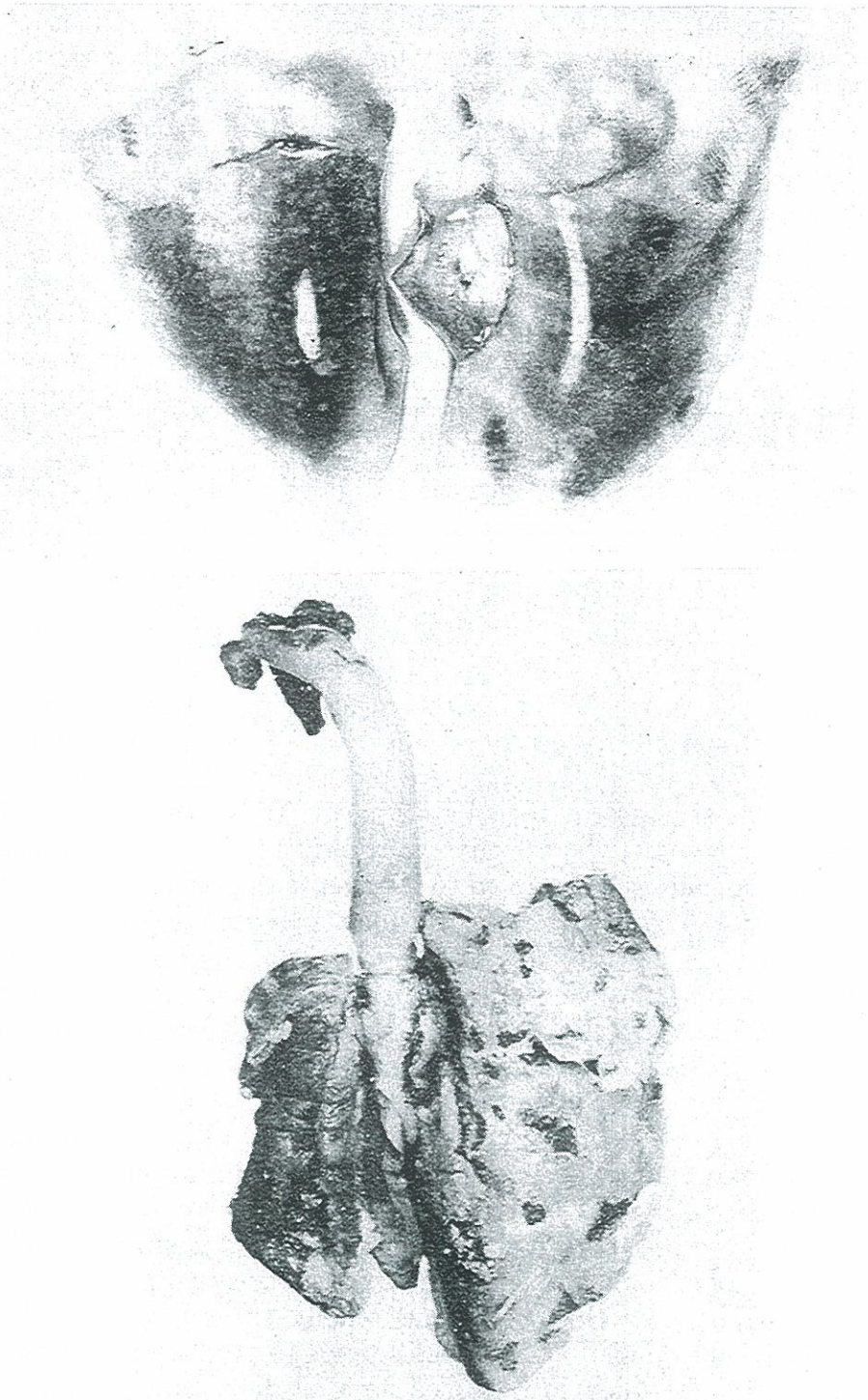


FIGURE 303. STREPTOCOCCAL PNEUMONIA. UPPER VIEW—LUNGS OF RABBIT WITH INFLUENZA, NOT FATAL TO RABBITS. LOWER VIEW—LUNGS OF RABBIT WITH INFLUENZA PLUS INOCULATION WITH SMALL AMOUNT OF DENTAL CULTURE, CAUSING DEATH FROM PNEUMONIA.

chete, which readily infects the emphysematous exudate in those individuals with the lower defense due to influenza or other causes. The very nature of the influenza involvement invites this result. The development of the frothy exudate in the alveoli of the lungs tends to produce violent spasms of coughing, which fail to raise this frothy exudate. A violent expiration compels a violent inspiration, with the result that oral and nasal mucous, with the infections they are carrying, are sucked into the lungs. For this reason influenza patients should have their mouths thoroughly cleansed and as free as possible from infection. Since this process develops suddenly, the only safety lies in the maintenance of a continually clean mouth. This also relates to those individuals who for any reason are given a general anesthetic. It is my personal judgment that many of the complications of pneumonia are nothing more or less than the inspiration into the lungs of infected material from the mouth.

There are the individuals of another group, however, who are very susceptible to streptococcal pneumonia, and these are the individuals suffering from either deforming arthritis or other forms of chronic streptococcal infection. It is probable that in these cases their pneumonias are produced in part by the focal infections throughout their body, particularly in the joints. In several instances where I have cultured the sputum of this type of pneumonia, it has proven to be streptococcal in pure culture. These individuals, besides furnishing probably many foci for streptococcal culture, are generally in a state of low defense for that organism, which susceptibility makes them an easy prey. The evidence suggests, however, that the walled-off infections in passive arthritic joints are not nearly so potential for harm as are focal infections about the teeth. Chapter 40 on the effects on the teeth of arthritic processes, strongly indicates that these individuals tend readily to have the arthritic involvement attack the teeth as it does other joints of the body, and I say other joints, since the tooth has its attachment by a membrane which gives it movement and which mechanism constitutes a joint. I have also shown that they tend readily to have calcifications within dental pulps. This process tends to produce the death of the tooth, in which case its degenerated pulp tissue becomes a pabulum for the blood stream streptococcal infection and a new focus is thereby readily established. In that chapter I show six teeth in succession that have become involved and the pulps

non-vital as a part of the arthritic process, quite independently of caries or ordinary processes of pulp involvement. Such teeth can, therefore, readily become the focus of an active streptococcal invasion, producing in a patient a pneumonia, during such period as the resistance is lowered. These patients from their moribund condition tend to invite respiratory involvements, which condition is probably aggravated by the fact that they tend almost universally to have a subnormal temperature, to be hypersensitive to cold, and tend to have their sleeping rooms too warm for the best efficiency of the respiratory tract.

For several years I have been observing my patients with deforming arthritis and other phases of acute rheumatic group lesions. They have particularly tended to develop pneumonia which, apparently, seldom with them proves fatal. In some instances I have secured cultures of the sputum raised from these patients and have found it to be, practically, pure streptococcal culture. My attention was drawn to this condition by the fact that in our experimental animals some strains of dental cultures, which were always streptococal, though occasionally carrying associated organisms, developed pneumonia which was often terminal, though in many cases it was found at necropsy as a complication, the animals having been chloroformed for examination. In practically every instance these lung involvements, as pneumonias and empyemas, were streptococcal and culturally corresponded to the organism which we had injected of dental origin.

One of the patients above referred to has been bedridden for years and almost every joint of her body seems rigid and deformed. She has had three severe attacks of pneumonia. At the time the sputum was taken for culture, I found her temperature 103, pulse 140, respiration 40; one lung apparently entirely consolidated, the other partially so.

These individuals seem to have evidences of a streptococcal susceptibility in that their rheumatic group lesions are streptococcal, their complications tend to be streptococcal, and, frequently, cultures made from their saliva and detritus from their mouths will grow out pure or nearly pure streptococcal cultures in broth media in contrast to cultures taken similarly from other types of constitutions.

In connection with the pneumonias I have referred to the fact, in the chapter on Tooth Implantations, that we find a marked tendency in our rabbits with teeth implanted to die of pneumonia.

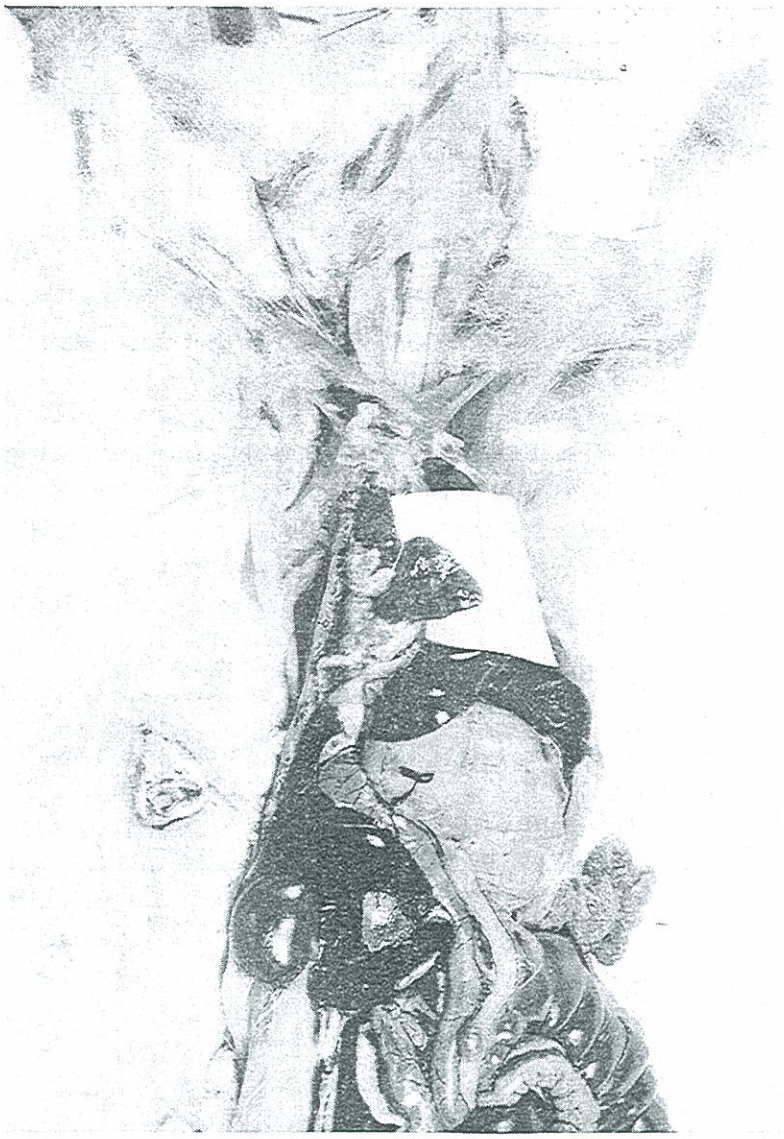


FIGURE 304. A PNEUMONIC LUNG WITH STREPTOCOCCAL PNEUMONIA FROM THE IMPLANTING OF AN INFECTED TOOTH BENEATH THE SKIN, SHOWN ALSO IN POSITION IN THIS FIGURE.

In Figure 304 will be seen the photograph of a posted rabbit, which shows the tooth in position beneath the skin where it has become partially encapsulated. The chest wall has been cut away to expose the lung. The dark area, which is shown leaning over the piece of white paper, is consolidated and gangrenous. This rabbit died in eighteen days after the placing of the tooth under its skin. The most significant feature, however, of these

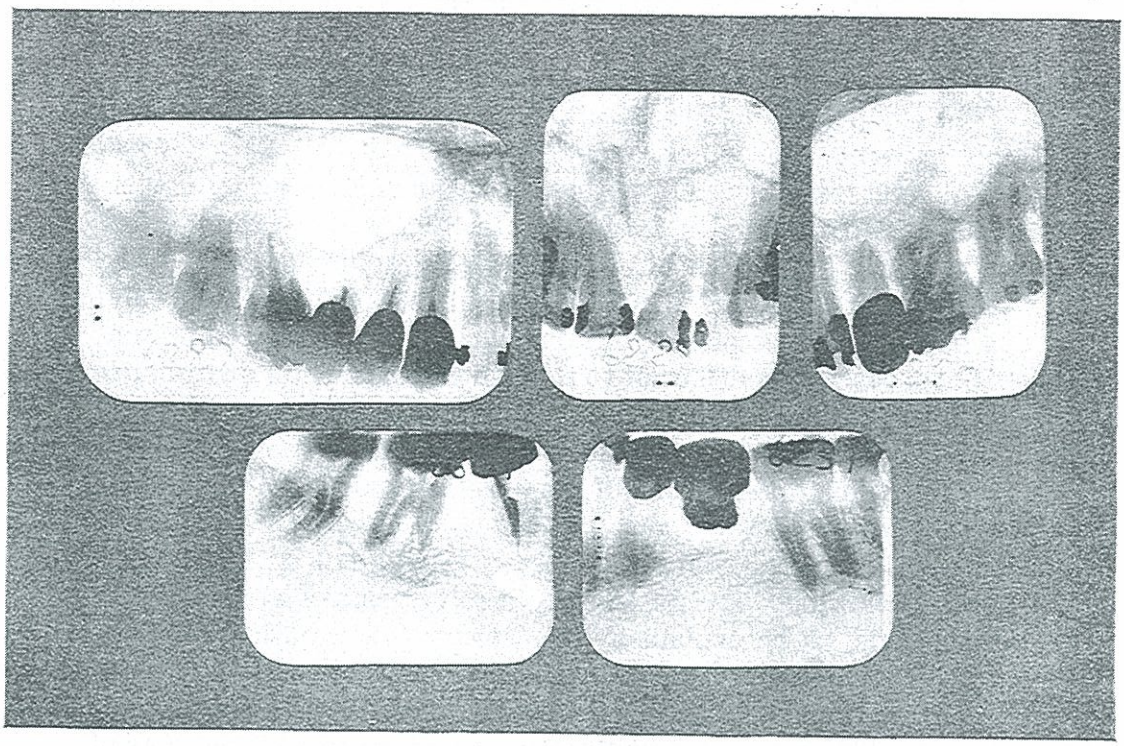


FIGURE 305. ROENTGENOGRAPHIC APPEARANCE OF THE TEETH PRODUCING A SENSITIZATION REACTION AS ACUTE RECURRING COLDS. NOTE EXTENSIVE ABSORPTIONS OF BOTH TEETH AND BONE.

pneumonias is the fact, that, on culture they show a streptococcus in diploid and chain forms, which is characteristic of a type of pneumonia that develops in patients with marked streptococcal susceptibility, such as those with deforming arthritis.

HEAD COLDS.

Under this heading I will discuss a group of disturbances which includes sensitization reactions in the mucous membranes of the air passages and sinus involvements. The characteristics of the former have been discussed in detail in Chapter 30 on Anaphylaxis and Sensitizations. I have found that sensitizations tend to appear in individuals who, normally, have a high defense and with it a considerable quantity of dental infection extending over a long period of time. Their good reacting power takes on the form or modification of a highly developed sensitization in some particular tissues of their bodies. These special tissues are probably most frequently (1) skin reactions, (2) mucous membrane reactions of the air passages, (3) asthmas, and (4) special organs

and tissues. I will discuss only the second and third of these in this connection, because the chief symptom tends to be an involvement of the respiratory system.

In Chapter 30 on Sensitization I have used as an illustration an extreme case which should be referred to at this time. This man had suffered from these acute inflammatory high fever-like disturbances with increasing frequency for several years, apparently regardless of season or geographic location. The removal of his dental infections has entirely relieved for one and a half years these acute symptoms though they had been present once or twice a month prior to that time, and the first disturbance of his dental infection brought on, within a few hours, the most severe attack he had ever had. With the description of this case we have illustrated the use of the sensitization test for identifying this type of case.

Another typical and striking case, though not so spectacular, is the following: The patient about forty years of age had recurring colds, as he explained them, every few months or weeks, winter and summer, and without apparent cause which he could discover. Figure 305 shows his dental infections which were characterized by an exceptionally extensive absorption of the roots of his teeth, a condition which, as we have shown, obtains only in certain types of systemic condition and usually those of very high defense. This man had never suffered from rheumatism, heart, or kidney involvement, or any of the rheumatic group lesions, also characteristic, as I have shown, of individuals with sensitization processes. It will be noted not only that the lower molar roots are absorbed but also the upper molar. I have elsewhere, in Chapter 1, used this case to illustrate the inability of the Roentgen-rays to reveal conditions as they are. With the removal of these dental infections, this patient's tendency to head colds entirely disappeared and for two years has not returned.

ASTHMA.

Asthma is now recognized as being frequently, if not generally, a sensitization reaction to an antigen which varies through a wide variety of proteins or albumins. They may be foods, vegetable products, or bacterial toxins from focal infections. A typical illustration of the latter is as follows:

A patient of good physique and habits suffered from recurring attacks of asthma. On questioning him, I found that these asthmatic attacks had a history of development since the history

of the beginning of his dental infections, that on different occasions he had had prostrating attacks following a sense of soreness and pain about the crowned teeth. He had several bad dental infections. They were particularly bad because there was the quantity of infection of the pulp chambers of very poorly filled roots of teeth that were crowned, and which did not have fistulæ. With the removal of these dental infections his asthmatic attacks entirely disappeared. He had, however, a long history of carditis and finally died of heart involvement.

The types of cases which we have been discussing in this chapter will only be found where the dentist or physician has taken pains to go carefully into the history and intelligently relate the clinical symptoms with the types of dental pathology which are present, and by use of sensitization tests such as we have described in Chapter 30.

There is a phase of involvement of the respiratory tract which is very confusing and obscure and should be stressed because it is of quite frequent occurrence. Patients running a typical afternoon temperature with much loss of weight will, in general, suggest to the internist a possibility of tubercular involvement. This will only need the presence of a typical rale to complete the diagnosis in many instances. We have referred to such a condition with involvement of the heart in this chapter. The rheumatic group lesions do not, in general, tend to be associated, as we have shown, with the type of oral infection such as is present in typical periodontoclasia, pyorrhea alveolaris. It is, however, a very important, and when it is understood will be a significant fact, that tuberculosis tends to develop in individuals who have had a marked predisposition to periodontoclasia. In another chapter we have discussed this relationship. The typical spirochete infections do not tend to develop in root-end abscesses unless that chamber is connected through a liberal opening with the mouth, and particularly an opening beside or between the teeth but following the cemental wall. In mouths with typical periodontoclasia pockets, apical abscesses tend to develop spirochete involvements when related to the mouth as suggested. It sometimes occurs that one tooth may have a very abundant infection and not be accompanied by other involvements in the same mouth. This involvement may be so located that an ordinary examination of the mouth will not disclose such a seriously involved tooth. Such a condition may exist and produce very

serious harm and with symptoms quite different from the typical rheumatic group lesions. Such a case is illustrated in the following:

Case No. 1120.—The patient presented with so serious a bilateral sacro-iliac involvement that she virtually had to be carried. She had not been able to roll over in bed for many weeks, had suffered very severely, and in addition to the neuritis was running a daily temperature with cough and rales. She also had a heart involvement as a murmur diagnosed as mitral disease.

An ordinary examination of her mouth revealed an apparently well kept mouth with excellent teeth and no evidence to suggest that they could possibly be related to her general condition. Had not the physician who sent her been a man of very unusual keenness and thoroughness he would not have suspected the teeth as a possible contributing factor. The roentgenogram of her teeth shown in Figure 302 showed the lower left second molar to have a very deep pocket between it and the third molar, which was displaced backward, and the pulp of the second molar was non-vital and putrescent, the cause for which could not be accounted for except by an extension of a distal suppurative periodontoclasia which extended to and involved the apices of the roots. There were no local symptoms about the tooth to cause the patient to have any suspicion of it. The culture was a most profuse spirochete and streptococcal involvement. With removal of this tooth the daily temperature ceased, the neuritis entirely disappeared and has not returned, which is now about two years. The patient advises that she has never in her life been in better health, does all her housework, and most important, the lung symptoms have entirely disappeared. In this instance but one tooth was involved, and while it was seriously so from the standpoint of its effect, there were no symptoms locally known to the patient and no suggestion from the appearance about the tooth to indicate any involvement. The physician or dentist, who on general principles for lack of efficiency in diagnosis, would condemn several or all of such a patient's teeth because one was involved would do a great injury as would also those who, judging from the appearance of the membranes of the mouth and the appearance of the teeth, supported by the patient's judgment regarding them, would pronounce the mouth free from all responsibility.

CHAPTER LXII.

PRIMARY AND SECONDARY SEX ORGANS.

DISCUSSION.

Neither the literature nor the teachings of the medical and dental professions have associated acute and chronic infections of the primary and secondary sex organs with dental focal infections. While the evidence we will herewith submit strongly suggests such a relationship, it is not clear what these relationships are. In some cases it would seem to be quite strongly suggested that the dental infection either selects or aggravates lesions of the ovaries, tubes, and uterus. In some other cases, as we will cite, it would seem that disease in those tissues has produced some changes in the system which expresses itself as an elective localization quality in the bacteria of the dental focus. Of over a thousand rabbits used in the last two years, localizations in ovaries, tubes, and uterus have occurred a number of times but in only a very few instances where these tissues were not affected in the patient from whom the dental infection was taken, and in two of those instances the cultures were taken from the teeth of male patients who had suffered from gonorrheal or syphilitic infection.

Case No. 1085.—The first case we will cite is that of a young unmarried woman twenty years of age, whose distress at the time of her menstrual periods was so severe that she was required to go to bed for several days, and whose health, both physical and mental, was apparently being seriously injured. Her history showed that some five years previously she was hit over the left ovary when playing golf. This injury was a matter of history without evidence of local injury except for a short period. At this time she had some infected teeth which she carried for the intervening period. Her condition was sufficiently serious so that it became necessary for her either to get relief or give up her university work. In addition to the menstrual disturbance she had an acute nervous disturbance affecting breathing, which began about a year previous to the time of her examination, and numbness followed by severe pain in the back of the neck which

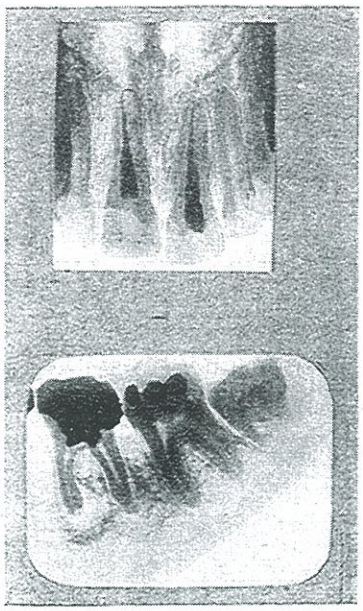


FIGURE 306. ROENTGENOGRAPHIC APPEARANCE OF TEETH, A CULTURE FROM WHICH PRODUCED THE OVARIAN AND TUBAL INFECTIONS IN THE NEXT TWO FIGURES.

was worse before her periods. An acute ovarian pain began three months before our history was made, at which time the numbness ceased.

At the time of our first operation we removed the upper left central and the lower right first molar, which are shown in Figure No. 306, with the result that her ovarian disturbance disappeared. She gained rapidly in weight with a very marked improvement both mentally and physically. Cultures were made from these first extracted teeth and inoculated into rabbits. Six rabbits were inoculated, four females and two males. All of the females developed acute infection in ovaries and tubes. The males remained negative. These are shown in Figures 307 and 308, and all reveal very highly congested ovaries and fallopian tubes. Owing to the fact that her university work in another city made it difficult for her to be absent long enough to have the other upper central incisor removed and replaced, it was not extracted at this time, but instead had the old root filling removed, the tooth sterilized, and the root refilled and an apicoectomy made. Her condition remained greatly improved for a few months when her old conditions returned, at which time we removed the central incisor, made cultures from it, and inoculated three other female rabbits, two of which showed acute infections of the ovaries and tubes.

The result of this operation has been to make so great a change in her health that her mother states that she is like an entirely

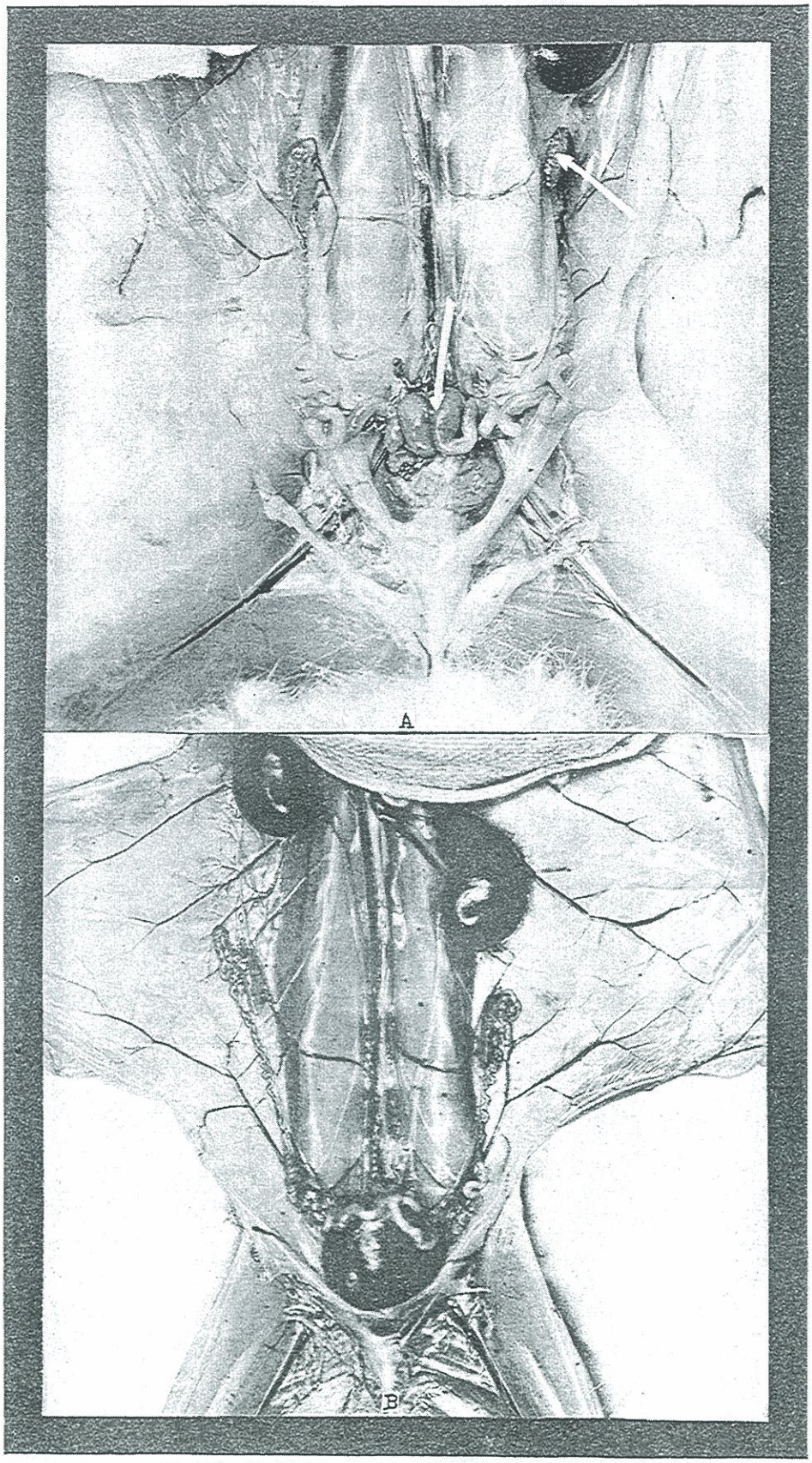


FIGURE 307. ACUTE OVARIAN INFECTIONS PRODUCED IN RABBITS INOCULATED WITH CULTURES FROM TEETH OF PATIENTS SUFFERING FROM SAME.

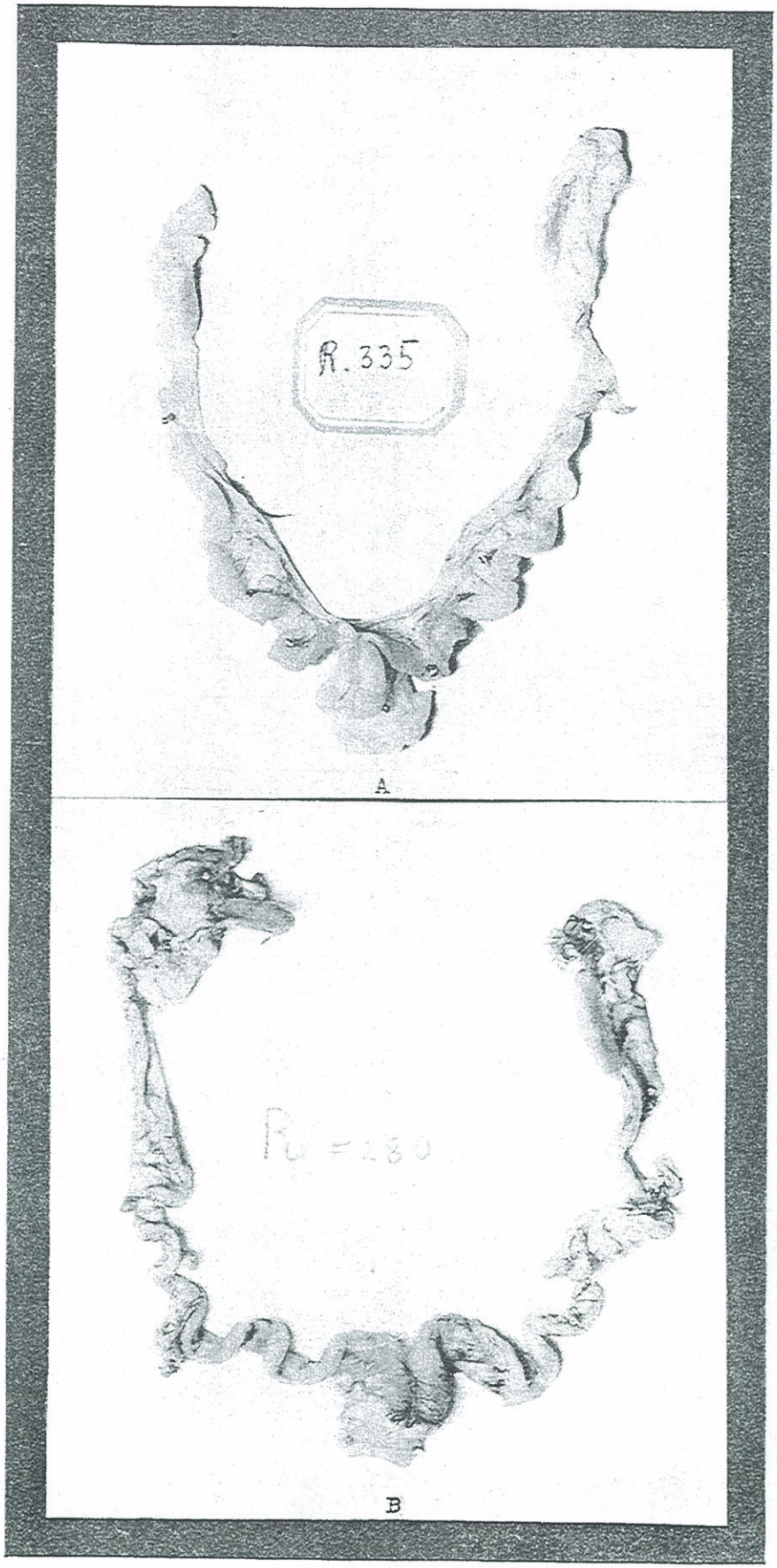


FIGURE 308. OTHER OVARIAN INVOLVEMENTS IN RABBITS FROM SAME CULTURE. CASE NO. 1085.

different person both mentally and physically. Her periods are normal and without pain. She has gained considerably in weight (over twenty pounds) and for approximately two years there has been no tendency to a return of her old trouble. It would seem, in the light of our study, that we have in this case an elective affinity developed in the organisms for ovarian tissue. That the organisms from the dental infection were selecting and irritating her ovaries seems very probable, if not quite certain; and that they are better, if not now quite normal, seems quite certain from the fact, that in every way her health seems perfectly normal. Whether, however, that quality on the part of the organisms was primarily due to the presence in her system of diseased ovarian tissue which, because of its influence on the culture medium—namely, the circulating body fluids—supplied to the organism in the dental culture by the system at large, tended to irritate that tissue, is not clear though it is strongly suggested in other cases.

For example, a woman of about fifty suffered severely from lameness and pain in the back of the neck and shoulders. Cultures taken from her dental infections, inoculated into rabbits, developed ovarian and tubal infection in several. Why this is true is difficult to state, particularly since she had been operated upon twice for ovarian infection, both ovaries being removed. At the time the second ovary was taken, the uterus was removed; and notwithstanding, according to her records, the primary sex organs were completely removed, the organisms showed this elective localization. This would seem to suggest that the normal blood plasma and fluids of the body carry defensive elements for each of the various organs and tissues of the body, the absence of which defensive elements may be an important factor in the development of elective localization qualities in the organisms. This may be a fundamental part of the quality we previously discussed as organ susceptibility, acquired and inherited, particularly the latter. The acute inflammatory process in the preceding case was accompanied by engorgement of the tubes with a serous fluid in which there were few organisms, but the chief characteristic was an acute inflammatory process.

This is quite unlike the process which has developed in some other cases in which the inflammation was limited almost completely to the ovarian tissue with the formation of ovarian cysts. In Figures 309 and 310 are shown several ovarian cysts; one (Figure 310) as large as a small hen's egg; (Figure 309-B) six

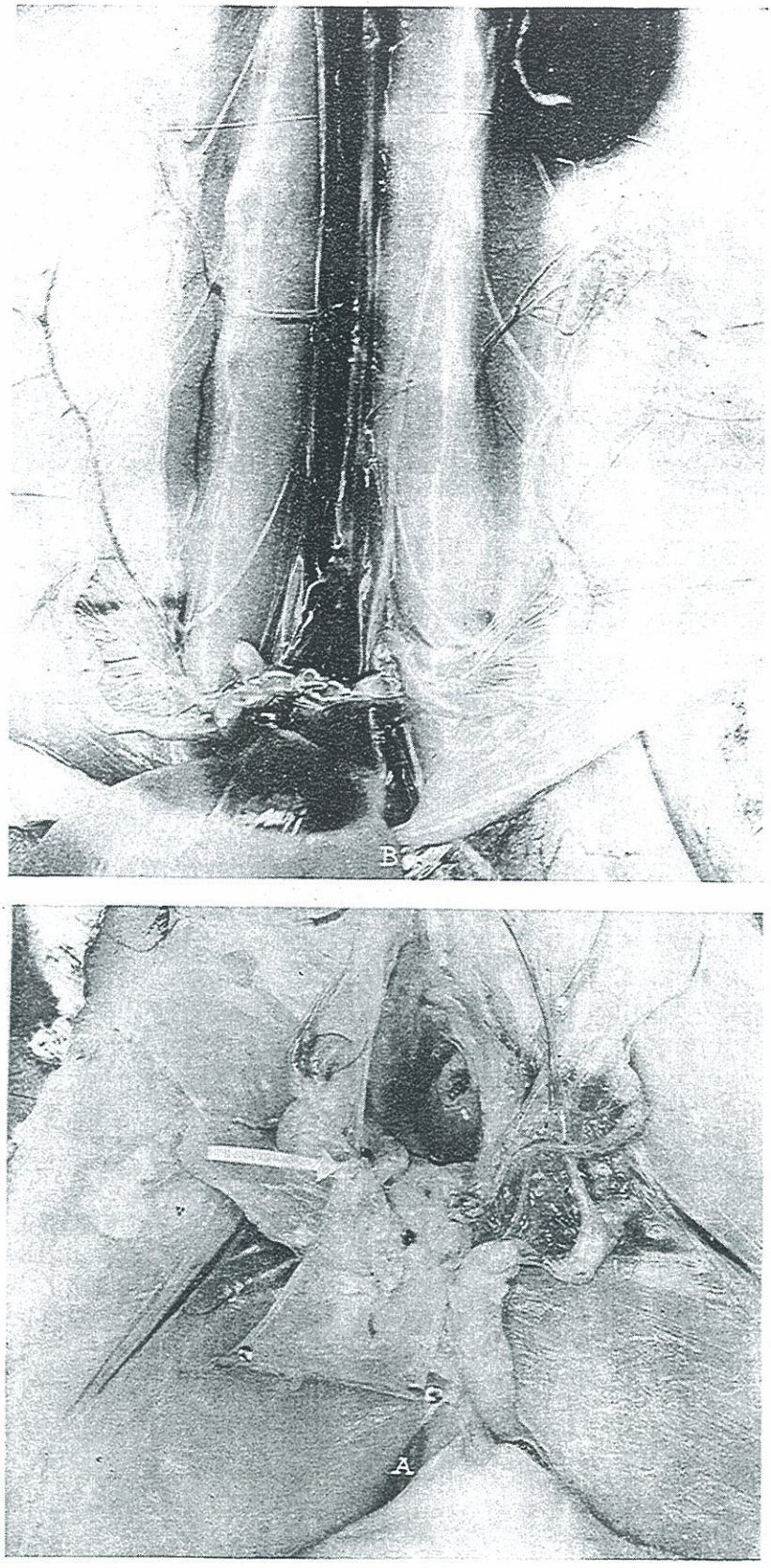


FIGURE 309. SEVERAL OVARIAN CYSTS PRODUCED FROM CULTURE FROM TEETH OF A PATIENT RECENTLY OPERATED FOR OVARIAN CYST, SHOWN IN B, AND CYSTS ON THE VAS DEFERENS FROM SAME CULTURE.

FIGURE 310. A VERY LARGE OVARIAN CYST PRODUCED IN A RABBIT FROM A DENTAL CULTURE.

small cysts on one ovary; and (Figure 309-A) a cyst on the vas deferens. Direct smear and cultures made from the cyst of 310 showed Gram-positive diplococci which corresponded morphologically with those inoculated into the animal from the dental infection. So far as we know, this is the first time ovarian cyst has been produced experimentally by the cultures from den-

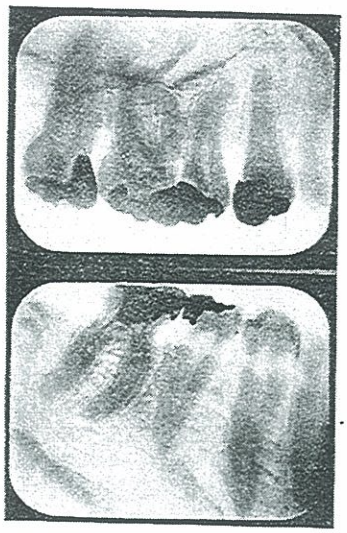


FIGURE 311. ROENTGENOGRAPHIC APPEARANCE OF TEETH OF CASE 1224, THE CULTURE FROM WHICH PRODUCED THE OVARIAN CYST SHOWN IN FIGURE 300. THE PATIENT HAD RECENTLY BEEN OPERATED FOR REMOVAL OF LARGE OVARIAN CYST.

tal infection and, so far as we know, the first suggestion that focal infection may be an etiological factor in its production. This is further strengthened by the following case.

Case No. 1224.—A married woman, age thirty-one, had been operated upon a few months previously for an ovarian cyst, which was about the size of a goose egg, and which had been diagnosed as the cause of sterility. Cultures made from her dental infection, shown in Figure 311, were inoculated into five female rabbits and two developed ovarian cysts, shown in Figure 312. Inasmuch as cysts are not developed rapidly, the fact that these rabbits were posted in from two to four days puts much greater emphasis on the results. The rabbit shown with the very large cyst in the previous figure was posted thirty-one days after inoculation.

It has frequently occurred that the development of infections of unusual tissues of this type in rabbits has been the first suggestion that we have had of such a condition in the patient, and the fact that the patient had suffered or was suffering from ovarian or uterine trouble was only brought out by careful questioning after this elective localization had been expressed by the animal inoculations. The next case illustrates this, as do several others.

Case No. 1050.—This patient presented with a history of heart involvement with rheumatism. After the inoculation of rabbits with the culture from her teeth, without thought of sex, the posting of a female rabbit a few days after its inoculation disclosed enormously enlarged tubes with uterine involvement. The patient was questioned and she stated that she had deliberately falsified when the history was made. She had been suffering from

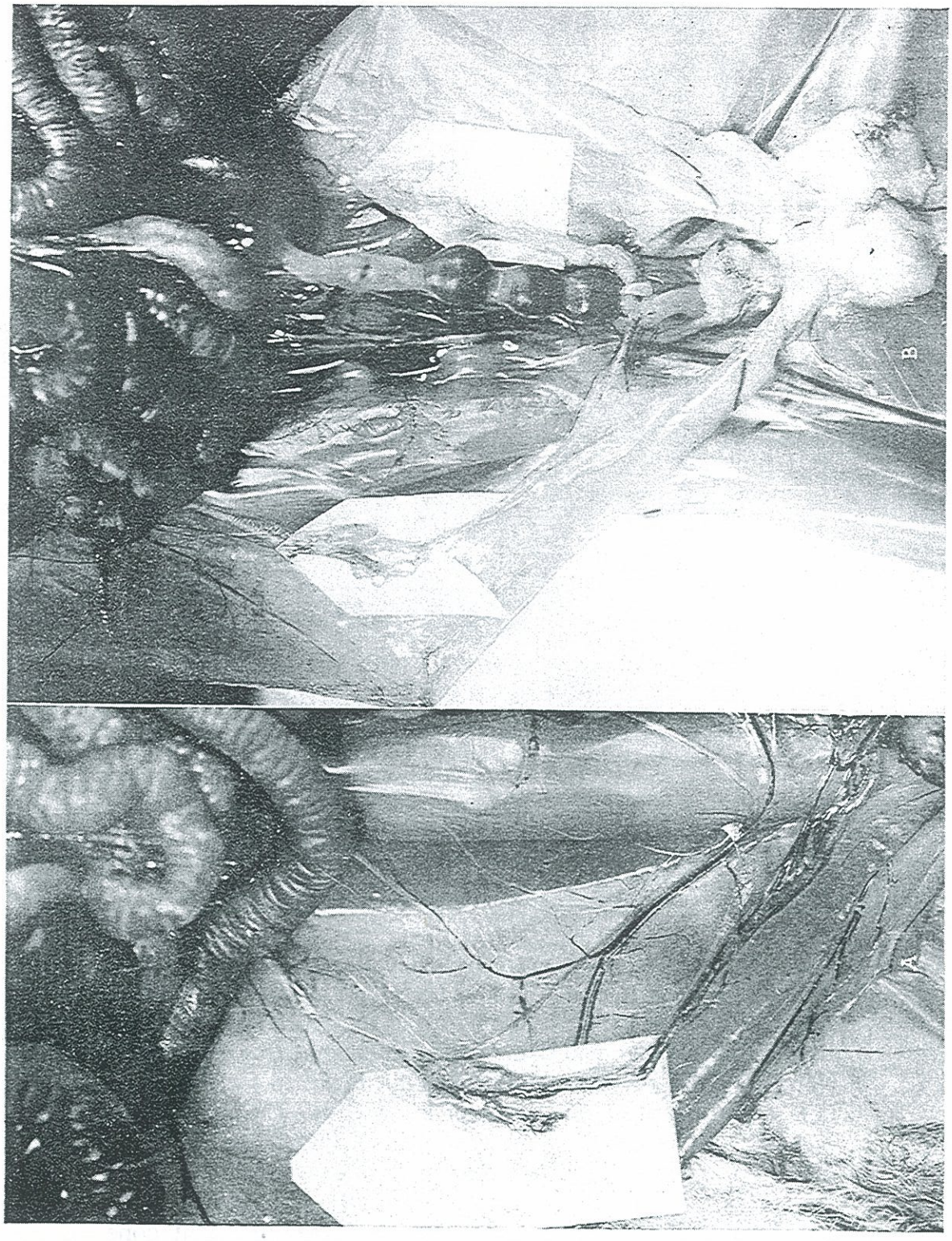


FIGURE 312. THE SECTIONS OF TWO RABBITS SHOWING OVARIAN CYSTS PRODUCED IN FROM TWO TO FOUR DAYS AFTER INOCULATION WITH A CULTURE FROM THE TEETH OF CASE NO. 1224.

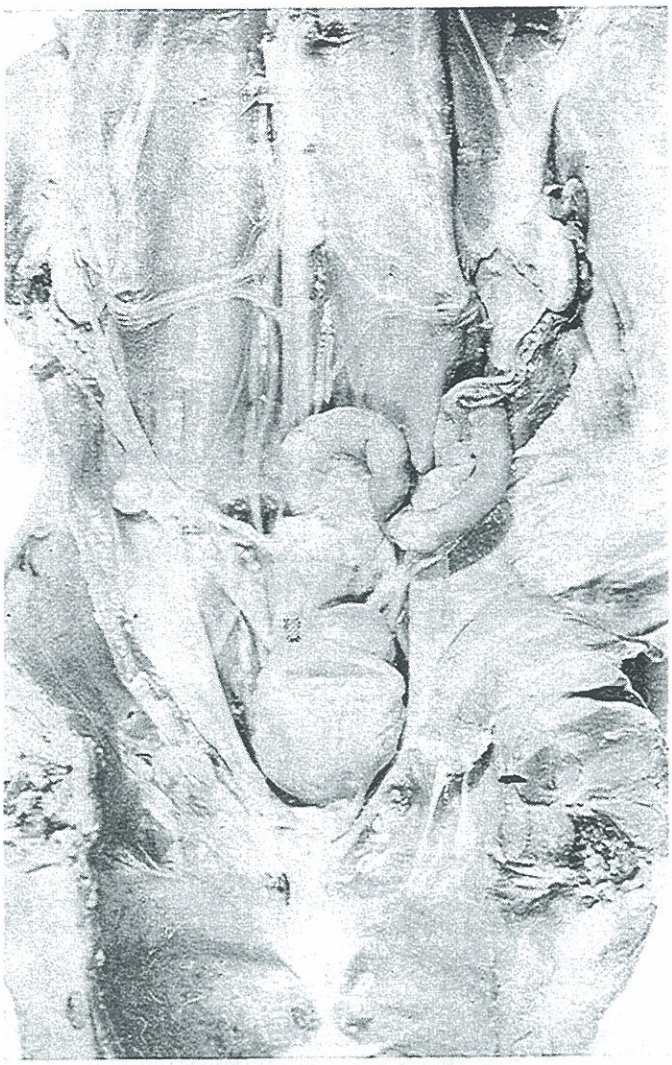


FIGURE 313. A VERY PURULENT UTERINE AND TUBAL INFECTION PRODUCED IN A RABBIT FROM THE DENTAL CULTURE FROM A PATIENT SUFFERING FROM A PURULENT UTERINE DISCHARGE WHICH ENTIRELY DISAPPEARED AFTER THE REMOVAL OF HER DENTAL INFECTION.

a purulent uterine discharge for eight months, which her physician had feared was malignant. This infection had been the reason for her physician's sending her to us for dental diagnosis and care. With the removal of her dental infections, this uterine discharge entirely disappeared and has not returned for two years and a half except at one time, for a few days, when one of the sockets from which an overgrown infected root (lower right) became acutely infected with development of a sequestrum, following the extraction. It disappeared promptly with treatment by the removal of the sequestrum. She has gained in weight, gone

back regularly to her work, and her heart is nearly normal. Figure 313 shows the dissection of a rabbit inoculated with the culture from her teeth, which showed very severe infection of the ovaries, tubes, and uterus. When we realize that approximately 550 of the 1100 rabbits have been females, and of that 550 not 2 per cent have developed ovarian infection from a culture which was not taken from the tooth of a woman suffering from ovarian and uterine involvement, and also that in many instances of women suffering from ovarian, tubal, or uterine involvements, percentages running as high as 100 per cent of the female rabbits develop localizations and acute involvements in these tissues, it is very suggestive, if not definitely significant.

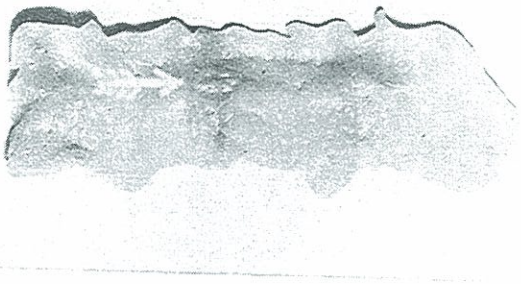


FIGURE 314. A DEEP INDURATED ULCER ON THE INNER SURFACE OF THE FALLOPIAN TUBE OF THE RABBIT SHOWN IN FIGURE 313.

In the photograph of this rabbit with uterine, ovarian, and tubal involvement, there will be seen greatly enlarged fallopian tubes. A photograph of the lining membrane of one of these tubes is shown in Figure 314, and there will be distinctly seen an ulcer which nearly perforates. The culture aspirated from the tubes of this case gave a pure culture of streptococcus growing chiefly in diploid form. Frequently, we find, however, that the content of these infected tubes, resulting from the inoculation into the ear vein of dental cultures, proves to be sterile, notwithstanding the extensive involvement of the ovaries and tubes.

In this connection I wish to illustrate what may be a significant condition and which developed in a rabbit. I have referred to the fact, that in exceedingly few instances have we had involvements of the ovaries, tubes, and uteri of rabbits where the patient from whom the dental culture was taken was not a woman suffering from such a condition or with a history of such a condition. In

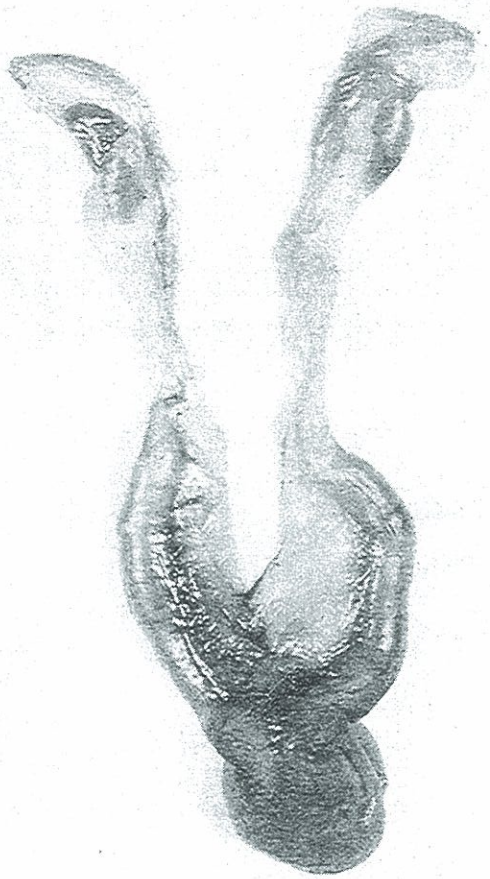


FIGURE 315. THE HIGHLY INFLAMED FALLOPIAN TUBES, OVARIES, AND UTERUS OF A RABBIT INOCULATED WITH A CULTURE FROM THE TEETH OF A PATIENT WITH SYPHILIS.

Figure 315 will be seen the dissection of a rabbit in which the ovaries, tubes, and uterus are very highly inflamed, and engorged with pus. This rabbit received four small inoculations of the culture from the teeth of a patient with syphilis. We do not know whether there is significance in this association. The fact, however, that while this type of disturbance is so rare, we have had this kind of reaction in cultures taken from the teeth of two different men with a history of syphilitic or gonorrheal infection, is at least suggestive, if not significant

This elective localization of primary and secondary sex organs is not limited to females. In approximately 550 male rabbits in

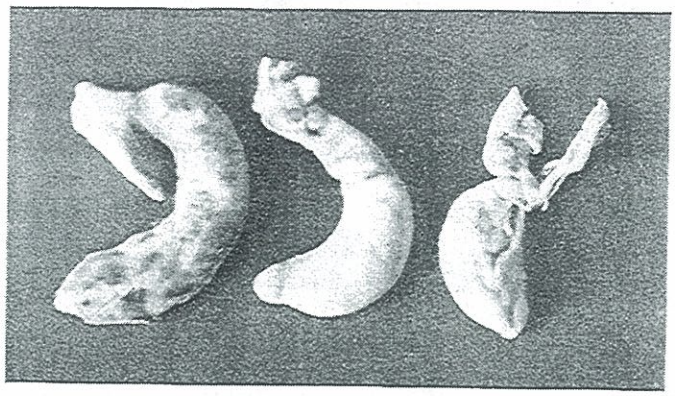


FIGURE 316. ACUTELY INFLAMED TESTICLES, ONE FROM EACH OF THREE RABBITS INOCULATED FROM THE CULTURES OF THREE DIFFERENT TEETH OF A PATIENT SUFFERING FROM ACUTE SWELLING AND PAIN IN TESTICLES. HE HAD PREVIOUSLY HAD GONORRHEAL OR SYPHILITIC INFECTION.

the group here reported, infections of the male generative organs have occurred rarely. In Figure 316, three testicles are shown from three different rabbits inoculated with cultures from three different teeth of the same patient. These are more instances than had appeared in any hundred male rabbits previously. Figure 317 shows the teeth from which these cultures were taken. When the patient was questioned, he stated that he had been afflicted with a painful swelling of the testicles during recent months in conjunction with rheumatic involvement. His rheumatism was completely relieved by the removal of the infected teeth and the testicular pain greatly relieved. He acknowledged that there had been gonorrheal or syphilitic infection twenty years previously.

It does not follow that the presence of involvement of the testicles in conjunction with dental infection is related to gonorrheal or syphilitic infection. In several instances where the pain and swelling of the testicles have been a very marked symptom and have been relieved by the removal of dental infections, the evidence has been satisfactorily established that there was no previous infection.

In Chapter 34, on Pregnancy Complications, we have discussed researches that we conducted for the purpose of studying the influence of dental infections, or the infection from that source, on pregnant animals, with reference to illustrations from practical cases. In this chapter, I wish to present some striking illustrations of the effect of overload in reducing the defense. We have stated in Chapter 21 that a very large number of our

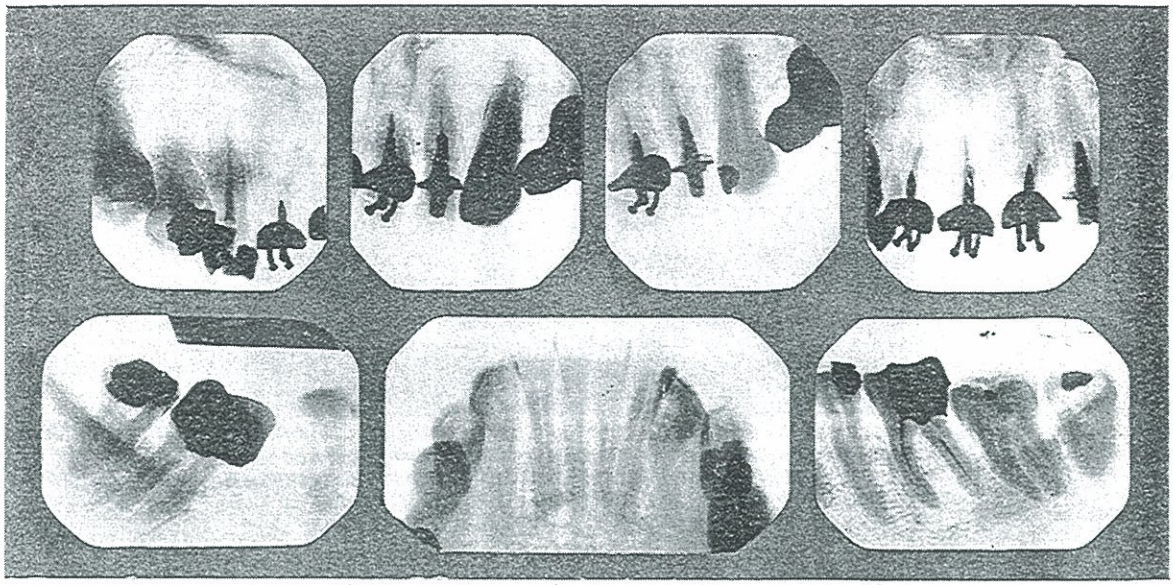


FIGURE 317. THE TEETH FROM WHICH THE CULTURES WERE TAKEN PRODUCING RESULTS SHOWN IN FIGURE 316.

FIGURE 318. A HELPLESS CASTING OF MULTIPLE ARTHRITIS. SHE CAN SCARCELY MOVE A JOINT OF HER BODY.

patients suffering from acute and chronic rheumatic involvements have histories which show that this condition dated back to pregnancy or lactation. (It is significant that nearly all bedridden cases are females.) The following is a striking illustration.

Case No. 338—The patient, eight years ago, age thirty-five, was suffering from very severe acute and chronic deforming polyarthritis. When carried to the office, she confided to me that she greatly wished to get better because her husband had told her that if she did not die or get better soon, he would leave her. Her four children had been taken from her and placed in public institutions; and recently, when brought to see her, they were in such a condition that she had a burning new desire to get well to get her family together again. Her utterly helpless bed-fast crippled condition is shown in Figure 318. She was entirely helpless; could be lifted into a chair for a little while, but her suffering was so great that she had to be moved frequently; could not feed herself or do anything to wait upon herself.

With the removal of the dental infections and the use of an autogenous vaccine, she very greatly improved, so much so that she was able again to feed herself, do the family cooking, and her four children were brought back from the institutions in which they had been kept, and her family was reunited. She could even comb her own hair as well as feed herself. While making this progress, the very great misfortune occurred that she became pregnant. She soon became bedridden again, for her system could not furnish the vitality and new tissues, particularly calcium, required for the new life. It was, as is so often the case, the flame to the smouldering fire. Three of her sisters died of complications attending childbirth, probably puerperal fever, which is a streptococcal infection. She has never since regained the use of her joints. The consolidation and ankylosis has gone steadily on until she can only quiver her fingers. The child born from that pregnancy is now seven years old, and she lives on. She has had penumonia three times. On one occasion, I went to her home; at the time, it seemed impossible that any person could be so ill and survive. Cultures made from the sputum showed a pure streptococcal pneumonia. She looks upon her affliction as a divine punishment for her pregnancy. In this connection, when we see, as I do, so many cases of bedridden complications in the form of arthritis, dating back to pregnancy and lactation, it emphasizes the very great need for a campaign of culture and education that will protect women in this most dangerous condition of streptococcal susceptibility.

After this patient's setback and later pneumonia, I had her brought in an invalid carriage to my ward to see if we might relieve her of some of her acute suffering, for she was again in very great distress from acute processes. She was practically as immobile as though lifeless, except that she could move her lips and her fingers. There was practically no movement in her knees, hips, spine, and elbows, and but little in her mandible. During the period of three years following her pregnancy, she had progressively gotten worse, and with this came a necessarily great neglect of the mouth. Some additional teeth had become non-vital. These were removed with the result that the acute inflammation and pain subsided; and she felt that great benefit had been derived although the increase of movement was only sufficient to allow her to move her arms slightly at the shoulders, permitting a swing of about six inches with each arm. Since that time, she has been quite free from pain, though she is compelled to lie rigid in every joint except her mandible and her fingers, about the only movements she can make being with her lips, throat, and voice.

Her history shows that her mother had rheumatism and heart involvement, and that her mother's mother died of acute and chronic arthritis. Her father was an alcoholic. Her first attack of rheumatism came on at twenty-one years of age when she was working in a foundry that was not properly heated, and her work was polishing the iron fixtures for harnesses which were frosty cold. With her rheumatic susceptibility and extreme chilling, together with dental infections which dated back to that period, she developed these serious lesions. I would like the dental readers of this to visualize what their feelings would or should be if they could know that even through ignorant conservatism they had contributed to such an almost endless living death.

Another and striking illustration is the following: The patient, Case No. 1269, brought by the Visiting Nurse Association, has both a central nervous system disturbance and myositic rheumatism which has made her a bedridden invalid for two years, as well as a very severe sufferer. Her history shows that she has had six pregnancies in seven years; and two years ago, she had a miscarriage with a two months' pregnancy and was again pregnant within a month; and her present acute involvement developed during that period, from which she has made almost no progress toward recovery. Since writing the above, this bedridden unfortunate who was making very definite improvement and progress toward a comfortable condition, has again become

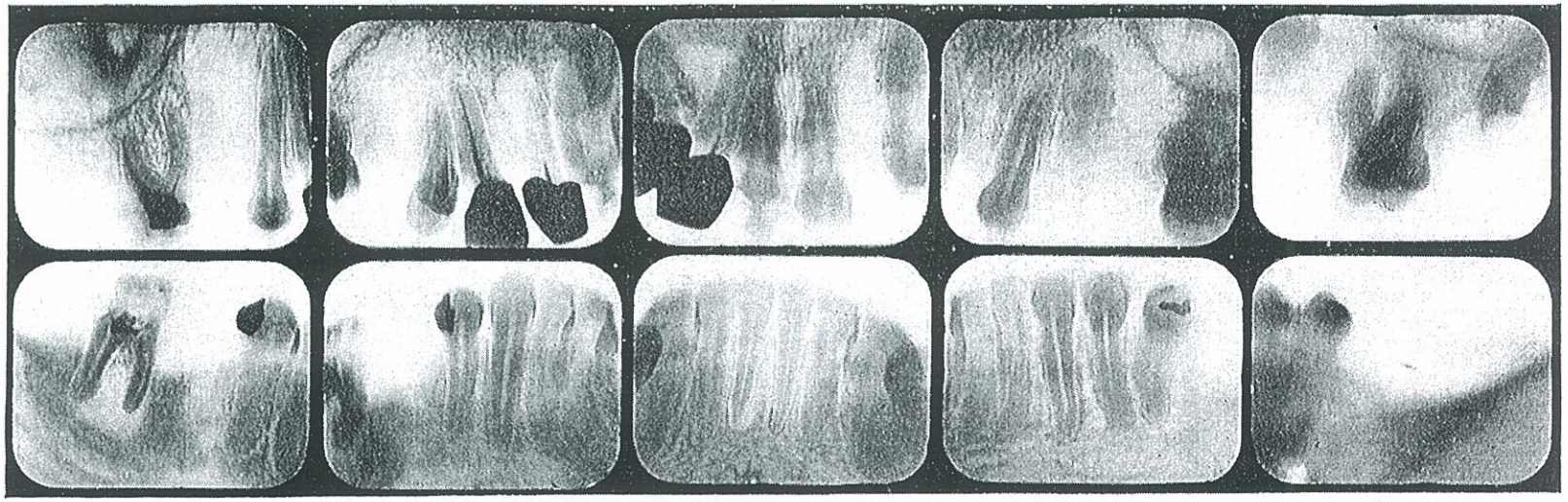


FIGURE 319. ROENTGENOGRAPHIC APPEARANCE OF THE TEETH OF THE PATIENT, CASE NO. 1269. THIS WOMAN IS A HELPLESS BEDRIDDEN CRIPPLE AND SEVERE SUFFERER, PROBABLY LARGELY BROUGHT ON BY THE OVERLOAD OF SIX PREGNANCIES IN SEVEN YEARS TOGETHER WITH DENTAL INFECTIONS.

pregnant, and her condition is very greatly worse than it has ever been before. She can now scarcely move any part of her body and is continually begging that she may die. She may live for years in this almost inconceivably distressing condition. The roentgenograms of her teeth are shown in Figure 319, and it will be noted, as, for example, in the lower molar, that there is evidence of a previously high defense which, however, is surrounded by a condensing osteitis, which change in structure probably relates in time to the overloads and the breaking of her defense.

These cases may be aggravated also by any infective fevers, such as typhoid, diphtheria, etc. The following is a typical illustration. The patient was a helpless invalid with deforming arthritis, as shown in Figure 320. In addition to her severe arthritic involvements, she had bed sores as large as half an orange. Her history showed that she had been in good health until a pregnancy which occurred at about forty-two years of age, with which she developed her acute rheumatism and preceding which, she had had considerable acute tooth-ache that received no attention. The condition of her mouth was one of apical infections. We removed her to a hospital where she could get better care and where it would be possible for me to carry out the proper program. With the removal of her dental infections and the use of a vaccine and her better care, she improved so greatly that she was able to get up in her wheel-chair, roll herself about, feed herself, and was practically without pain. She returned to her home with a vision of enjoying again the happiness of her five-year-old little girl and of being able to cook once more for her husband. Shortly after her return, this little girl came down with diphtheria which her mother contracted, with the result that her acute rheumatism was again lighted up and she became almost as rigid as previously. Could she have been properly protected and properly cared for, we believe she might have made much further improvement which was progressively occurring up to the time of her contracting diphtheria.

These researches show clearly that when society becomes more intelligent, motherhood will get a very different protection. I have recently been informed by a patient, when getting her family history, that her mother, who had lived in Europe, died at thirty-four after having given birth to eleven children besides which she had two miscarriages. Several of the children of this woman died in childhood from symptoms which indicate rickets.

FIGURE 320. A HELPLESS BEDRIDDEN ARTHRITIC CRIPPLE, WITH BED SORES AS LARGE AS HALF AN ORANGE. HER CONDITION STARTED DURING PREGNANCY LATE IN LIFE WHEN SHE HAD CHRONIC DENTAL INFECTIONS.

We do not know what all is involved in the maternal overload of gestation. In the chapter on Overloads I have reported the result of our researches on the deficiencies of gestation as indicated by blood analysis. It is very significant that the ionic calcium of the blood is often lowered in this condition, as it is also in the saliva; and the tendency to dental caries has been shown, in the chapter on Caries, to be related directly to this state.

Dental and medical care of expectant mothers must finally include an intelligent estimation of the calcium starvation as well as other elements, particularly phosphorus, and it must become a part of intelligent living that this condition shall not be allowed to occur, where the system has not an ample factor of safety, and is free from sources of focal infection against which the body may have ample defense during normal stress, but an inadequate defense during this overload. This is particularly illustrated by the effect on rabbits of inoculations with culture producing serious streptococcal lesions, from which the rabbits apparently, completely recovered after several months' time. But while their recovery was adequate to let them return to apparently normal health under ordinary stress of life, they were not able to hold this walled-off infection in check after the overload of pregnancy was established. I will, accordingly, refer for detailed descriptions of this to Chapter 21 on Overloads, Figures 140 and 141.

CHAPTER LXIII.

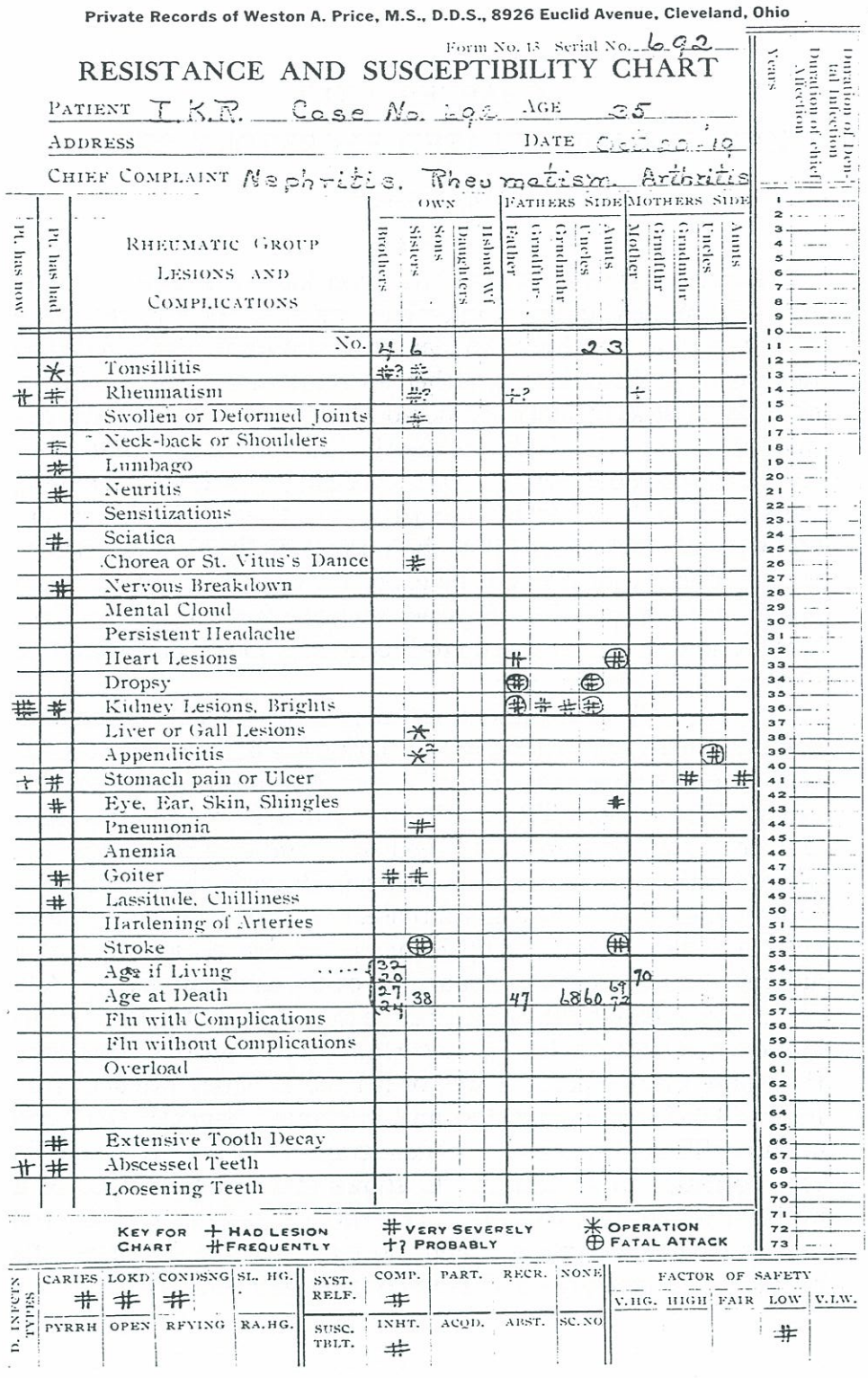
KIDNEYS AND RELATED EXCRETORY ORGANS.

DISCUSSION

KIDNEY.

Whereas, formerly, we looked upon kidney lesions as being remotely related to dental infections, we have come to recognize a very great responsibility in leaving dental focal infections in the mouths of patients having either an acute or chronic nephritis, or marked susceptibility by heredity for same. We have frequently found in patients, in the thirties and forties, that he or she was already developing nephritic changes without its having been suspected, either by the patient or the family physician, and was only looked for by us, because of finding in the susceptibility study, that it might be expected, that there might be an hereditary susceptibility, together with the fact that the patient was found to have definite dental focal infections. This would be illustrated by the following:

Case No. 692—The patient, female, unmarried, age thirty-five, had generally been in good health during her lifetime with the exception of rheumatism, from which she had been free for several years. The susceptibility study, as shown in Figure 321, revealed the fact that her father had died of Bright's disease, that the father's father and mother had each had Bright's disease, that one brother had died of Bright's disease, and one sister had died of heart trouble. The urinalysis made for the patient revealed albumin and a great abundance of casts, shown in Figure 322. Some teeth had been considered border-line until this information was secured; but, on ascertaining this serious condition, they were condemned. Three of her teeth, which are shown in Figure 322-I, were extracted and implanted beneath the skins of three different rabbits, roentgenograms of which are shown in two positions in A and B. C shows casts in the urine of a rabbit inoculated in this way. D shows the organism recovered from the blood stream when posted. F and G show the histological appearance of the kidney, revealing acute parenchym-



Private Records of Weston A. Price, M.S., D.D.S., 8926 Euclid Avenue, Cleveland, Ohio

Form No. 13 Serial No. 692

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT T.K.R. Case No. 692 AGE 35

ADDRESS DATE Oct. 20-19

CHIEF COMPLAINT Nephritis. Rheumatism. Arthritis

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf	Fathers Side: Father	Fathers Side: Grandfthr	Fathers Side: Grandmthr	Fathers Side: Uncles	Fathers Side: Aunts	Mothers Side: Mother	Mothers Side: Grandfthr	Mothers Side: Grandmthr	Mothers Side: Uncles	Mothers Side: Aunts
		No.	4	6							2	3					
	*	Tonsillitis	#?	#?													
#	#	Rheumatism		#?				+?					+				
		Swollen or Deformed Joints		#													
	#	Neck-back or Shoulders															
	#	Lumbago															
	#	Neuritis															
		Sensitizations															
	#	Sciatica															
		Chorea or St. Vitus's Dance		#													
	#	Nervous Breakdown															
		Mental Cloud															
		Persistent Headache															
		Heart Lesions						#				⊕					
		Dropsy						⊕			⊕						
#	#	Kidney Lesions, Brights						⊕	#	#	⊕						
		Liver or Gall Lesions		*													
		Appendicitis		*?												⊕	
+	#	Stomach pain or Ulcer													#		#
	#	Eye, Ear, Skin, Shingles										#					
		Pneumonia		#													
		Anemia															
	#	Goiter	#	#													
	#	Lassitude, Chilliness															
		Hardening of Arteries															
		Stroke		⊕								⊕					
		Age if Living	32 / 20										70				
		Age at Death	27 / 24	38				47			68	60 / 69 / 72					
		Flu with Complications															
		Flu without Complications															
		Overload															
	#	Extensive Tooth Decay															
+	#	Abscessed Teeth															
		Loosening Teeth															

Years

Duration of Dental Infection

Duration of chief Affection

KEY FOR CHART: + HAD LESION; # FREQUENTLY; # VERY SEVERELY; +? PROBABLY; * OPERATION; ⊕ FATAL ATTACK

D. INFCTN TYPES	CARIES	LOKD	CONDSNG	SL. HG.	SYST. RELF.	COMP.	PART.	RECR.	NONE	FACTOR OF SAFETY: V.HG.	HIGH	FAIR	LOW	V.LW.
	#	#	#			#								
	PYRRH	OPEN	RFYING	RA.HG.	SUSC. TRLT.	INHT.	ACQD.	ARST.	SC.NO				#	

FIGURE 321. SUSCEPTIBILITY STUDY SHOWING MARKED SUSCEPTIBILITY TO KIDNEY INVOLVEMENT, INCLUDING PATIENT AND FOUR MEMBERS OF FATHER'S FAMILY. CASE NO. 692.

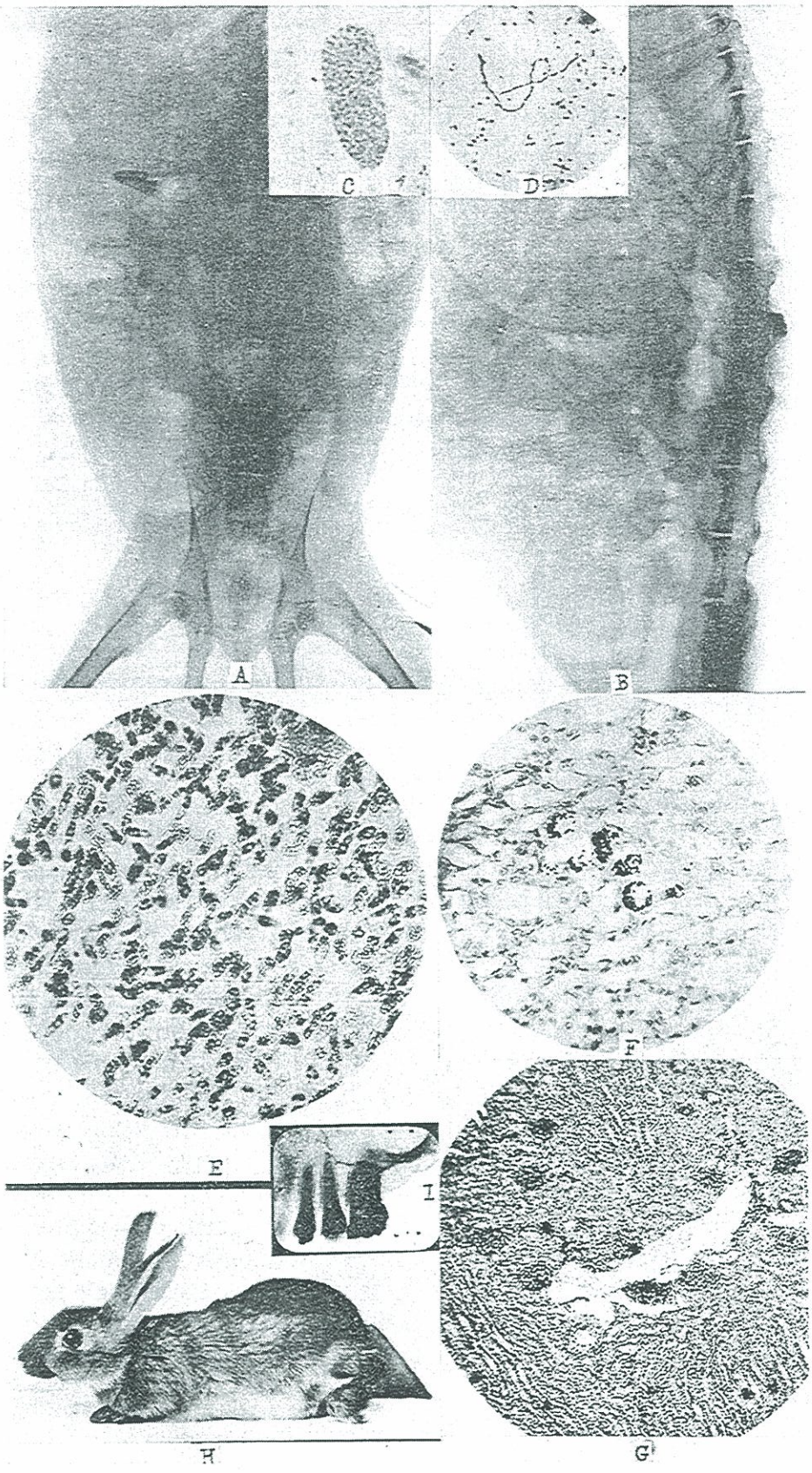


FIGURE 322. RABBIT REACTIONS TO TOOTH IMPLANTATIONS OF CASE IN PREVIOUS FIGURE. A AND B, IMPLANTED TEETH. C, CAST IN THE RABBIT'S URINE. D, ORGANISMS IN THE RABBIT'S BLOOD. E, CASTS IN THE PATIENT'S URINE. F AND G, NEPHRITIC KIDNEY SECTIONS.

atous nephritis. All three rabbits, so treated, developed acute nephritis. H shows the involved rabbit. It is interesting to note that, after these teeth had been in rabbits' tissues for a period of time, they lost their ability to produce nephritis, and, at this time, three months after their extraction, these teeth are being carried in rabbits without apparent effect upon them.

It sometimes occurs that, when teeth are implanted, they produce quite violent reactions with abundant development of pus, and at other times there is exceedingly little reaction about the tooth. It does not follow, however, that the former condition is necessary in order that serious lesions may develop in animals. In the following case (No. 861) the patient, male, age sixty-eight, had both sugar and albumin with casts and renal cells in the urine. A tooth that had been considered border-line, shown in Figure 323,

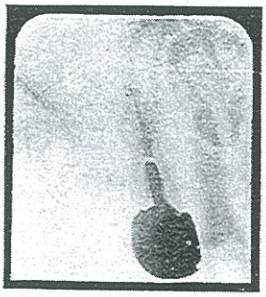


FIGURE 323. TOOTH FROM PATIENT WITH NEPHRITIS. SEE NEXT FIGURE.

was accordingly condemned, and when extracted was planted beneath the skin of a rabbit which was posted in two weeks' time. Figure 324 shows the appearance of the tissue about the tooth when the rabbit was posted. As will be seen, there was exceedingly little local irritation about the tooth; but, notwithstanding this fact, the rabbit was losing in weight, and developed an acute nephritis, as shown by the kidney section in Figure 325. Some of the borings of the interior of this tooth, which was apparently well root-filled, were inoculated into another rabbit after being ground finely enough for them to pass through a hypodermic needle. The normal salt suspension of these tooth chips was injected beneath the skin of the rabbit. It also developed acute nephritis.

From these last two cases it will be noted that the quantity of infection that was inserted in the rabbit was exceedingly small, not a grown mass of culture inoculated into the circulation, and the organisms in the tooth placed beneath the skin, or small

FIGURE 324. TOOTH OF PREVIOUS FIGURE BENEATH THE SKIN OF A RABBIT PRODUCED A SLIGHT LOCAL REACTION BUT RABBIT DEVELOPED ACUTE NEPHRITIS, AS SHOWN IN NEXT FIGURE.

quantity of the chips drilled from the tooth, had to take the chance of being obstructed or annihilated by the various defenses of the body, and all tissues had equal opportunity for making a defense, so far as other parts of the body were concerned. But notwithstanding this, the elective localization quality was suffi-

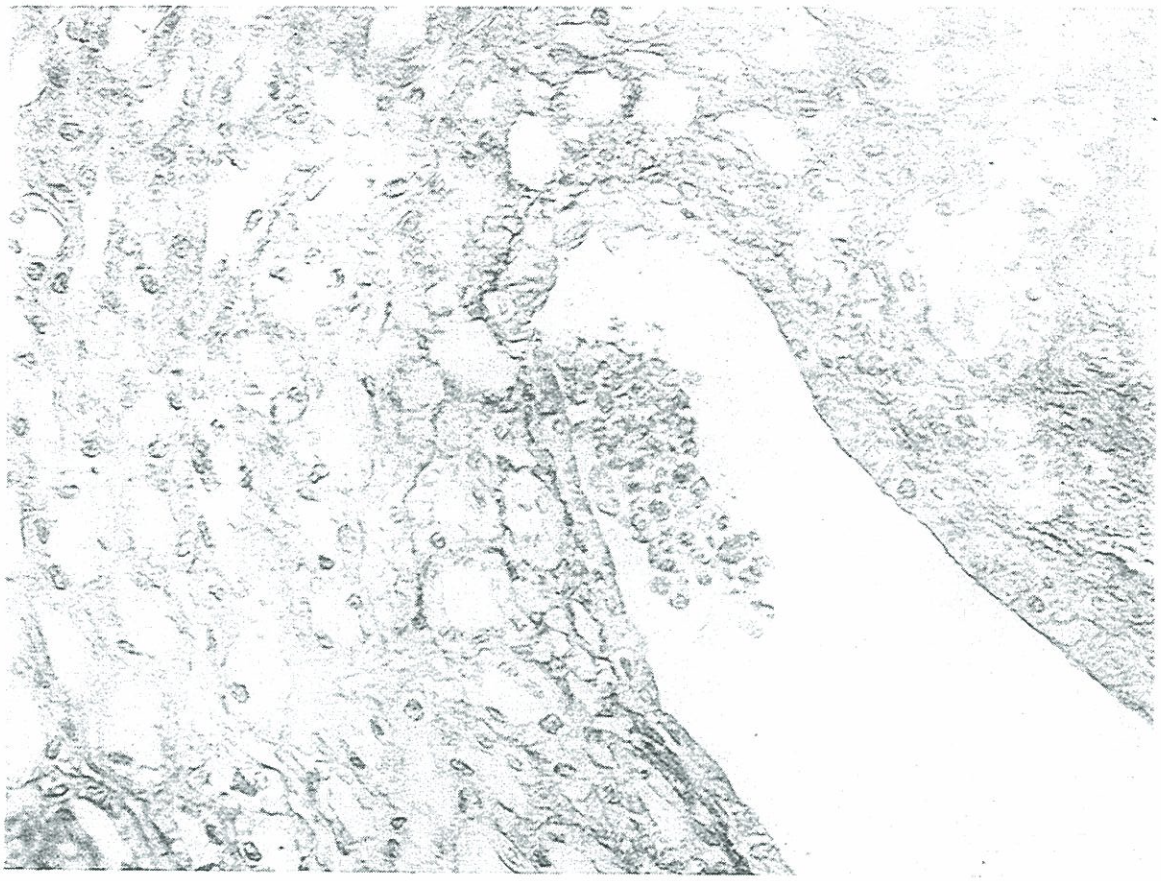


FIGURE 325. SECTION OF NEPHRITIC KIDNEY WITH PUS CELLS.

ciently strong for these organisms to select the kidney, as shown. The total quantity, by weight, of organisms injected with the fine borings would be less than a millionth part of a gram, yet they were sufficient. This is a fact we have demonstrated in many ways many times, and we are stressing it because of the misapprehension that the organisms growing in dental infections are, of necessity, of such low virulence that the quantity that would have to be injected into a man would be from a teacupful to several quarts.

It is very evident that this generation of dentists very much prefers to hear evidence that will justify the leaving of root-filled teeth and particularly justify the retention of teeth for operative procedures, such as crowns, bridges, inlays, etc., from which there could be no further income for the operative dentist after they have once been condemned and assigned to the exodontist and

the prosthetic specialist. I fear another generation of the profession, which we must expect will have much greater information on these subjects, will find it difficult to distinguish between the blindness of ignorance and the blindness of desire.

Kidney involvements express themselves quite differently from different strains. In the two previous cases shown, the hypertrophy of the kidneys was not great. In the next case (No. 573) we have that of a married woman, age forty-one years, suffering from rheumatism and heart trouble. Incidentally, as a part of this study, a urinalysis was made with the result that evidence of nephritis was disclosed. Her extracted tooth was cultured and a rabbit inoculated in the marginal ear vein with 1 cc. of the 24 hour culture. In 49 days the rabbit was posted with the result shown in Figure 326. D shows the two enormously enlarged kidneys of the rabbit, five times their normal weight for the weight of the rabbit, and a normal kidney beside them; A and B show the histological appearance of the kidney; and C shows a cast from the patient's urine. The following is the pathologist's interpretation of the sections from this kidney:

"*Inverted Ocular* shows a large wedge-shaped piece of tissue of a spongy character, stained with a light pink color. The large part of the section shows a great number of dilated spaces, resembling small cysts. Among them one can see the very small, shrunken down glomeruli. Most of those dilated, cyst-like spaces have a pinkish stained material.

"*Low Power.*—The cortical portion of the kidney is represented entirely by a great number of dilated tubules and glomeruli, giving the picture of a multiple cystic condition. Practically every one of the glomeruli is gone; only a small piece of the tuft is left and has lost its attachment to the Bowman's capsule. All these tubules are markedly dilated, the lining membrane gone, and the walls in between the tubules are only of a fibrous tissue. In some places some of the tubuli are seen to be compressed among the neighboring dilated tubules, their lining also disappearing and being represented as small empty vesicles. In some of the tubules, large dilated and small compressed, one can see a colloid material, in some instances mixed with a few desquamated epithelial cells. As one examines the tissue from the cortex down toward the medulla, the dilated tubes are larger and larger and in many cases two or three have joined together. The tubules in the medulla show degenerative changes, vacuolation in the cells

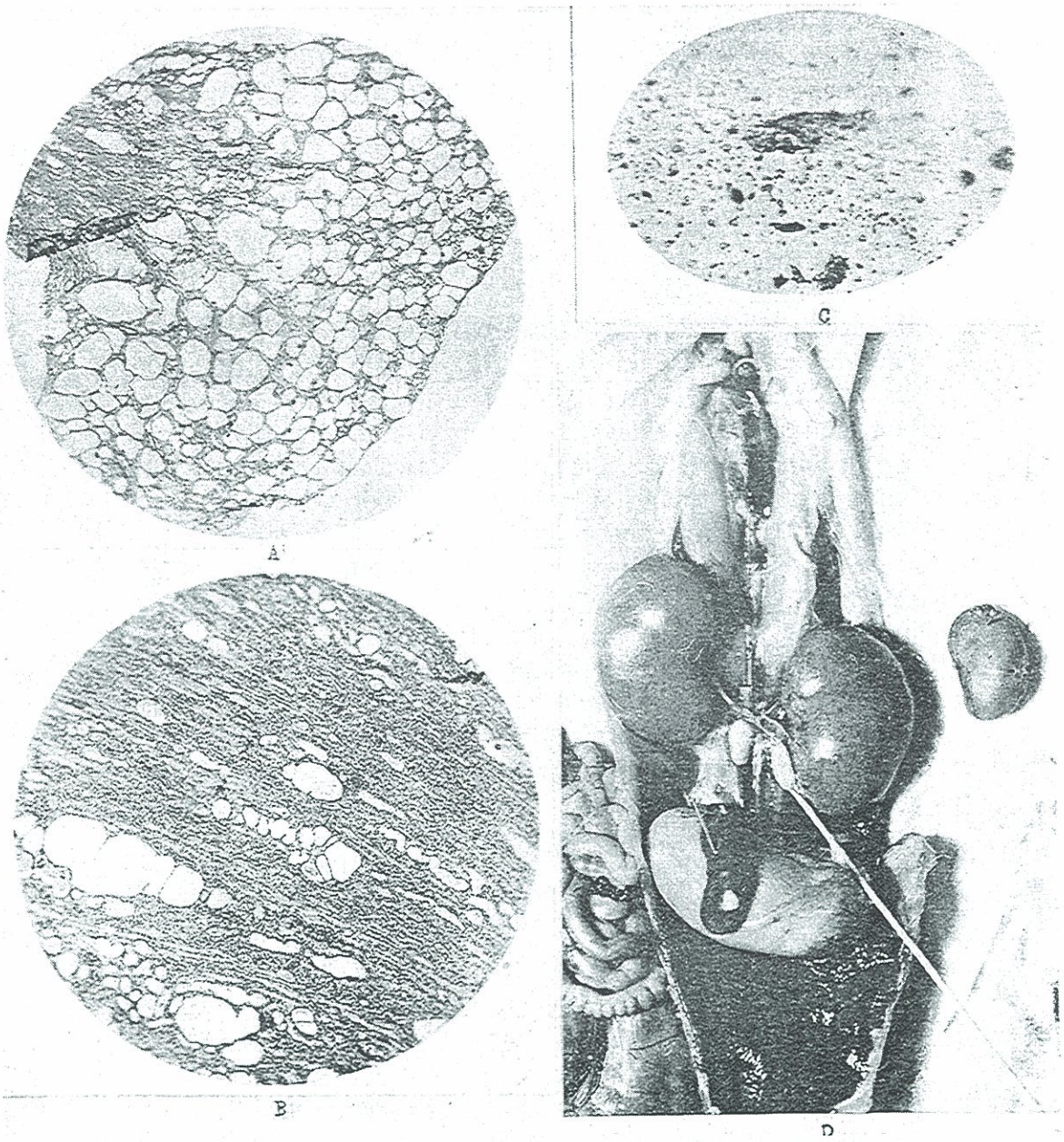


FIGURE 326. ACUTE INTERSTITIAL NEPHRITIS PRODUCED IN A RABBIT. A AND B, TISSUE SECTIONS SHOWING CELLULAR NECROSIS AND EDEMA. D, BOTH KIDNEYS OF INJECTED RABBIT, FIVE TIMES NORMAL SIZE. SEE NORMAL KIDNEY TO RIGHT, ALSO HYPERTROPHY OF ADRENALS. C, CASTS FROM PATIENT'S URINE. CASE NO. 573.

of the lining membranes. In some places many cells show complete cellular necrosis. The blood vessels are dilated.

"*High Power* shows the same changes as above.

"*Diagnosis.*—Acute interstitial nephritis with marked, acute edema of the tubules and glomerular structures of the cortex (especially)."

As this case is not reviewed in the heart cases, we will state that the patient's mother and mother's mother, and a brother and sister of her mother, all died of heart lesions. This was, accordingly, a susceptible tissue in this patient. Her lassitude, rheumatism, and nephritis all cleared up quite promptly and have been absent for three years so that she has again taken up her routine hard work as an office secretary and is carrying a very heavy overload without recurrence of her almost prostrating symptoms from which she formerly suffered. Two of the teeth that were extracted are shown in Figure 327, and you will note the marked

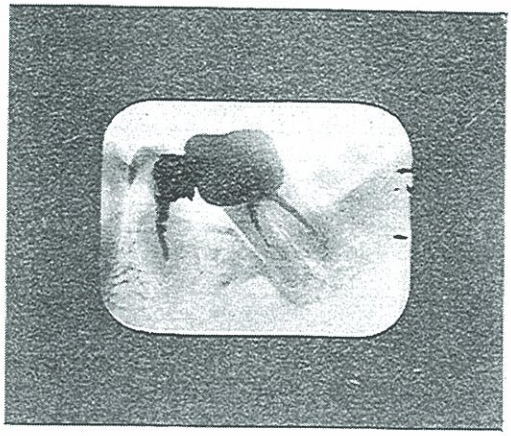
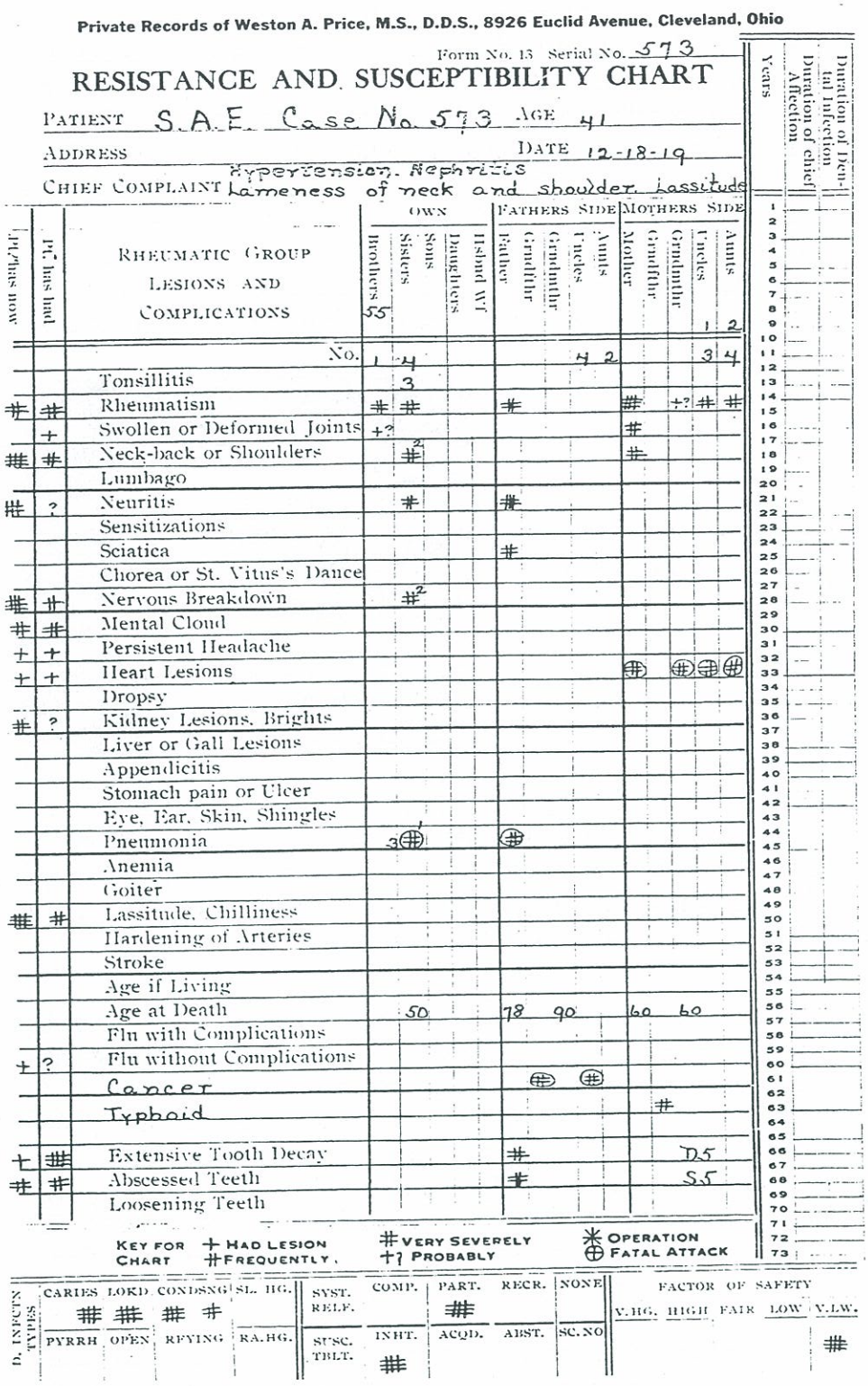


FIGURE 327. TWO OF THE TEETH OF PREVIOUS CASE PRODUCING KIDNEY INVOLVEMENT. NOTE CONDENSING OSTEITIS, NOT RAREFYING.

tendency to condensing osteitis and the absence of the rarefying osteitis so generally looked for. The culture was taken from the teeth shown in Figure 327, which was inoculated into the rabbit which produced the acute nephritis shown in Figure 326. Figure 328 shows the susceptibility chart of her case.

BLADDER.

Bladder irritations are frequently caused or aggravated by dental infections. This will be illustrated by the following case. A man of sixty-five was so distressed with cystitis that for five years he had been unable to leave his home to visit his family, and was required to void his urine from every thirty minutes to one hour or his distress would be unbearable. This, of necessity, greatly disturbed his rest. A bacterial examination of his urine showed an abundant staphylococcal infection. The teeth shown in Figure 329 were extracted and his cystitis improved within twenty-four hours, and in two weeks' time he was retaining his urine for five hours with so complete a relief of his distressing symptoms, that he went to New York to visit his son and remained several weeks without annoyance or discomfort.



Private Records of Weston A. Price, M.S., D.D.S., 8926 Euclid Avenue, Cleveland, Ohio

Form No. 13 Serial No. 573

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT S.A.E. Case No. 573 AGE 41

ADDRESS DATE 12-18-19

CHIEF COMPLAINT Hypertension. Nephritis Lameness of neck and shoulder. Lassitude

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers 55	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf.	Fathers Side: Father	Fathers Side: Grandfthr	Fathers Side: Grandmthr	Fathers Side: Uncles	Fathers Side: Aunts	Mothers Side: Mother	Mothers Side: Grandfthr	Mothers Side: Grandmthr	Mothers Side: Uncles 1	Mothers Side: Aunts 2
		No.	1	4						4	2					3	4
		Tonsillitis		3													
#	##	Rheumatism	#	#				#					##		+?	#	#
	+	Swollen or Deformed Joints	+?										#				
##	#	Neck-back or Shoulders		#2									#				
		Lumbago															
##	?	Neuritis		#				#									
		Sensitizations															
		Sciatica						#									
		Chorea or St. Vitus's Dance															
##	#	Nervous Breakdown		#2													
#	##	Mental Cloud															
+	+	Persistent Headache															
+	+	Heart Lesions											⊕		⊕	⊕	⊕
		Dropsy															
#	?	Kidney Lesions, Brights															
		Liver or Gall Lesions															
		Appendicitis															
		Stomach pain or Ulcer															
		Eye, Ear, Skin, Shingles															
		Pneumonia	3⊕					⊕									
		Anemia															
		Goiter															
##	#	Lassitude, Chilliness															
		Hardening of Arteries															
		Stroke															
		Age if Living															
		Age at Death		50				78		90			60		60		
		Flu with Complications															
+	?	Flu without Complications															
		Cancer						⊕		⊕							
		Typhoid													#		
+	##	Extensive Tooth Decay						#							D5		
#	#	Abscessed Teeth						#							S5		
		Loosening Teeth															

Years: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73

Duration of chief Affection

Duration of Dental Infection

KEY FOR CHART: + HAD LESION; # FREQUENTLY; +? PROBABLY; ✳ OPERATION; ⊕ FATAL ATTACK

D. INFECTN SITES

CARIES	LOKD	CONDSNG	SL. HG.	SYST. RELF.	COMP.	PART.	RECR.	NONE
##	##	##	#			##		
PYRRH	OPEN	REVING	RA.HG.	SUSC. TBLT.	INHT.	ACQD.	ABST.	SC. NO
					##			

FACTOR OF SAFETY: V.HG. HIGH FAIR LOW V.LW.

V.LW. ##

FIGURE 328. SUSCEPTIBILITY OF PREVIOUS CASE, NO. 573. NOTE FOUR CASES OF DEATH FROM HEART INVOLVEMENT ON MOTHER'S SIDE.

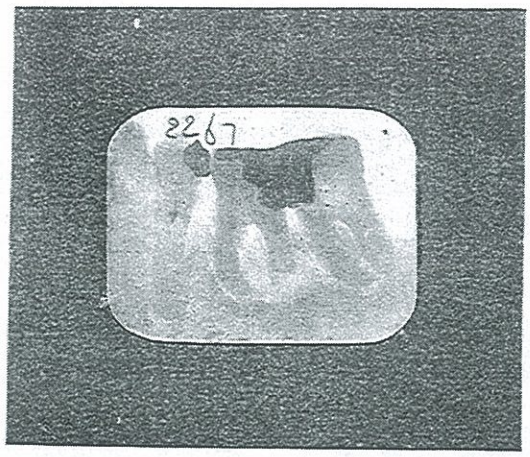


FIGURE 329. TEETH WHICH PRODUCED ACUTE AND CHRONIC CYSTITIS, WHICH PROMPTLY DISAPPEARED AFTER THEIR EXTRACTION.

In our experimental animals we frequently see very marked distention of the urinary bladder, following our inoculations, with ulcer formation on the bladder wall. Figure 330-B shows a bladder approximately twenty times its normal size. Figure 330-A shows a large ulcer on the inner surface of this bladder. This rabbit was inoculated with the culture of a tooth shown in Chapter 66 on the Central Nervous System, and the retention of urine was due to a complete paralysis from a lesion of the spine. The patient, from whose tooth the culture was taken, was suffering from recurring central nervous system disturbance. This rabbit had been affected with incontinence of urine prior to the development of retention. This lesion is of particular interest because of the recent important work of the surgeon, Dr. Richard Cabot, in which he has shown the importance of the prevention of retention of urine because of the important role it plays in the production of bladder lesions. It is very significant in looking over our records that, approximately, three per cent of the rabbits inoculated with dental cultures, show gross evidence of cystitis at necropsy.

The great importance of the susceptibility study and physical history of the patient will be shown in a review of Case No.781. The patient, twenty-eight years of age, presented for dental care. The only physical disturbance complained of was lameness in her back. A roentgenographic study of her teeth did not reveal conditions that were considered serious. A crowned molar was considered border-line. A susceptibility study, shown in Figure 331, was made. This and her history revealed that her personal condition had been good until her recent disturbance. Her father was living, was sixty-three years of age, and has had excellent health and freedom from all rheumatic group lesions. His father lived to eighty-five. Her mother's record, however, shows that she

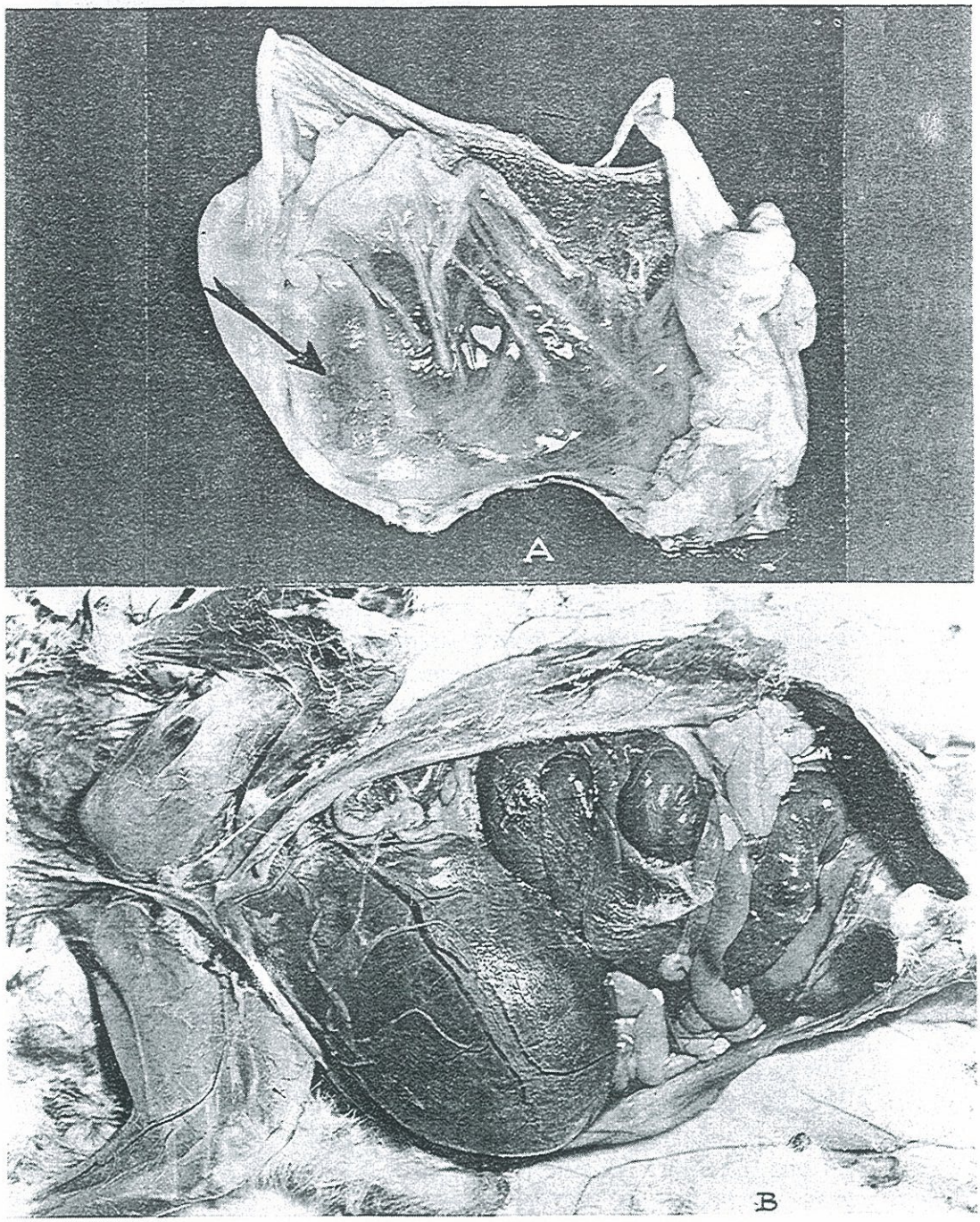


FIGURE 330. PARALYSIS OF THE BLADDER WITH RETENTION, PRODUCED IN A RABBIT BY DENTAL INFECTION. BLADDER IS TWENTY TIMES ITS NORMAL SIZE, AS SHOWN IN B. A SHOWS DEEP ULCER ON INNER SURFACE OF DISTENDED BLADDER.

Private Records of Weston A. Price, M.S., D.D.S., 8926 Euclid Avenue, Cleveland, Ohio

Form No. 13 Serial No. 781.

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT S.W.D. Case No. 781 AGE 28

ADDRESS DATE Mar. 1, 20

CHIEF COMPLAINT Neuritis of Spine

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf	Father's Side: Father	Father's Side: Grandfthr	Father's Side: Grandmthr	Father's Side: Uncles	Father's Side: Aunts	Mother's Side: Mother	Mother's Side: Grandfthr	Mother's Side: Grandmthr	Mother's Side: Uncles	Mother's Side: Aunts
		No.	0	0							½	0				3	5
		Tonsillitis															
		Rheumatism															
		Swollen or Deformed Joints															
		Neck-back or Shoulders											#				
		Lumbago															
#	#	Neuritis						Excellent									
		Sensitizations															
		Sciatica															
		Chorea or St. Vitus's Dance															
		Nervous Breakdown															
		Mental Cloud															
		Persistent Headache											#				
		Heart Lesions											⊕				
		Dropsy														3	3
#	#	Kidney Lesions, Brights											⊕	#		⊕	⊕
		Liver or Gall Lesions															
		Appendicitis															
		Stomach pain or Ulcer															
#	#	Eye, Ear, Skin, Shingles															
		Pneumonia															
		Anemia															
		Goiter															
		Lassitude, Chilliness															
		Hardening of Arteries															
		Stroke															
		Age if Living						63								3	3
		Age at Death							85	24			60	86	40	30	30
		Flu with Complications															under
		Flu without Complications															
		Neuralgia											#				
	#	Extensive Tooth Decay															
		Abscessed Teeth															
		Loosening Teeth															

Years | Duration of Chief Affection | Duration of Dental Infection

KEY FOR CHART: + HAD LESION; # FREQUENTLY; # VERY SEVERELY; †? PROBABLY; ✱ OPERATION; ⊕ FATAL ATTACK

D. INFLUX STATE

CARIES	LOKD	CONDSNG	SL. HG.	SYST. RELF.	COMP.	PART.	RECR.	NONE
#								
PYRRH	OPEN	REVING	RA. HG.	SUSC. TBLT.	INHT. #	ACQD.	ABST.	SC. NO

FACTOR OF SAFETY

V. HG.	HIGH	FAIR	LOW	V. LW.
			#	

FIGURE 331. SUSCEPTIBILITY CHART OF APPARENTLY NORMAL PATIENT. NOTE EIGHT CASES OF DEATH FROM BRIGHT'S DISEASE ON MOTHER'S SIDE. EXAMINATION OF PATIENT SHOWED SAME ACUTELY DEVELOPED, THOUGH UNSUSPECTED, AT AGE TWENTY-EIGHT.

died at sixty of acute heart involvement and kidney involvement. Her mother's father died of Bright's disease as did three of her mother's brothers at about thirty years of age and three of her mother's sisters at about that age. In other words, of nine children of which her mother was one, seven died and their father died either because of, or with, Bright's disease, only two of the nine escaping. This strongly suggested that a careful examination and study be made of this patient's kidney function. This was done and it was found that she already was showing albumin and casts. She was accordingly referred to her physician for careful observation and treatment and the tooth in question was no longer border-line. It was extracted, for our interpretation, growing out of our experience, is that no person should be permitted to carry definite dental infection who has an involvement of an organ of which that infection would be likely to increase the severity, if that organ is one whose impairment would seriously injure or endanger the patient's life or health. In other words, I do not consider it safe for a patient having a distinct evidence of either heart or kidney involvement, to carry a root-filled tooth, because I do not know of any method which has stood the test as being competent to make such a tooth completely free from infection and source of toxin, and retain it so, and because I feel that patients with susceptibility to these affections will, of necessity, have a low factor of defense immediately about the tooth. In other words, they will not have the ability to maintain an adequate quarantine against either or both the toxic substances developing in the tooth or the bacterial infection from that source, if it should develop. I further believe that all root-filled teeth sooner or later, and most of them sooner, become infected to some extent, if they are not already so at the time of root filling, unless that patient has a very high defense and is able to maintain a high state of systemic defense and protection of the culture medium which develops in even well root-filled teeth from systemic infection.

There is a phase of kidney function which should be discussed in this connection and is related to a disturbance of the ionic calcium of the blood as a pathological condition of that fluid. Under normal conditions of sugar content of the blood there is an ample factor of safety which adequately prevents sugar from appearing in the urine. If, however, for such reasons as we shall present, sugar does appear in the urine without its elevation beyond the threshold of danger in the blood, it does not constitute a diabetes

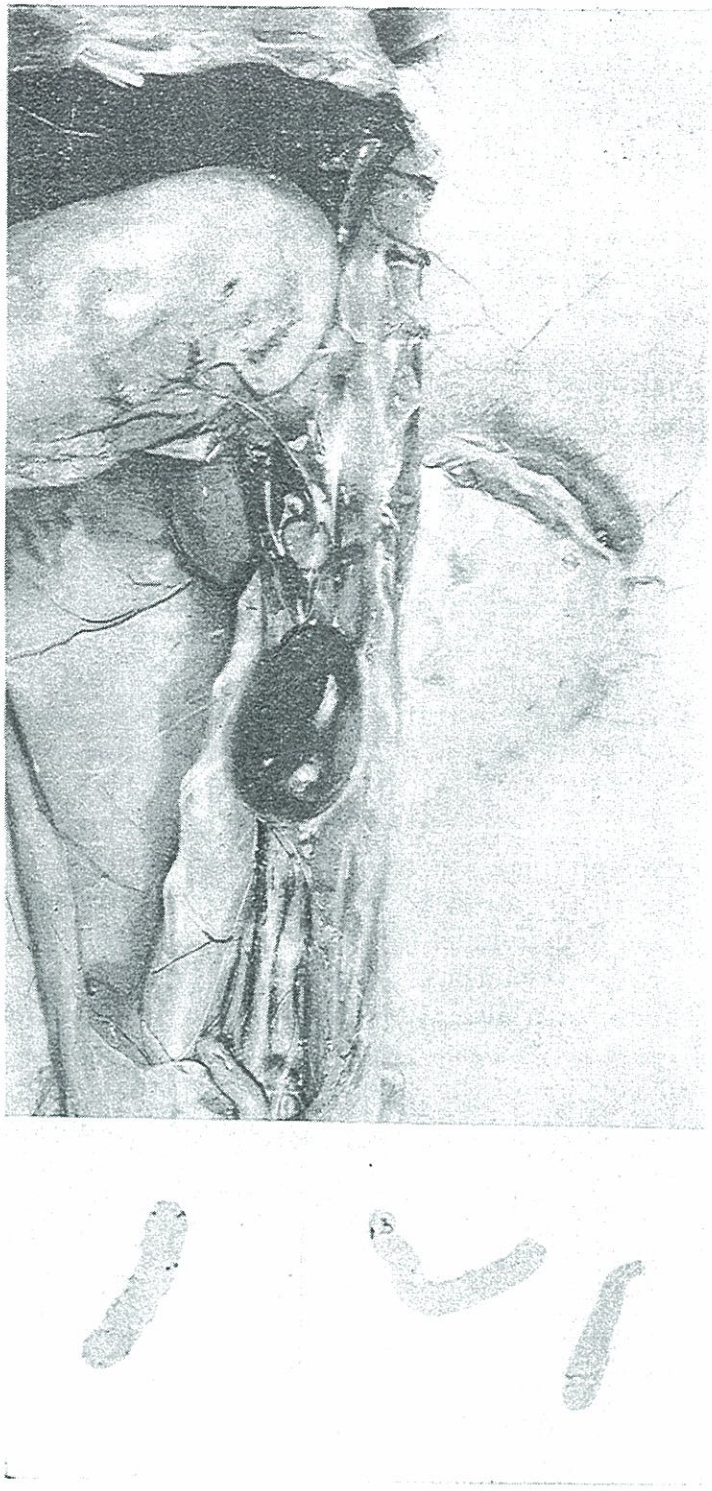


FIGURE 332. HYPERTROPHIED KIDNEY AND CASTS FROM URINE OF A RABBIT WHICH DEVELOPED SEVERE NEPHRITIS IN SIXTEEN DAYS FROM THE IMPLANTED TOOTH SHOWN, WELL ENCAPSULATED.

mellitus. The secreting cells of the glomeruli which normally are impervious to the sugar of the blood as it passes through the adjoining venules, may become permeable by an increase in the ionic calcium of the blood above its normal. It is not yet established to what extent a loss of function of the island of Langerhans of the pancreas tends to increase the ionic calcium of the blood. It is, however, an apparently associated condition in that, as we have shown in other chapters in our study of the relation of periodontoclasia to diabetes, the ionic calcium of the blood is, practically, always high and tends to be pathologically so in both these conditions. We have then the suggested possibility, if not a probability, that disturbed kidney function through the medium of disturbed ionic calcium of blood may be directly related to periodontoclasia or pyorrhea alveolaris.

I have now had so many instances where rabbits developed acute nephritis from each of the procedures, the inoculation of cultures and the planting of teeth from patients with and without nephritis, but particularly so in patients with nephritis, that I find no way of escaping the placing of the responsibility of a great many of the kidney disturbances on this source. In Figure 332 will be seen the dissection of a rabbit which had a bicuspid tooth planted beneath the skin. It died in sixteen days with a loss of 310 grams, or approximately 25 per cent of its weight. On opening up the skin there was an encapsulated subcutaneous abscess about the tooth, a smear from which showed Gram-positive streptococci in individual forms and small chains, and also some Gram-negative organisms. The heart showed hyperemia of the myocardium, with ulceration of the aortic arch. The kidneys showed parenchymatous nephritis. The urine showed casts. In the illustration of this case, the encapsulated tooth is shown, and also the hypertrophied kidney and casts from the urine of this rabbit.

In Figure 333 will be seen a cast from the urine of a rabbit dying with kidney involvement from the planting of a tooth in two days after the planting of the tooth. (Rabbit 1144.) It is probable that any infection that will sufficiently overwhelm an animal or individual and produce death will, at death, so overload the kidney as to produce marked disturbance of function, and it must not be considered that the presence of casts will, of themselves, be an indication or proof of an acute or chronic nephritis. Their presence, however, is distinctly pathognomonic and, as such, have very clear significance.

FIGURE 333. CASTS FROM URINE OF A RABBIT DYING IN TWO DAYS WITH KIDNEY INVOLVEMENT, FROM THE PLANTING OF AN INFECTED TOOTH BENEATH THE SKIN.

CHAPTER LXIV.

SKELETAL AND MUSCULAR SYSTEM.

DISCUSSION.

It is exceedingly difficult, in the present state of our knowledge, to differentiate between lesions of the nervous and muscular systems, and it seems very probable that frequently both are involved in the same case. We shall, however, endeavor to adhere to our classification according to the biological classification of tissues. We will, accordingly, present the cases under the subclassifications of (1) acute rheumatism, (2) deforming arthritis, (3) synovitis, (4) osteomyelitis, and (5) myelitis.

It is not clear, as yet, to what extent the reactions are to toxins or to bacterial invasion. I will show cases in which I have secured the culture from the mycsitis of both the patients and the rabbits and show them *in situ* in sections of the tissues from both sources. The evidence is, therefore, convincing to me that the organisms do localize in the muscles in certain cases. This is not only true of muscles but of synovial membranes, for we have on scores of occasions located the same strain, which we have inoculated, by culturing from involved joints. A typical illustration of such is shown in Figure 334. I have shown in the experimental chapters of Part One, that these inflammatory processes very frequently have their first expression as zones of local ischemia, and the evidence is accumulating to emphasize the possibility, if not probability, of many of these localizations beginning as sensitization processes. In patients carrying focal infections, the presence of the toxic substance from these zones produces anaphylactic reactions. Such tissues, as in that patient, readily develop or occlude the antibody which combines with the antigen, thereby producing locally the various phases of sensitization reaction, one of the first of which is the marked and rapid relaxation or enlargement of the capillaries. This is followed by a rapid accumulation of leucocytes about the zone receiving the acute hyperemia. This may be followed by localized stagnation sufficient to develop degeneration or even necrosis of cells. The antigen producing this reaction may, I believe, be the toxic substance from the focal

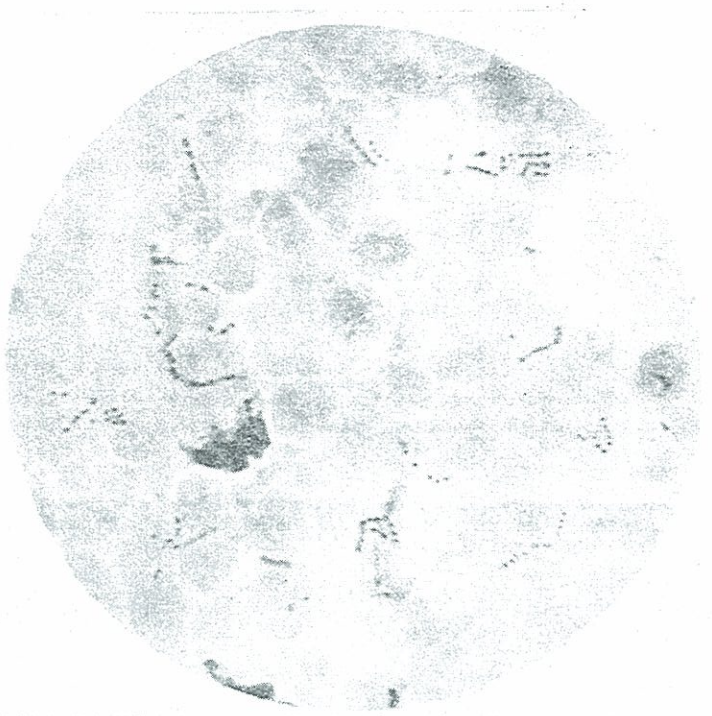


FIGURE 334. TYPICAL ILLUSTRATION OF STREPTOCOCCI AND DIPLOCOCCI IN JOINT FLUIDS OF ANIMALS INOCULATED WITH A DENTAL CULTURE.

infection without the presence of any bacteria. When, however, degeneration or death of a few or many cells has occurred, they readily become the pabulum for infection, and particularly for the strain producing that toxic substance. We have, therefore, as a secondary process, the infection of the lesion produced by the preliminary anaphylactic reaction.

In highly vascularized tissues it becomes readily possible for these degeneration products to be limited quite sharply and for an ultimate quite complete repair by the successive processes of inflammation. In the poorly vascularized tissues, however, such as bone, synovial membranes, dentin, etc., the repair is less simple and frequently less complete; and since mechanical destruction of hard tissue may involve much greater problems of readjustment and repair, fixation and deformity may readily develop. In these hard tissues we must recognize two distinct types of inflammatory reaction, one largely degenerative with the tearing down of hard structures, and the other proliferative with the building on on hard tissue and the calcifications of soft tissues, first as fibrosis and then a calcification of this tissue. It is not possible

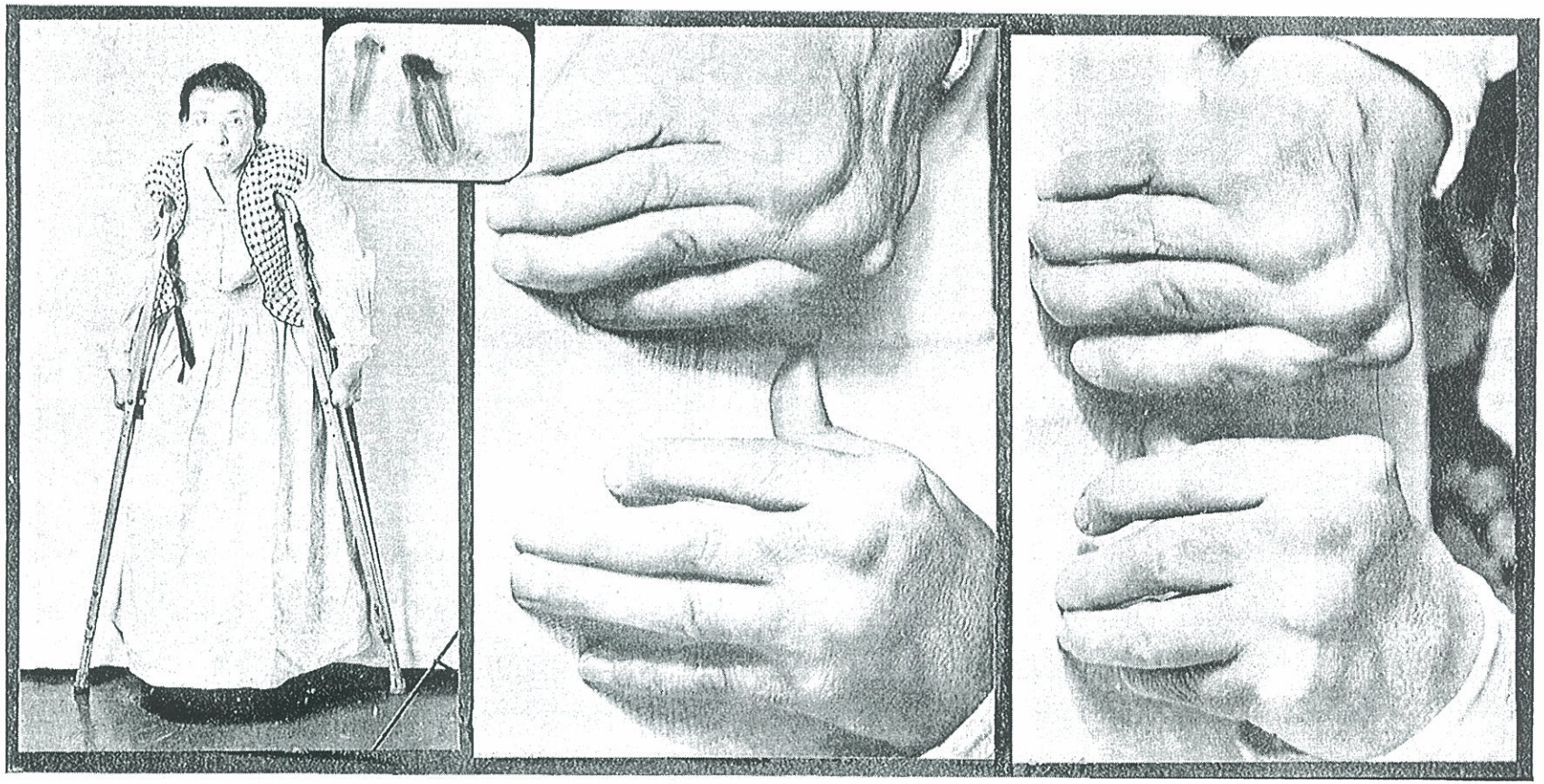


FIGURE 335. CHRONIC DEFORMING POLYARTHRITIS. THIS WOMAN WAS A BEDRIDDEN CRIPPLE, COMPLETELY HELPLESS FOR SIX YEARS. SHE NOW WALKS ABOUT HER HOUSE WITHOUT EVEN A CANE AND DOES BEAUTIFUL FANCYWORK. NOTE CONDENSING OSTEITIS, NOT RAREFYING, ABOUT TOOTH. CASE NO. 709.

yet, clearly to define and differentiate between these two types. I will, however, show illustrations of both, and with some will give some suggestions as to important etiological factors.

In Chapter 3 I have discussed the different types of bone change found in patients and produced in rabbits by inoculation of different strains. The problem of prognosis is very greatly influenced by the type of lesion that has been produced by the infection. Nature seems capable of making very complete repair of rheumatic group lesions in muscle tissue, and frequently very poor repair of lesions in bone tissues, particularly if the latter have involved the destruction of the vascularization. We have, accordingly, come to be very guarded in the matter of giving encouragement for marked relief in all cases of deforming arthritis, because of the serious structural changes, the abundance of the scar tissue (in this case of bony scar tissue), and the permanent susceptibility of such individuals; for it is generally recognized that in these lesions one attack predisposes another. This, however, can be said of most, if not all, of the rheumatic group lesions which are, apparently, associated with the biologic characteristics of these strains of the streptococcus group of organisms. We have, however, had some very marked improvements in even severe cases. Figure 335 shows such a case.

Case No. 709.—This woman, unmarried, forty-seven, was carried to us seven years ago with such extreme deforming arthritis that she had been bedridden for six years. When first brought to us, her spine, hips, knees, and neck were so stiff that she could be lifted by her head when lying down and without muscular effort could be raised to standing position; and if she had been leaned against the wall, she would remain there as incapable of moving as a broom handle leaned against a wall. She had not been able to feed or wait on herself for five years. Figure 336 shows the teeth that were extracted at that time. She was given an autogenous vaccine made from the extracted teeth. Improvement was so marked and rapid that in three months' time she was walking with crutches, and has continued to improve continuously for five years except at one time. She is now one of the busiest seamstresses in Cleveland and does most beautiful embroidery and drawn-work, takes care of herself and her room, and with the return of her health is one of the most grateful, happy souls one could ever find. Her hands that were as stiff as castings, or nearly so, have limbered up so she can thread needles and exe-

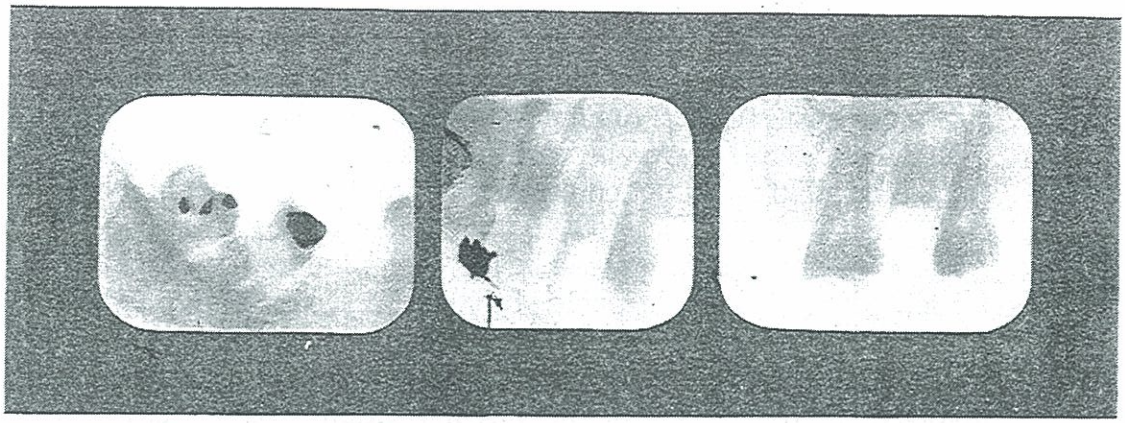


FIGURE 336. SOME OF TEETH OF PREVIOUS CASE OF DEFORMING ARTHRITIS, EXTRACTED SEVEN YEARS AGO.

cute most difficult lace patterns. Her work is eagerly sought because of its exquisite beauty. At one time she had a return of her symptoms for a few months. A careful examination disclosed a non-vital pulp, shown as an insert in Figure 335. This tooth was not painful to mastication, nor had she at this time any symptoms from it though there was a history of its having been hypersensitive to heat and cold several months previous. Note this tooth does not have an area of rarefaction about its apex expressed as radiolucency in the roentgenogram but, on the contrary, an area of radiopacity due to a condensing osteitis. Her hands in two stages of her arthritis are shown in Figure 335. At the time of the extraction of this lower right first molar, a trephine was used to remove for sectioning a piece of the condensed bone. This is shown in Figure 337. Note its structure not unlike that of a curly maple. The blood vessels have been greatly reduced in size. A culture was taken from the pulp of this tooth and inoculated into rabbits, one of which is shown in Figure 338 with acute purulent arthritis with marked suppuration.

This patient is shown in this picture with her crutches, but we are glad to report that since writing the above we are advised that she is going about her home and yard without her crutches and is, accordingly, progressively improving whereas she had been progressively growing more and more bed-fast. It should be noted that the treatment of her case consisted not only in the removal of her dental infections but the use of an autogenous vaccine, which is a very important procedure in many of these cases whose defenses are just below the level needed for keeping them on the aggressive fight against the strain.

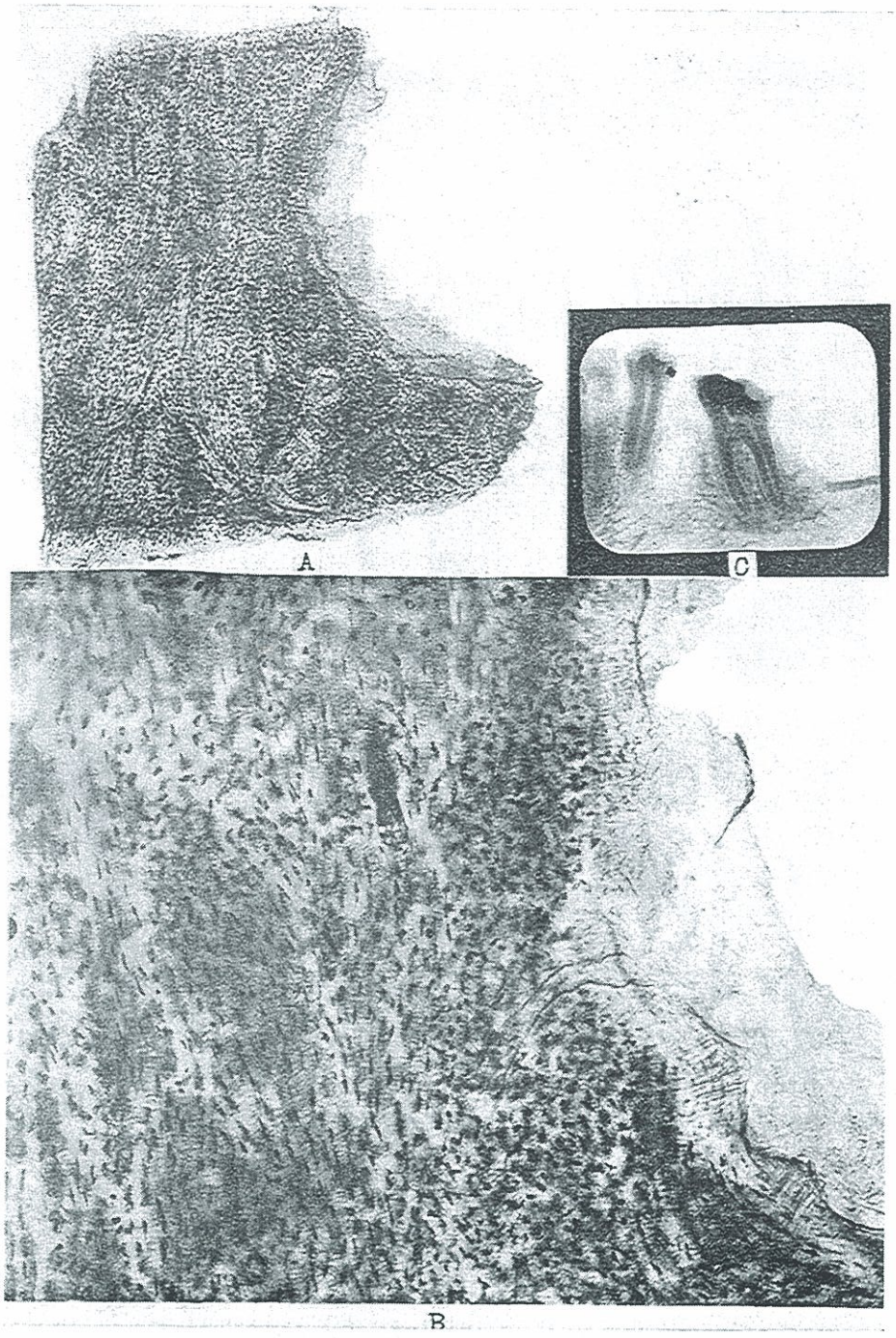


FIGURE 337. HISTOLOGICAL STUDIES OF PERIAPICAL BONE. A, PHOTOGRAPH OF TREPHINED CYLINDER. B, HISTOLOGICAL SECTION. NOTE DENSITY. C, ROENTGENOGRAPHIC APPEARANCE. CASE NO. 709.

Still another type of deforming arthritis, which would usually be considered to have a very bad prognosis, affects, chiefly, the spine, hips, and shoulders, without much involvement of the

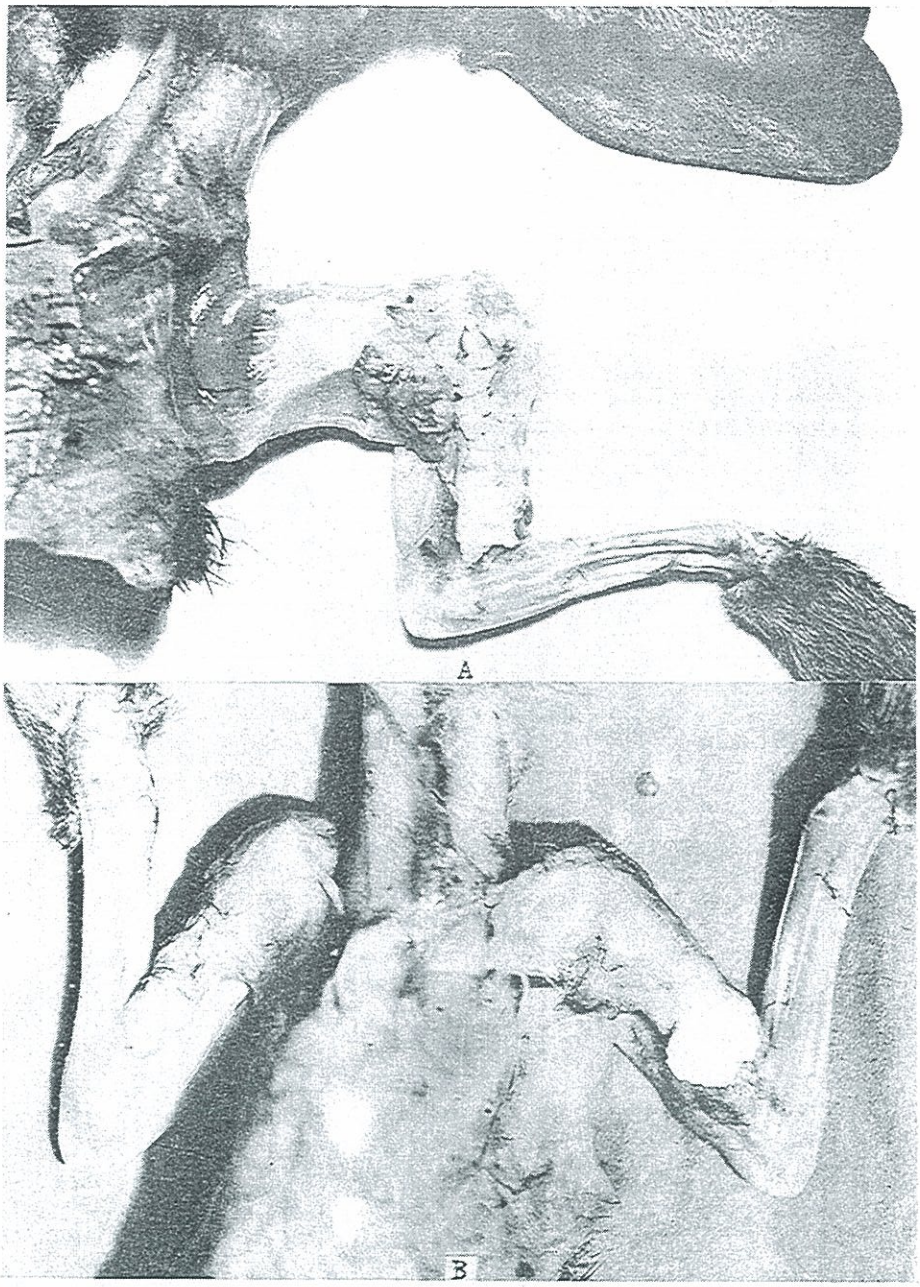


FIGURE 338. ACUTE PURULENT ARTHRITIS PRODUCED IN RABBIT FROM CULTURE FROM TOOTH SHOWN IN C OF PREVIOUS FIGURE. CASE NO. 709.

extremities. We have, however, seen such marked relief in some of these cases, that we have come to be much more hopeful and encouraging, provided there is a locked dental infection of the type that we have come to consider particularly causative in this type of disturbance. Such a case is shown in Figure 339.

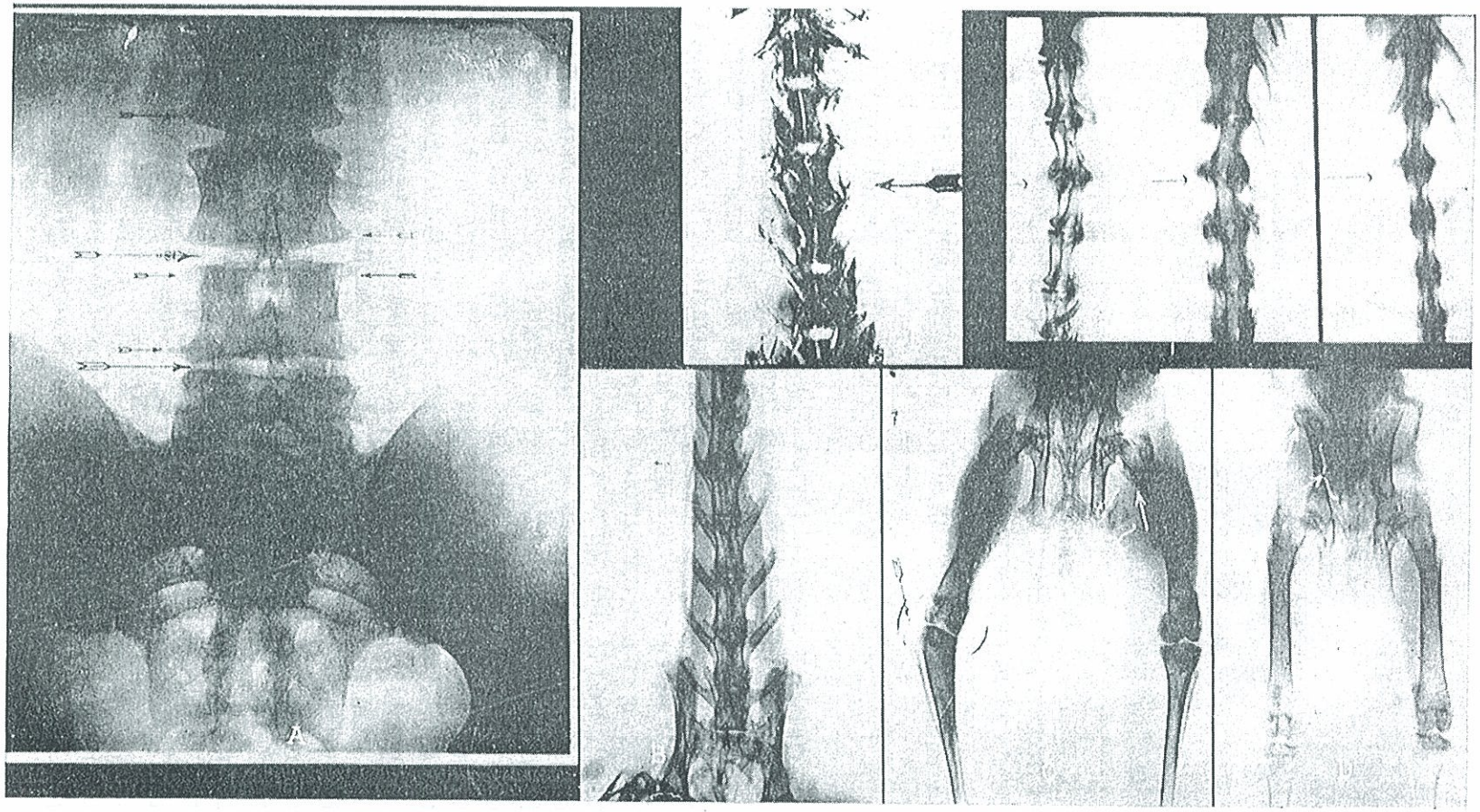


FIGURE 339. ARTHRITIS OF THE SPINE AND HIPS OF PATIENT SHOWN IN A, AND IN SPINES AND HIPS OF RABBITS INOCULATED WITH CULTURES FROM HIS TOOTH. CASE NO. 1125.

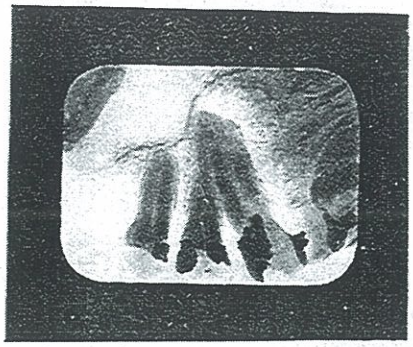


FIGURE 340. PUTRESCENT UNFILLED ROOT OF CUSPID. TOOTH HAD BUT SLIGHT APICAL ABSORPTION AND NO FISTULA.

Case No. 1125.—This case, a male, age forty-seven, laborer, is of particular interest because it seems to be very definitely related to bad dentistry; and while the profession of the past may not have been responsible for its ignorance, the time should soon come, and doubtless will, when the public will see to it that they shall not, because of ignorance, be given a lifetime of suffering, thus becoming dependent cripples. The dental condition in question, a very imperfect operation on a root canal of the upper left cuspid, is shown in Figure 340. The pulp chamber had been entered and a very incomplete root filling placed underneath the metal filling twenty-three years prior to the patient's presenting to us, with the extreme deforming arthritis with ankylosis of the spine. Seventeen years ago, he injured his back by lifting, this not being considered serious at first. Acute rheumatism set in in the injured tissue, stiffness began about fourteen years ago, and during this period he has had exacerbations with acute and painful processes, always followed by greater stiffness following the course of progressive arthritis. At the time of presentation eighteen months ago, he was not able to rotate the body or bend the spine, appreciably, from his hips to his head. He had been compelled to give up his work and was becoming very despondent. The pain was extending down the left sciatic with involvement beginning in the left leg. The tooth in question had the history of having been painful at recurring periods soon after it was filled, but had presented no symptoms whatever of discomfort for many years, the patient thought not since the rheumatism had developed. He had no other treatment than the removal of this infected cuspid which was surrounded by a zone of condensing osteitis outside a zone of rarefying osteitis. As shown in the roentgenogram, there is a zone of excementosis on the side of the root. His nervous symptoms had become quite marked at the

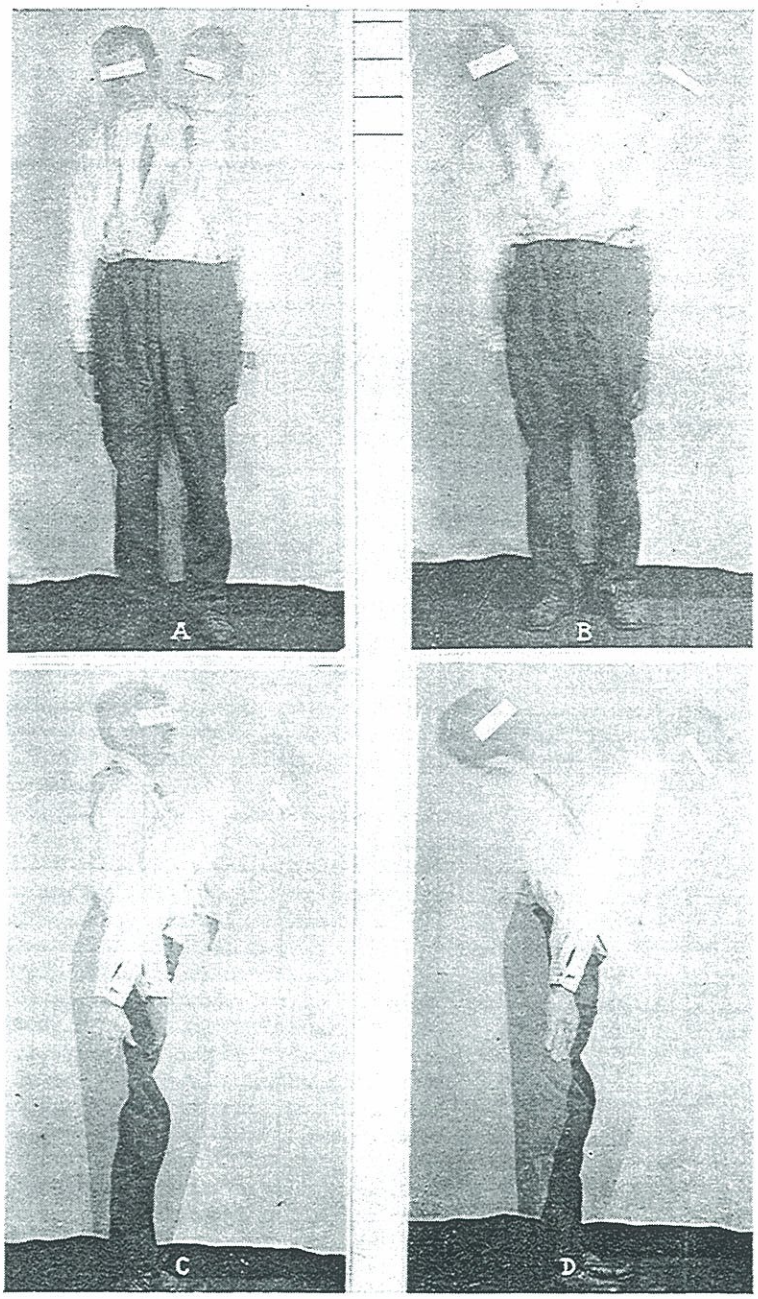


FIGURE 341. SHOWS IMPROVEMENT IN THE MOVEMENT OF THIS MAN'S SPINE IN THREE MONTHS' TIME AFTER EXTRACTION. A, LIMIT OF LATERAL MOVEMENT AT BEGINNING. B, IN THREE MONTHS. C, LIMIT OF FORWARD AND BACKWARD MOVEMENT AT BEGINNING; AND D, AFTER THREE MONTHS.

time of the extraction, the first effect of which was to aggravate them. However, in three months' time he could move his spine both forward and backward as well as make considerable rotation of it, as shown in the photograph, Figure No. 341, which

Form No. 13 Serial No. 1125

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT R. S. D. Case No. 1125 AGE 46

ADDRESS DATE 6-21-21

CHIEF COMPLAINT Arthritis of Spine. Temporary Blindness

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf	Father's Side: Father	Father's Side: Grandfthr	Father's Side: Grandmthr	Father's Side: Uncles	Father's Side: Aunts	Mothers Side: Mother	Mothers Side: Grandfthr	Mothers Side: Grandmthr	Mothers Side: Uncles	Mothers Side: Aunts
		No.	2	1	4	1					8	1				2	0
		Tonsillitis															
##	###	Rheumatism	#														
##	##	Swollen or Deformed Joints															
##	##	Neck-back or Shoulders															
		Lumbago															
+	#	Neuritis						Excellent					Excellent				
		Sensitizations															
+	##	Sciatica															
		Chorea or St. Vitus's Dance															
	#	Nervous Breakdown															
		Mental Cloud															
		Persistent Headache															
#	#	Heart Lesions															
		Dropsy															
		Kidney Lesions, Brights															
		Liver or Gall Lesions															
		Appendicitis															
		Stomach pain or Ulcer															
#	##	Eye, Ear, Skin, Shingles															
		Pneumonia															
		Anemia															
		Goiter															
		Lassitude, Chilliness															
		Hardening of Arteries															
		Stroke															
		Age if Living										95					
		Age at Death						79	105	76			58	old			
		Flu with Complications											Change of life				
	#	Flu without Complications															
	#	Typhoid															
	###	Over-load															
	+	Extensive Tooth Decay															
#	##	Abscessed Teeth															
		Loosening Teeth															

Years

Duration of Dental Infection

Duration of chief Affection

KEY FOR CHART: + HAD LESION; # FREQUENTLY; #? PROBABLY; # VERY SEVERELY; ✳ OPERATION; ⊕ FATAL ATTACK

D. INFECTN TYPES	CARIES	LOKD.	CONDSNG	SL. HG.	SYST. RELF.	COMP.	PART.	RECR.	NONE
	#	#	#						
	PYRRH	OPEN	REVING	RA. HG.	SUSC. TBLT.	INHT.	ACQD. #	ABST.	SC. NO

FACTOR OF SAFETY				
V. HG.	HIGH	FAIR	LOW	V. LW.
				#

FIGURE 342. SUSCEPTIBILITY RECORD OF PREVIOUS CASE, NO. 1125. NOTE GOOD INHERITANCE; ALSO IN COLUMNS TO RIGHT, DURATION OF CHIEF AFFECTION WAS LESS THAN THAT OF THE DENTAL INFECTION. SPINAL DISTURBANCE FOLLOWED AN INJURY PLUS HIS FOCAL INFECTION.

shows the limit of movement sideways, forward, and backward, before and after this three months' period. He had complete relief from the acute rheumatic processes; and in about six months, he went back to work. Life had an entirely new prospect. He changed from progressively getting worse through a period of fourteen years, to suddenly getting progressively better. Nothing was done except the removal of dental infection. We shall expect, however, that this patient will readily develop arthritic processes again and it will be quite probable that his improvement will not be continuous or permanent after the development of such a severe focus, which is true of many, if not most, of these extreme cases.

A study of his susceptibility is particularly instructive. See Figure 342. His is a case of acquired susceptibility. He had about as bad a type of dental infection as it is possible to have: namely, the quantity of infection that may exist in a putrescent pulp and the entire dentin and tooth structure of a tooth for a long period of time. During the early period of the history of this tooth, when his resistance was high and he had no injured tissues, the reaction about the tooth was sufficiently good to protect him from this infection and expressed itself, locally, in extensive rarefaction, with an apical abscess and fistula. With a lowering of his resistance, he lost the ability to maintain the quarantine about the tooth and became injured by its contents. At this time the local reaction was much less efficient, the fistula healed and closed, and the old scar was plainly visible at the time we operated. It was like a quiescent volcano. The toxic material was now taking a new route: namely, through his system. It was injuring the most susceptible tissue which began with his injured spine. As shown in Figure 342, there were practically no rheumatic group lesions in the brothers or sisters, sons or daughters, or on either side of the ancestry, his father's father living to be one hundred five, his father to be seventy-nine. His mother died at fifty with nervous disturbance developing with the menopause. Her parents died old. There were no cases of arthritis on either side of the family. His father was one of ten children and the father's sister is still living at ninety-five. We should expect that if all his overloads could be removed, the prognosis should be very much more favorable than in a person whose normal defense should not be expected to be high, which his should be. Clinically, this type of susceptibility does not often

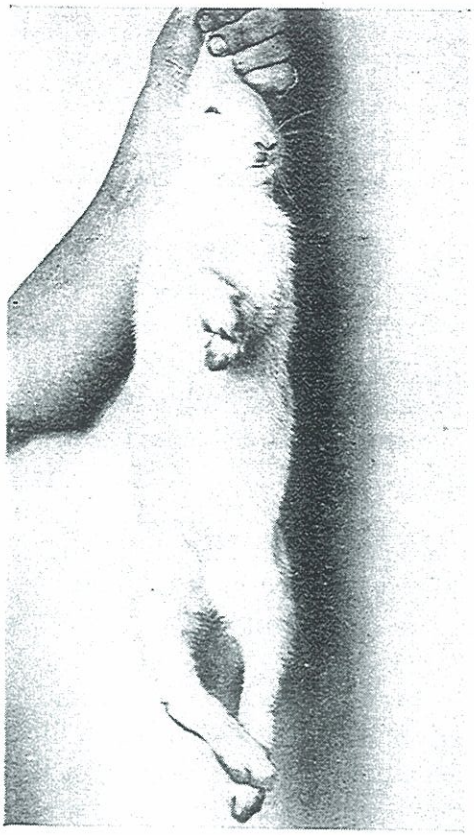


FIGURE 343. EXTREME DEFORMING ARTHRITIS PRODUCED IN A RABBIT INOCULATED WITH CULTURE FROM THE TOOTH SHOWN IN FIGURE 340, PREVIOUS CASE, NO. 1125.

have an involvement, as deforming arthritis, and we would put considerable importance upon the fact of the type of tissue that was injured and which thereby became a prey to his infection. The marked symptoms of his nervous system were in accordance with the general experience in cases of acquired susceptibility.

Returning to Figure 339, it will be noted that there was a very marked tendency to the formation of osseous spicules on the spines and bodies of the vertebræ of the patient. It is very important that the type of reaction produced in animals, with the culture taken from this case, was quite like that in the patient. One of the rabbits developed acute involvement of the spine. (See Figure 339) and also spicula on pelvic bones. Another developed marked deforming arthritis with bowing of both hind legs, as shown in Figure 343. We have discussed this case in connection with the different expressions of bone changes, rarefying and condensing, etc., in Chapter 3.

Case No. 896.—In comparison with the two preceding cases with regard to the type of bone changes, we will present as the next case that of a woman, age at the time of this writing forty-eight, who presented two years ago with a type of multiple deforming arthritis in which there was much disfigurement without extensive arthritic deposits. This patient had not walked for five years, during most of which time she had not been able to feed herself. The extreme deformities of her feet and hands began about eight years ago and are shown in Figure 344, as she is propped up in a wheel chair for the purpose of having her photograph taken. Within four months from the time her dental infections were removed, which was followed by a vaccine made from an autogenous culture, she was able to feed herself and put her hands to her hair, which she had not done for many years. In five months' time she was able to walk out of the ward of our institution to go home to her family. This was the first time her five-year-old child had ever seen her mother standing on her feet or walking. This pregnancy occurred after she was laid up from rheumatism and contributed greatly to aggravating it. At this point, we wish to refer to the chapter in which we discuss the relationship of pregnancy as an overload (Chapter 21) and pregnancy complications (Chapter 34). In about six months' time, this woman was doing all her household duties except the laundry work. At one time when we called on her, she was making berry pie. Figure 345 shows the dental conditions. Note that there has been a tendency to both alveolar absorption and to condensing osteitis. The mesial root of the lower left first molar is shown overgrown with bone which is distal to, and close beside, the lower left second bicuspid, with a curved root and surrounded by much condensed bone. Also note the condensing of the bone below the zone of rarefaction beneath the root of the lower left second molar. You will also note a small zone of rarefaction just above the imbedded root of the lower left first molar. This imbedded root was removed and was found to be covered by a full eighth of an inch of very dense bone. A section of it was removed by operation in order to expose the root, which bone was sectioned and is shown in Figure 346. While the bone is a compact homogeneous mass so far as trabeculæ and medullary spaces are concerned, the original trabecular structure can be traced, as shown in Figure 346-A. The medullary spaces had been filled in with a very compact bone, as shown. In Figure 346-D, a blood vessel is shown, the lumen of which has been so reduced in size that it is

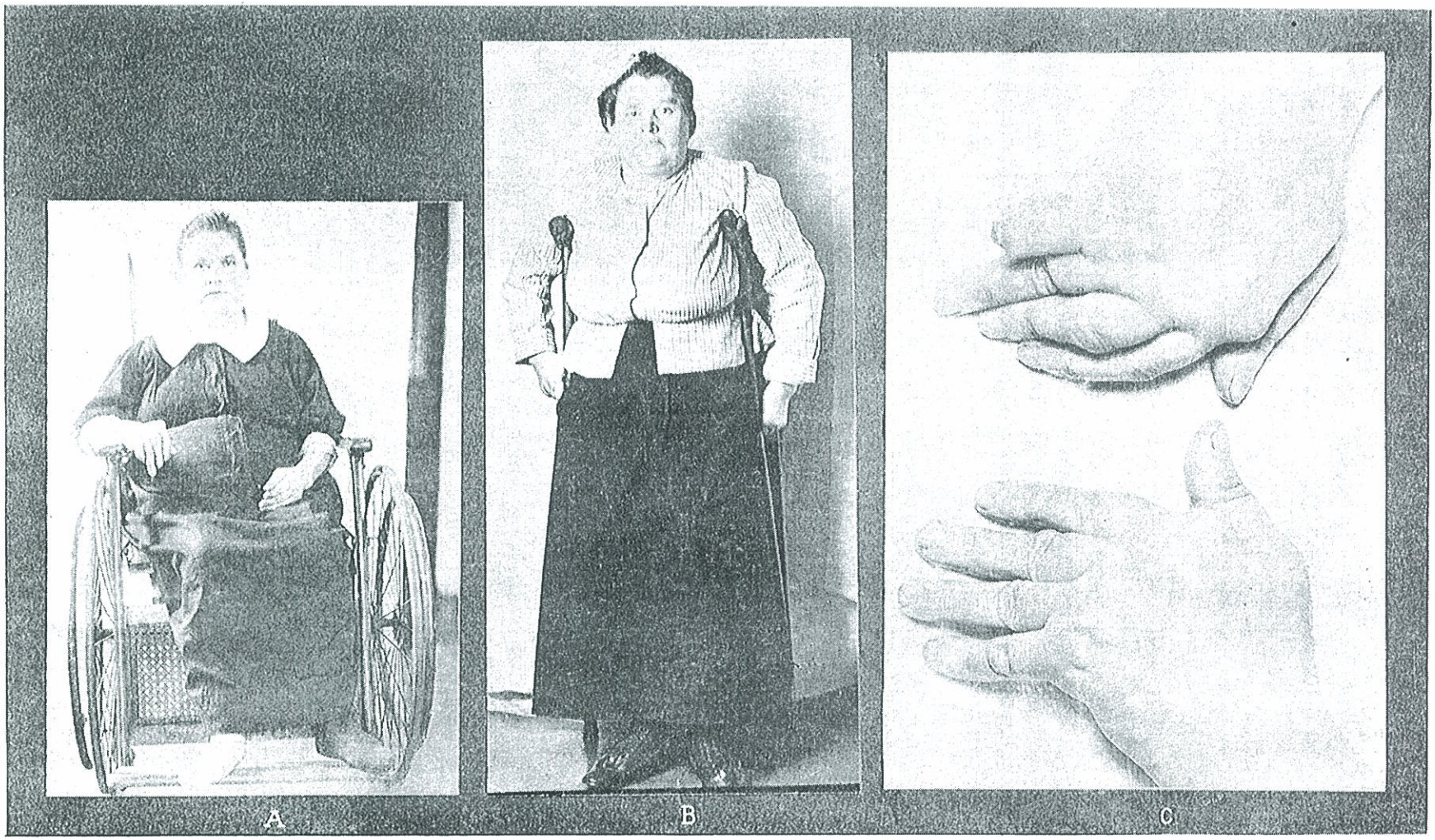


FIGURE 344. CASE OF DEFORMING ARTHRITIS, BEDRIDDEN FOR FIVE YEARS, PROGRESSIVELY GETTING WORSE; SO GREATLY RELIEVED BY REMOVAL OF HER DENTAL INFECTION AND USE OF A VACCINE THAT SHE NOW DOES HER OWN HOUSEWORK AND HAS FOR SEVERAL YEARS. CASE NO. 896.

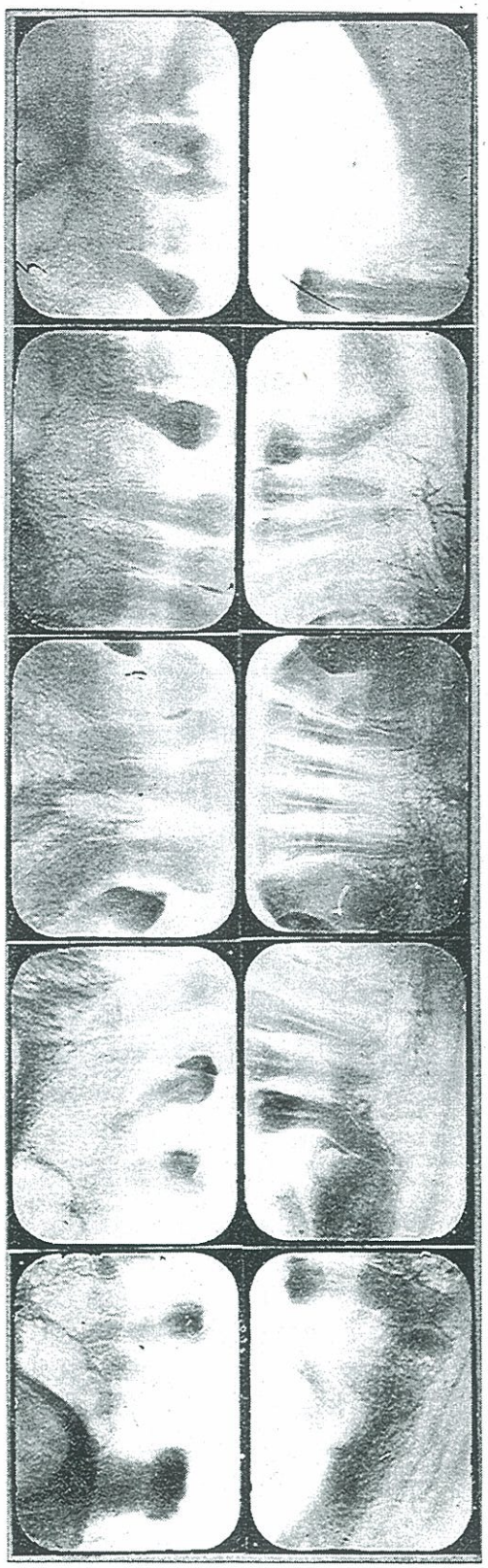


FIGURE 345. ROENTGENOGRAPHIC APPEARANCE OF TEETH OF PREVIOUS CASE. THIS PATIENT HAD THE DEGENERATIVE TYPE OF ARTHRITIS, NOT PROLIFERATIVE. NOTE DIFFERENCE IN ALVEOLAR CHANGES. AN OVERGROWN SEGMENT OF MESIAL ROOT OF LOWER LEFT FIRST MOLAR WAS UNCOVERED BY TREPHINING. THE BONE CHANGES ARE SHOWN IN NEXT FIGURE.

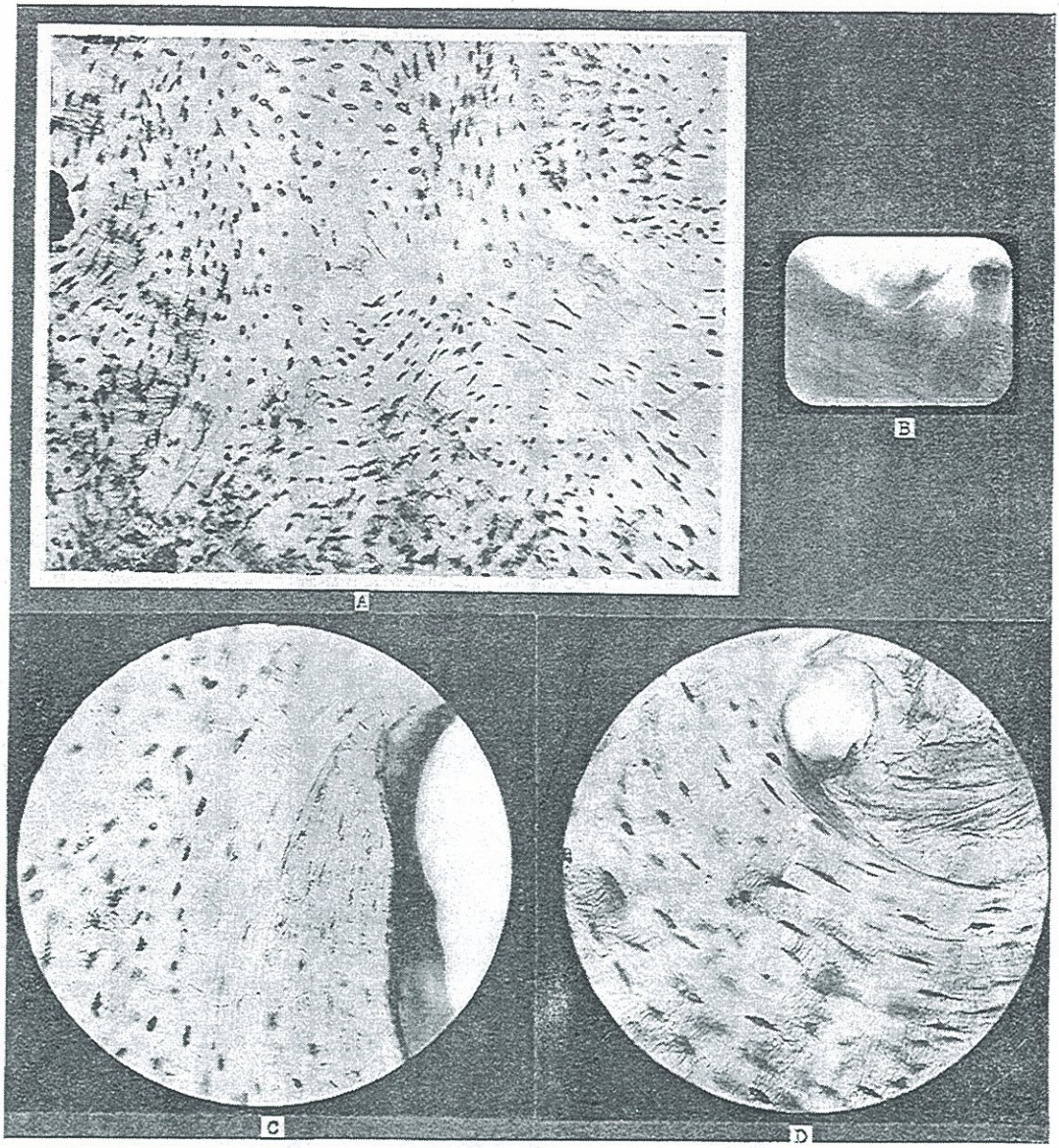


FIGURE 346. B, THE OVERGROWN ROOT REFERRED TO IN PREVIOUS FIGURE. A, SECTION OF BONE SHOWING ORIGINAL OUTLINE OF TRABECULÆ; C AND D, CONCENTRIC LAMINATION OBLITERATING A BLOOD VESSEL.

now but a fraction of its original cross section; and in Figure C, will be seen the successive layers of the laying down of bone within the lumen of a blood vessel. This root was cultured, the organisms growing from which were injected into rabbits, one of which, Figure 347, developed paralysis from the center of its spine backward, followed by a marked structural change, as shown in the roentgenograms, Figure 348. This rabbit lost complete control of the sphincters for urine and fæces for several weeks, and dragged

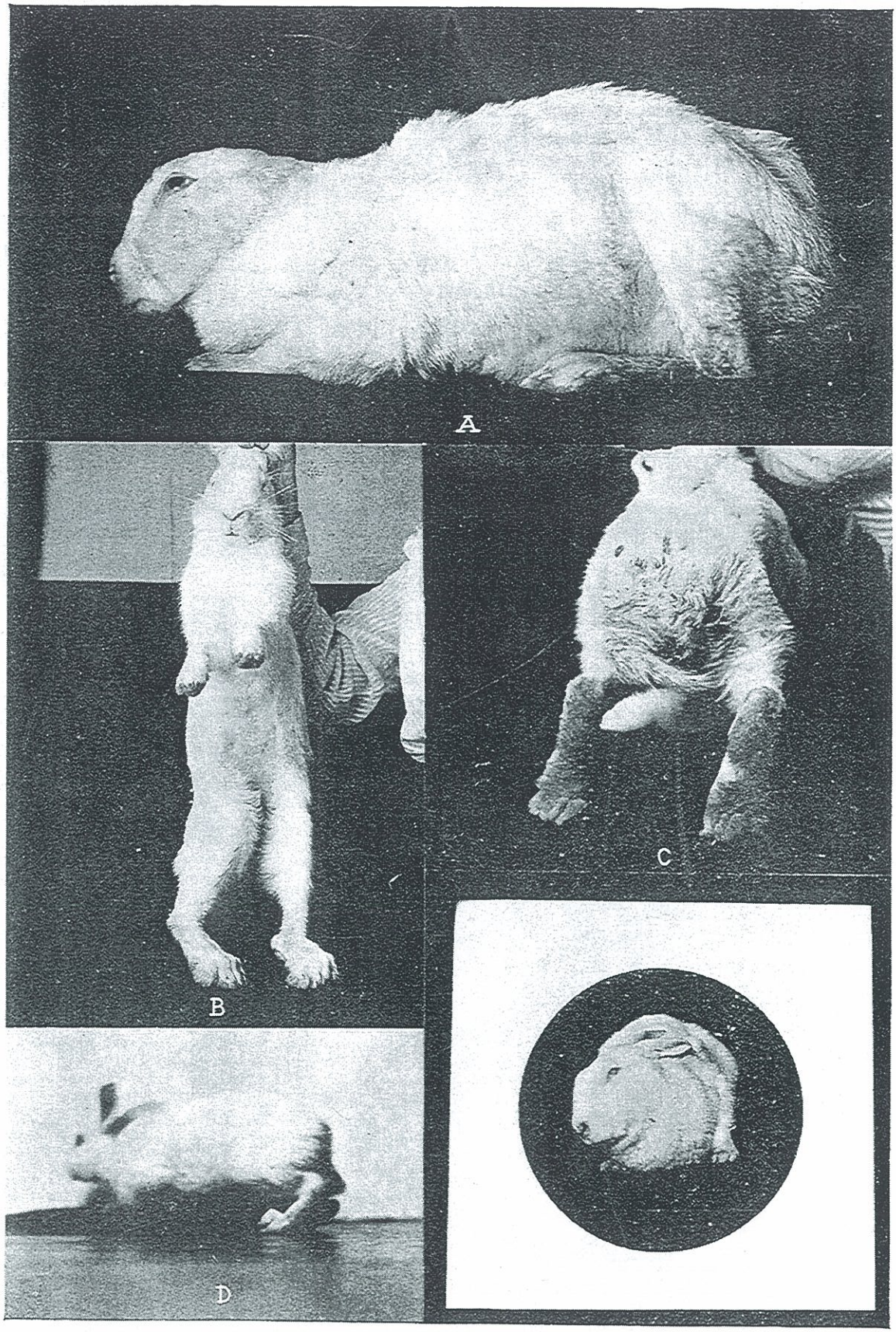


FIGURE 347. VARIOUS VIEWS OF A RABBIT PARALYZED BY AN INOCULATION FROM DENTAL CULTURE FROM PREVIOUS CASE, NO. 896.

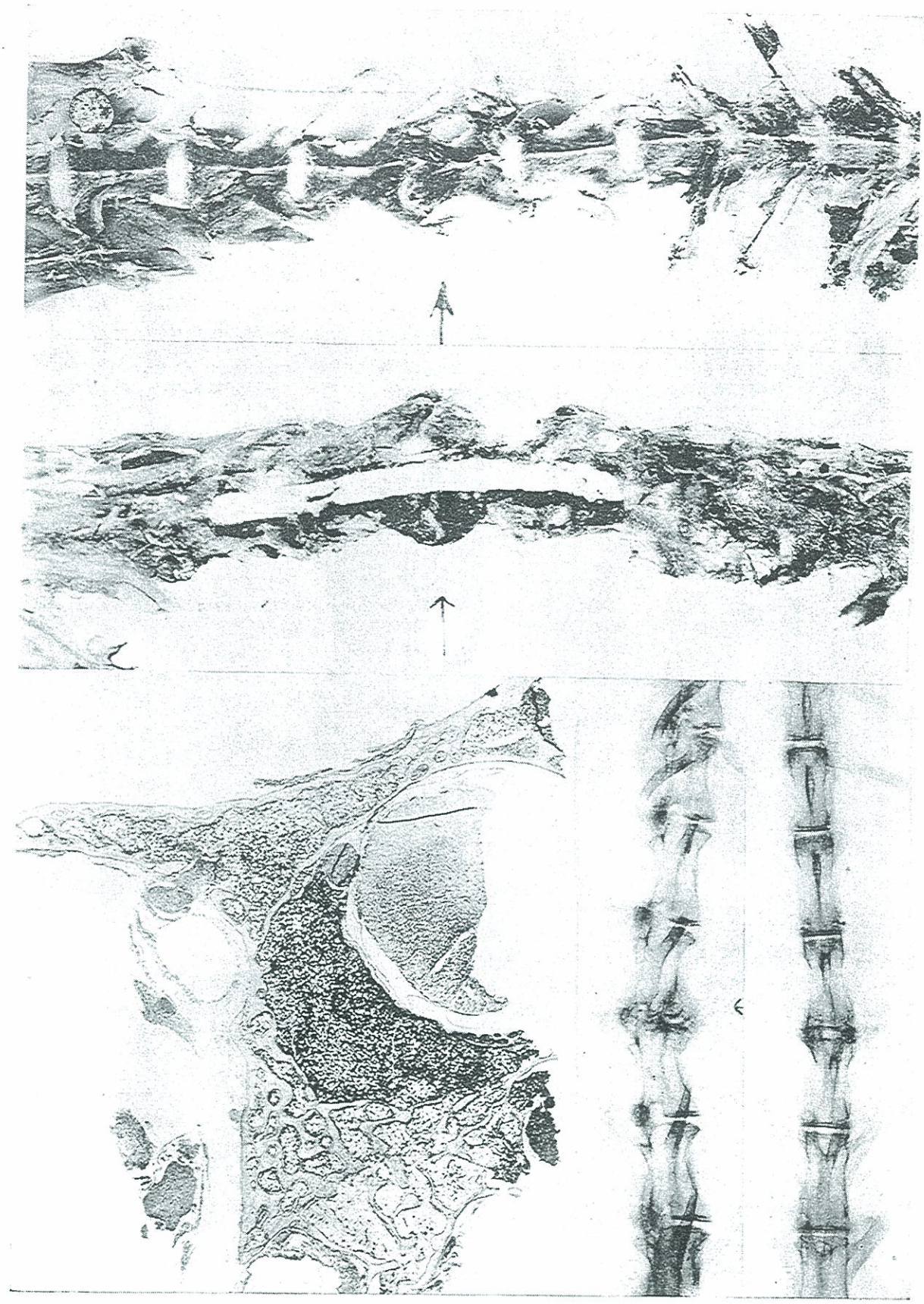


FIGURE 348. LESIONS OF SPINE OF RABBIT SHOWN IN FIGURE 347. A AND B, PHOTOGRAPHS SHOWING DISEASED VERTEBRÆ. C, DEGENERATIVE NECROSIS OF VERTEBRÆ ADJOINING THE SPINAL CORD. D AND E, ROENTGENOGRAPHIC APPEARANCE.

its hinder parts as though they were something foreign to it. It was not particularly sick, ate well, and made an apparently complete recovery except that it walked with difficulty, having a permanent impediment, similar to a child that has had infantile paralysis. We have motion pictures of this rabbit and many others in various stages. This rabbit is discussed in Chapter 21, in which it was used to study the effect of maternity on an apparently healed infection, with very striking results, as will be seen by that text. The structural changes in the vertebræ and spinal column are shown in cross section in Figure 348, our pathologist's report of which is as follows:

"*Inverted Ocular* shows a large, irregular-shaped piece of tissue, representing on one side bony tissue with its marrow and one side the spinal cord cut half. The cord stains with a pink color; the bony structure is stained with a reddish color, while the marrow is pale pink. In between the cord and the bony structure there is a large blood vessel, and next to this the marrow of the bone is of a muddy color.

"*Low Power.*—The cord proper tissue appears mushy, the nuclear structures are very few, with a large amount of the interstitial tissue, which appears more or less spongy, mushy. There will be seen many places where the neurogliar cells appear vacuolated, nuclei staining poorly. Same changes can be seen also in the gray matter. All the blood vessels at the periphery of the cord are well dilated and some filled with blood cells. In some instances there can be seen a few of what appear to be round cells, around the blood vessels. The spinal cord membranes are detached, somewhat thickened. The periosteal covering of the bony part of the vertebral column is thickened in some places and all the blood vessels are markedly dilated and filled with red blood cells. There appears to be a marked loss of bony tissue at the center where the spinal cord is in contact with the bony structure, a condition of bone resorption present; the bone marrow is increased in amount, likely due to the loss of bony tissue; otherwise, the marrow tissue proper appears rarefied, loss of cellular structures, and takes a darker stain. Everywhere there are many dilated blood vessels in the marrow. In other places the marrow tissue has nearly disappeared, only a few cells left. Those spaces between the bony structures stain with a very light bluish stain.

"*High Power* shows the same changes as above.

"*Diagnosis.*—Chronic osteomyelitis of the vertebral column (lumbar region) with degeneration (parenchymatous) of the spinal cord."

This patient had been progressively getting worse with recurring exacerbations from which she suffered severely. She has been almost completely without pain since very shortly after the teeth were extracted and is progressively improving. We have motion pictures of her doing stunts and she is shown in Figure 344. To those dentists who have not found a supremely compensating joy in the practice of dentistry, we would suggest that the satisfaction of having been able to assist even one mother like this (of whom we have had many,) so that she has been enabled to go back to her home and carry on the duties of the household, and mother her several children, is sufficient to compensate for a lifetime of effort and in a way that no monetary consideration can reward. Unfortunately, a large number, if not a large per cent, of these individuals are financially incompetent even to take care of the incidental expense, let alone remunerate.

Diagnostic and Prognostic Interpretation.—A study of this woman's history shows that her first attack of rheumatism began following childbirth, fifteen years prior to her coming to us. She had another attack following the birth of her second child eight years preceding. She was unable to walk for a period after her attack of arthritis which followed her first childbirth fifteen years ago, and again with an attack that occurred after the birth of a child eight years ago. Each of her six pregnancies has been followed by acute rheumatism. The history further shows that her mother suffered from rheumatism and died of pneumonia at fifty-nine. Her one brother died at thirty-nine of heart involvement. Her only involvements have been rheumatism and arthritis. Figure 349 shows the marked disfigurement of the hand, due to the shortening of the flexor and adductor muscles.

While it is too early to differentiate between the pathology or the etiology of these different types of arthritis, as shown in the last three cases, we wish to note that the last patient studied is of the degenerative type, while the two preceding are the proliferative type. In the experimental chapters I have shown many different phases of disfunction of tissues and organs which seem definitely to be related to calcium metabolism. The fact, that patients with the proliferative arthritis tend to have a lowered ionic calcium at the time of the active process, whereas those with the degenerative arthritis tend to have a higher than normal ionic calcium, strongly suggests that the process is not primarily one of a quantitative presence of either calcium or ionic calcium, but of its availability and utility in the process of metabolism. In

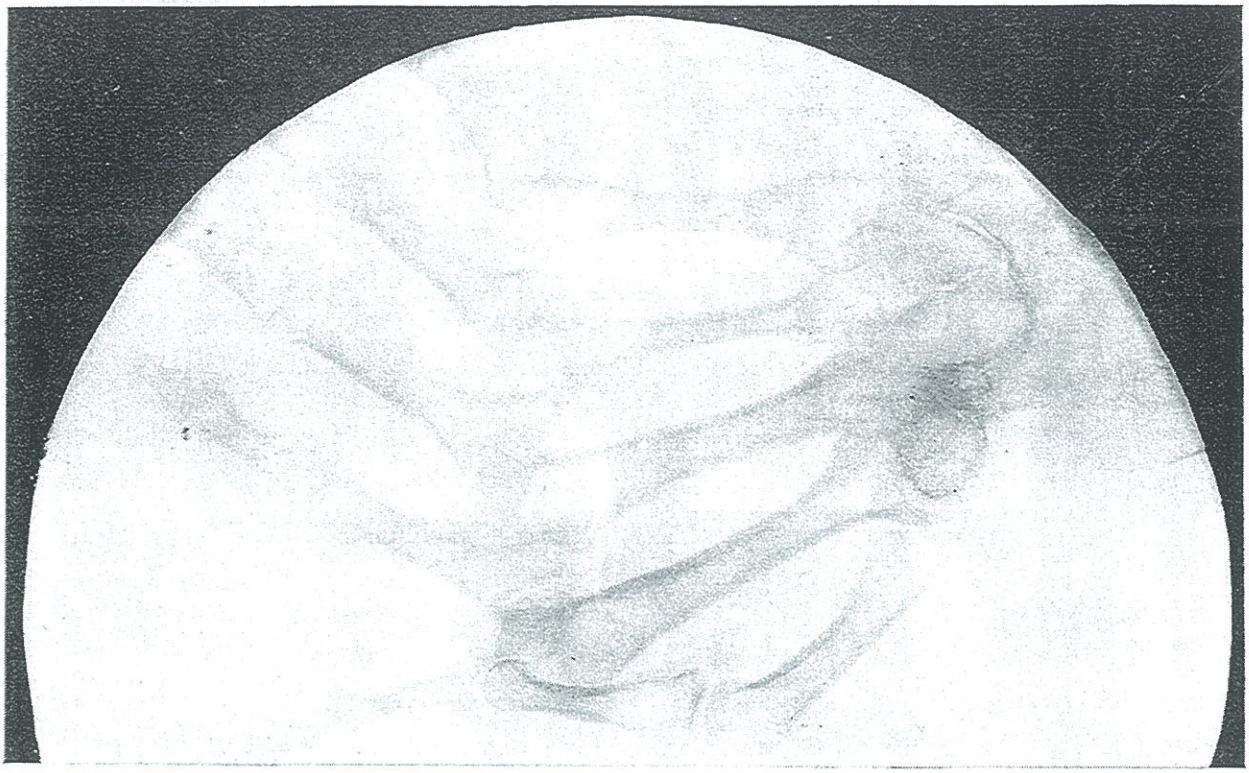


FIGURE 349. DEGENERATIVE ARTHRITIS OF HAND OF PATIENT, CASE NO. 896, WITH DISLOCATION DUE TO SHORTENING OF FLEXOR AND ADDUCTOR MUSCLES.

Chapter 43 I have shown that the available calcium in ionic form is largely dependent upon the demands made upon it for neutralizing improperly reduced acids, which substances normally should not exist in the blood and body fluids in a perfect metabolic state, nor should their neutralization use up the available ionic calcium so requisite for metabolic processes.

But if there is a pathos in the development of deforming arthritis of adult life, it is doubly a tragedy if both the childhood and adult life are clouded by this misfortune. In the chapter on heredity, we emphasized that in cases of marked hereditary susceptibility from both sides, the affection tended to develop, not only more strongly, but earlier in life in the offspring. A striking illustration of this is seen in the following case.

Case No. 381.—Figure 350 shows the patient as he appeared at seventeen years of age when we were called to see him at the hospital. At that time, his mother said to me repeatedly that she believed she would be the happiest mother in the world if she could see her suffering child die and end his misery, for he cried by

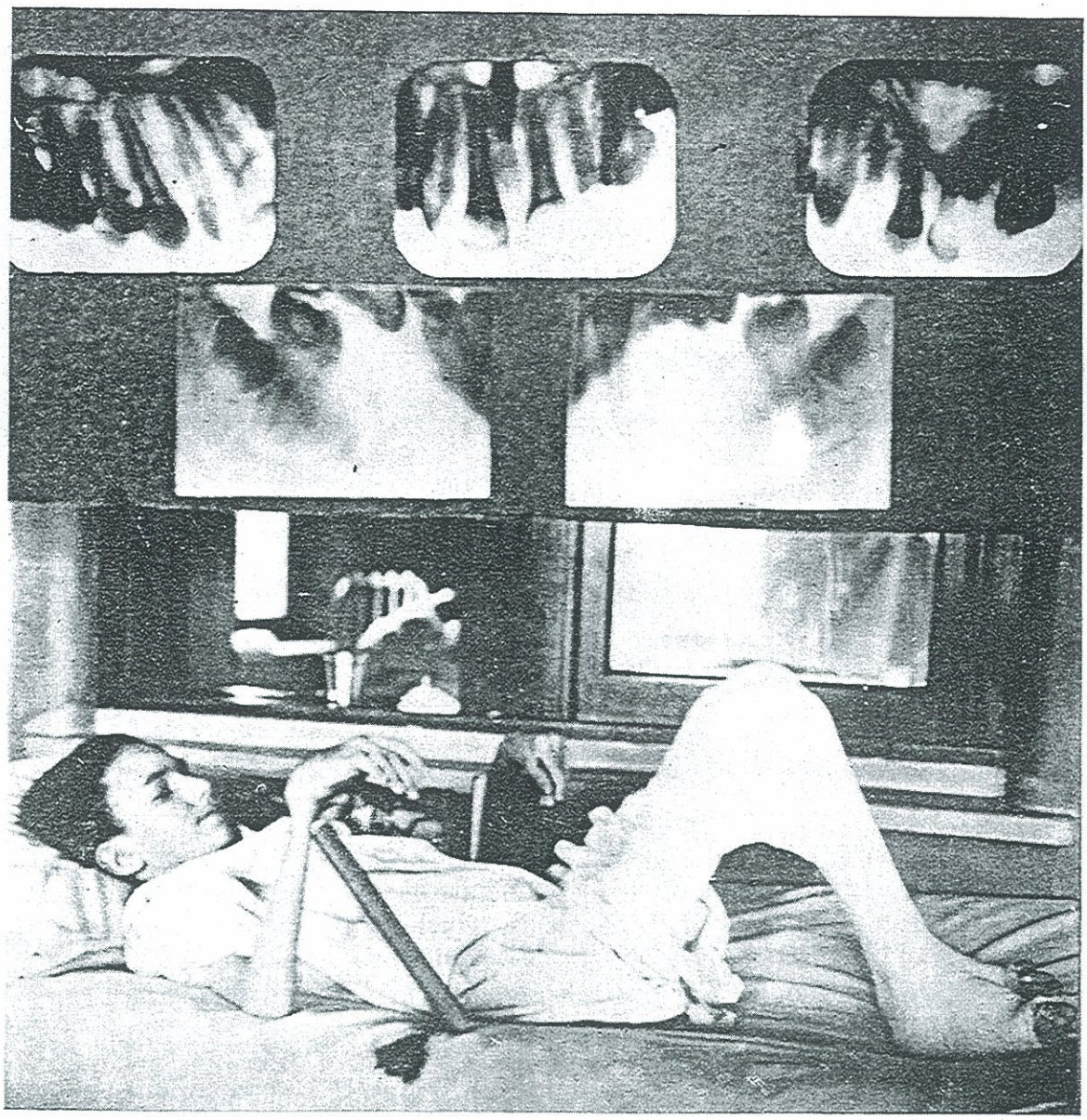


FIGURE 350. ACUTE DEFORMING ARTHRITIS IN BOY SEVENTEEN YEARS OF AGE, BEDRIDDEN MUCH OF THE TIME FOR FOUR YEARS AND CRYING BY THE HOUR WITH PAIN. ALMOST COMPLETE ABSENCE OF ALVEOLAR ABSORPTION ABOUT PUTRESCENT TEETH. CASE NO. 381.

the hour from acute pain, and was mere skin and bone. The extreme deformity of his hands is shown in the picture. His history showed that there had been very acute rheumatism on both his father's and mother's sides. His father died at fifty-six from cerebral hemorrhage, from which affection both the father's father and mother died. One of the father's brothers died of

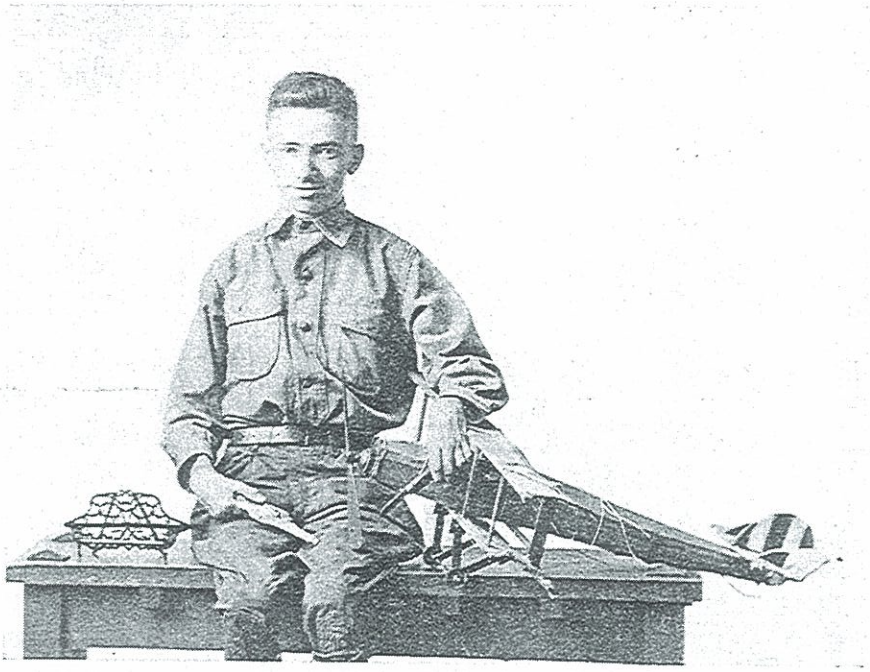


FIGURE 351. SAME BOY AND SOME OF HIS HANDIWORK, NOW GREATLY IMPROVED BUT DEFORMED FOR LIFE. IS HE HAPPY?

heart, one of heart and rheumatism, and two had rheumatism severely. The mother's father had very severe rheumatism, as did also the mother's sister. The boy's father was an invalid as a young man. This boy's acute rheumatism began at four years of age and he was in bed for eight months. Another attack at five years of age made him bedridden again for many months. At seven years of age, he fell through the ice into ice cold water and before he could get his clothes off, his trousers froze on him. This severe exposure was followed by severe rheumatism which lasted for one year. His right leg was drawn up. It became rigid. At nine years of age, he learned to ride a tricycle, which took the stiffness out of both limbs. During the ninth year, he had both scarlet fever and measles, after which his rheumatism reoccurred. His attacks of acute rheumatism were preceded by acute nausea. At about twelve, when trying to fly a kite, he sat in his stiffened condition on the damp ground, which exposure was followed by pneumonia and acute rheumatism. At twelve years of age, he was carried to a dentist with severe tooth-ache. A devitalizing paste was placed in the tooth to devitalize the pulp. The boy was so frightened and hurt that he did not go back. The dentist warned him that the medicine should be removed, but it

was not done. The mother states that the dentist told her that if the medicine was left in the tooth, it would rot every bone in his body. Owing to his fear, she could not persuade him to go back. After this incident his arthritis was progressively worse. At the time we took his case it was at the request of the hospital staff as they suggested they were at the limit of their resources and he was receiving morphine to control his pain. He was entirely helpless and had to be fed through a tube or with a spoon, the ankylosis of the mandible being so complete that nothing thicker than a spoon handle could be placed between the teeth. We took him to the x-ray room and made roentgenograms of his teeth, with very great difficulty, since films could only be placed flat between the two incisal planes. These poor and distorted pictures were sufficient, however, to give much important evidence, as shown in the inserts in Figure 350. The most striking thing is that, while several of these teeth had such extensive caries, that the pulps had been exposed for a long time and were putrescent, there was exceedingly little evidence of apical rarefaction and none of his teeth were sore or had been painful. Seven were non-vital. He was placed under a general anæsthetic and with exceeding difficulty the non-vital teeth were removed. The ankylosis of the mandible was so severe and rigid that it was impossible to open, even by force under the anæsthetic, for fear of fracturing the mandible. All extractions had to be done through the alveolar border, and the teeth were surrounded with much condensing osteitis. The incisors and bicuspids could be reached, but it was with great difficulty that the roots of the first permanent molar, upper left, could be reached. A tendency to cyanosis and to ceased breathing kept the anæsthetist and myself in the most extreme anxiety, and several times the operations had to be temporarily stopped to resuscitate the patient. The buccal roots of this molar were found very close to a very low maxillary sinus, as shown. The fact that his mouth could not be opened, made the operation almost impossible, both because of the difficulty of access and of maintaining anæsthesia. Following this operation, he made most remarkable improvement for a few weeks, when he had a new attack of acute rheumatism in his left ankle, which was the only important joint that had not been seriously crippled. Because of the difficulty of taking care of him in a general hospital which is not adapted either in its equipment or in the training of its nurses for the care of these special dental cases, we trans-

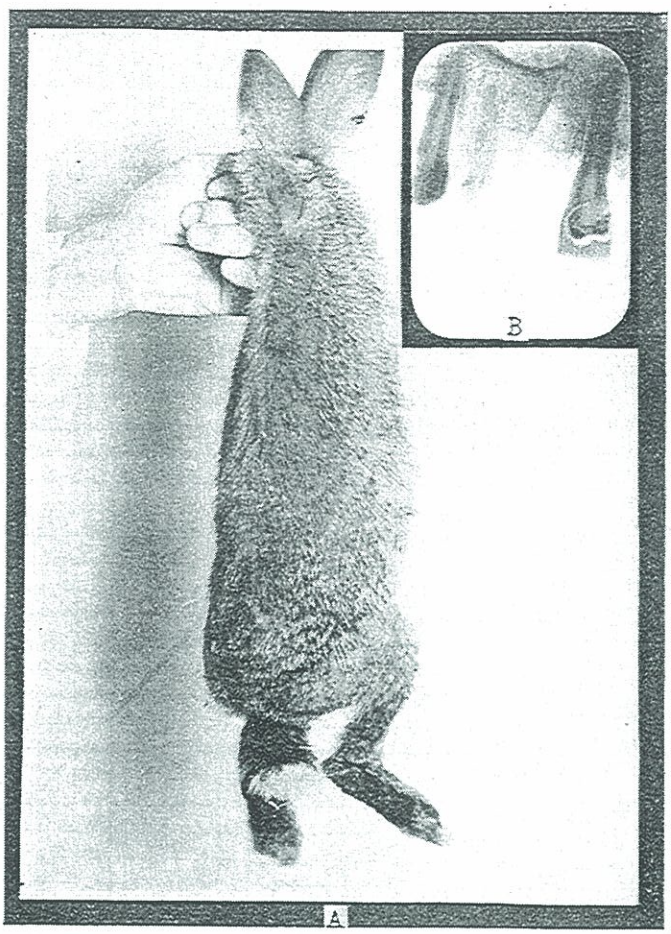


FIGURE 352. RABBIT WITH ACUTE RHEUMATISM, INOCULATED WITH A CULTURE FROM A PUTRESCENT LATERAL SHOWN IN B. NOTE THE NEARLY COMPLETE ABSENCE OF APICAL ABSORPTION.

ferred him to a private room, four miles nearer the office, from which we could conveniently carry him to the office surgery for care and treatment. (We did not then have a private dental hospital with specially trained nurses, which we do now.) He was coming to know some of the thrills of a boy's heart. Some of his joints, particularly his knees, were so severely ankylosed as to be almost entirely rigid, one completely so. His improvement since that time has been nearly continuous except for a setback from pneumonia during the past winter. He rolls himself about in a wheel chair, sells confections and papers, and does remarkable carvings, some of which are shown beside him in Figure 351. He has made with his jacknife and handsaw, the aeroplane and pistol which, with its coat of aluminum paint, is so realistic that he came nearly being arrested for carrying firearms. The handkerchief

Private Records of Weston A. Price, M.S., D.D.S., 8926 Euclid Avenue, Cleveland, Ohio

Form No. 15– Serial No. 381

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT R.L.R. Case No. 381 AGE 20

ADDRESS DATE 4-4-21

CHIEF COMPLAINT Multiple Deforming Arthritis

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf	Father's Side: Father	Father's Side: Grandfthr	Father's Side: Grandmthr	Father's Side: Uncles	Father's Side: Aunts	Mother's Side: Mother	Mother's Side: Grandfthr	Mother's Side: Grandmthr	Mother's Side: Uncles	Mother's Side: Aunts
		No.	1	2							6	3					
	+?	Tonsillitis		#									#				
##	##	Rheumatism		+?				#			(#)			##			#
##	##	Swollen or Deformed Joints															
##	##	Neck-back or Shoulders															
		Lumbago															
#	#	Neuritis															
		Sensitizations															
		Sciatica															
		Chorea or St. Vitus's Dance															
		Nervous Breakdown															
		Mental Cloud															
		Persistent Headache															
+	#	Heart Lesions															
		Dropsy															
		Kidney Lesions, Brights															
		Liver or Gall Lesions											#				
		Appendicitis															
##	##	Stomach pain or Ulcer											#				
		Eye, Ear, Skin, Shingles															
		Pneumonia		#													
		Anemia															
		Goiter															
#	#	Lassitude, Chilliness															
		Hardening of Arteries															
		Stroke						(#)⊕⊕									
		Age if Living												80			
		Age at Death						56 82 70									
		Flu with Complications															
		Flu without Complications															
#	#	Extensive Tooth Decay															
#	#	Abscessed Teeth															
		Loosening Teeth															

Years: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73

Duration of chief Affection

Duration of Dental Infection

KEY FOR CHART: + HAD LESION; # FREQUENTLY; #VERY SEVERELY; +? PROBABLY; ✳ OPERATION; ⊕ FATAL ATTACK

D. INFECTN TYPES	CARIES	LOKD	CONDSNG	SL. HG.	SYST. RELF.	COMP.	PART.	RECR.	NONE
	##	##	##	##			#		
	PYRRH	OPEN	RFYING	RA.HG.	SUSC. TBLT.	INHT.	ACQD.	ABST.	SC. NO
						##			

FACTOR OF SAFETY				
V. HG.	HIGH	FAIR	LOW	V.LW.
				##

FIGURE 353. SUSCEPTIBILITY OF THE PRECEDING CASE, NO. 381. NOTE DOMINANCE OF RHEUMATISM ON BOTH SIDES OF FAMILY.

FIGURE 354. ROENTGENOGRAPHIC VIEW SHOWING THE FREE MOVEMENT OF MANDIBLE WHICH BEFORE DENTAL EXTRACTIONS WAS ANKYLOSED CLOSED.

box is also a remarkable evidence both of his genius and of his wonderful dexterity with hands that previously were so stiff that he could not hold a pencil or spoon.

Our first surgical operation on his case occurred about five years ago. The mandibular ankylosis entirely disappeared. He returned to the South and we did not see him for a couple of years. He came back two years ago, at which time he was having some return of his rheumatism. He had had no further care of his mouth and was wearing a denture with which we replaced the missing teeth. A lateral was found with deep caries, with a pulp non-vital, but without periapical absorption of such extent and type as would be expected with this amount of infection, as shown in Figure 352. The culture was taken from the pulp of this tooth and inoculated into a rabbit which developed very acute rheumatism and is shown in Figure 352 with its right hind leg drawn up and which it carried when it hopped.

DIAGNOSTIC AND PROGNOSTIC INTERPRETATION.

The susceptibility chart for this boy is shown in Figure 353. We would consider, as shown, that his factor of safety is very low for he has by inheritance a marked susceptibility, in which condition his best will always be low. Since each attack of streptococcal infection, such as rheumatism, heart, etc., seems to make the individual ultimately more susceptible, he has, in addition to his inherited low defense, an increased acquired susceptibility, and every new infection of this type will tend to bring about a recurrence of the old symptoms. We have no thought that he ever can be a normal man, but he is happy to be free from pain and to have even the joys that a boy can have with his companions, with his pictures, and his business, for he has at last become an asset to his mother whose chain of misfortunes had left her completely destitute and who could not leave him for an instant to go to earn. But he has come to be one of the happiest souls you could meet, for everything in this world is by contrast. The improvement in his mandibular articulation is practically complete, as illustrated by the roentgenogram of his head showing the mouth open. Figure 354.

OSTEOMYELITIS.

In Chapter 3 we have discussed the different types of bone lesions produced by streptococcal infection of dental origin and presented cases and also rabbit tissues illustrating the different

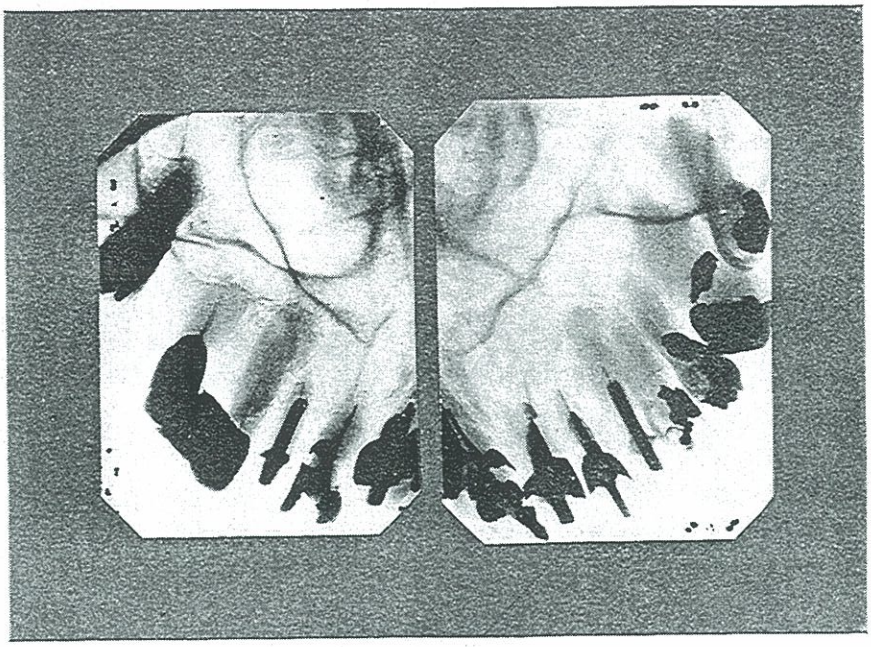


FIGURE 355. EXTREME EXCEMENTOSIS. CASE 311 WITH CARDITIS.

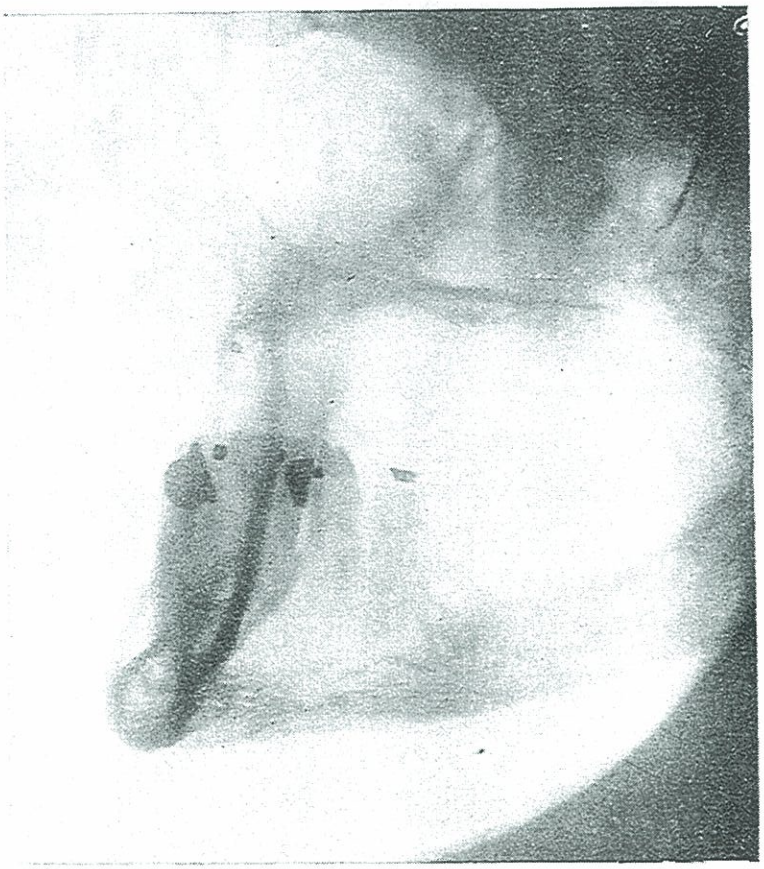


FIGURE 356. OVERGROWN BICUSPID ROOT OF CASE 311.

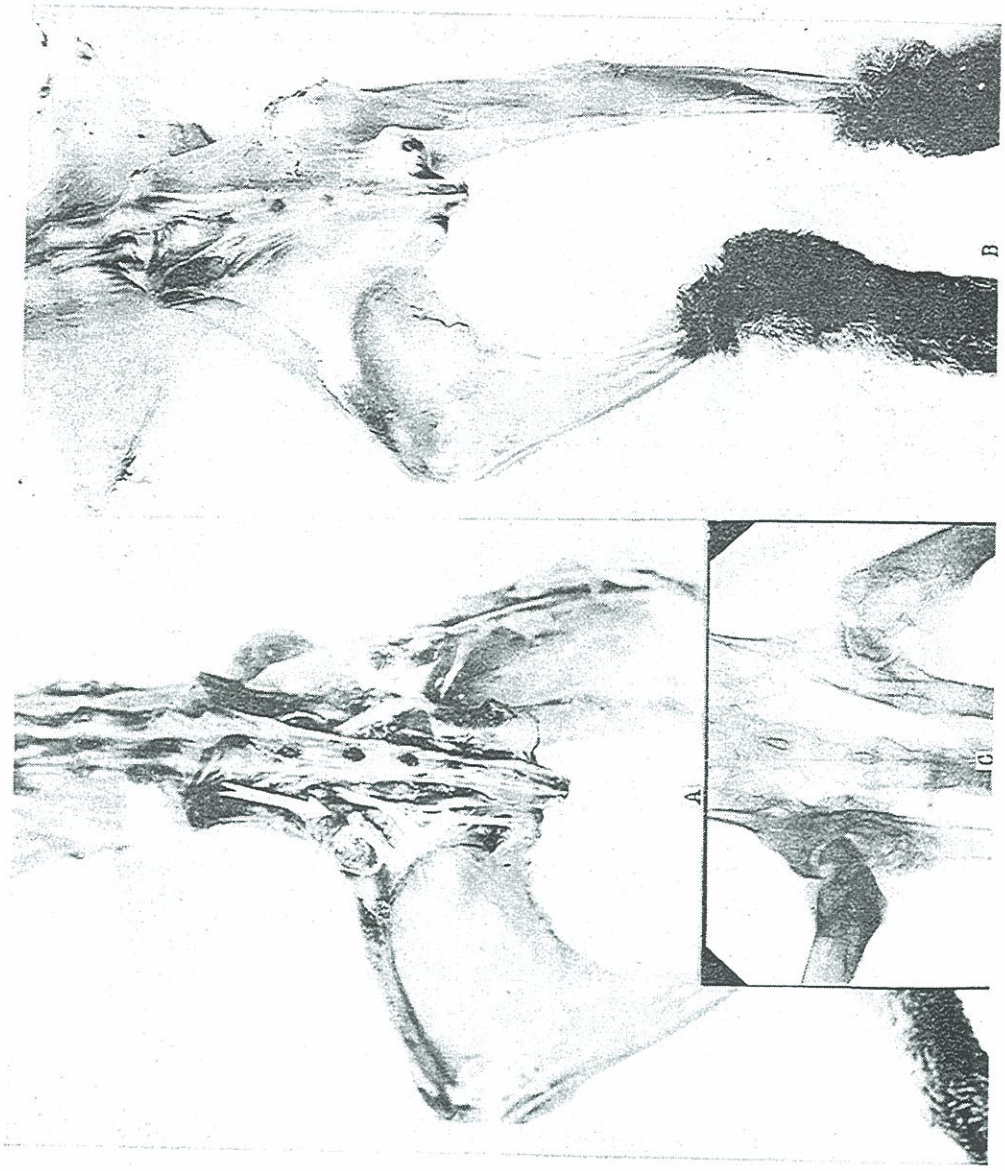


FIGURE 357. OSTEOMYELITIS IN A RABBIT'S HIP, PRODUCED BY THE CULTURE FROM THE OVERGROWN ROOT TIP SHOWN IN FIGURE 356.

types. We present here, under skeletal and muscular system studies, the history of a case and result of animal inoculation as a matter of interest and information.

Case No. 311.—The patient, at the time of this writing seventy-one, has had recurring attacks of rheumatism with very severe cardiac disturbance, extending over a period of several years. The appearance of the structural changes, as revealed in the roentgenograms of the teeth, is particularly instructive. These are shown in Figure 355. Note the very extensive excementosis. This type of local reaction is very important. We have discussed the significance of this type of pathology in other chapters and would stress here the clinical rather than the histopathology. This patient did not suffer from marked rheumatism or from joint lesions with deposits. The root shown in Figure 356, left after a difficult gas extraction, made at the time she was suffering from a severe heart involvement, was cultured internally and the strain injected into rabbits. One of these is shown in Figure 357 with marked osteomyelitis. In A the flexed position of the limb is shown. The animal carried it and the limb seemed painful to touch. B shows the mechanical displacement of the sciatic nerve, due to the swelling. It also shows the femur with the destruction of the shaft and part of the head. C shows a roentgenogram of both femurs with the partial destruction of the head of one femur and the zones of rarefying and condensing osteitis. Figure 361 shows a longitudinal section through a zone of osteomyelitis.

MYOSITIS.

While neck and shoulder involvements are among the most frequently found lesions related to dental infection, they are very largely nerve involvements. Some of them, however, have very definite myositic lesions. This may take the form of torticollis with a simple muscle spasm, or with petechial hemorrhages in the muscles, with or without considerable local infection. In the latter form the involvement is very painful and slow of recovery. Some of the most striking lesions, produced in our animal inoculations, have been the reproduction of neck involvements with the culture taken from dental infections of patients suffering from acute neck involvements. This will be illustrated in the following case.

Case No. 455.—This is the case of a woman fifty-seven years of age. Some years ago she had the roots of a broken tooth smoothed off and a plate was extended over them. These roots became in-

fected and with the pressure of the plate, which prevented the drainage from the suppuration around the teeth, this infection was forced more or less directly into the tissues in the circulation. During a period of two years a neck involvement developed with recurring and increasing severity until it finally became so severe that she was compelled to sit in a chair for eight days and nights, not able to lie down because of the extreme pain and discomfort. Because of her weakness the roots were extracted under a general anæsthetic. They were cultured and animals were inoculated. Several of these rabbits developed myositis. In order to determine whether the infection in the muscle tissue corresponded with that in the tooth, a local anæsthetic was used in the neck and a piece of the trapezius muscle removed, both for section and for culture. Great care was used in removing the tissue without contamination. The section of muscle, about five millimeters square, was removed, one-half of which was ground in sterile sand and inoculated into culture media. The other half was sectioned and is shown in Figure 358. In this section there will be seen streptococci in diploid and chain form within the sheath of the muscle fibres which are seen in cross section. The culture grown from the tissue was inoculated into a group of rabbits, several of which developed myositis and two of the rabbits showed marked neck involvements. A was inoculated with the culture from the tooth and B was inoculated with the culture from the muscle. We have motion pictures of several of these rabbits which, at one time, had marked involvement of neck muscles with their heads turned sideways and with serious nervous disturbances. The patient's condition improved promptly and completely after removal of the infected roots, and she had no return of these or similar symptoms for two years, when suddenly the condition developed in her neck on the opposite side, the right side. At this time, infection was found in the pulp of an infected molar, the pulp being invaded by caries underneath an old gold crown carrying a bridge, shown in Figure 359. With the removal of this infection, her neck involvement ceased completely within twenty-four hours and she was again free from infection for approximately two years at which time she developed symptoms again in her neck and swelling in her left hand, as shown in Figure 360. A putrescent pulp was found in the lateral shown in Figure 360-B, and the extent to which the rarefying osteitis extends behind a condensing osteitis is illustrated by

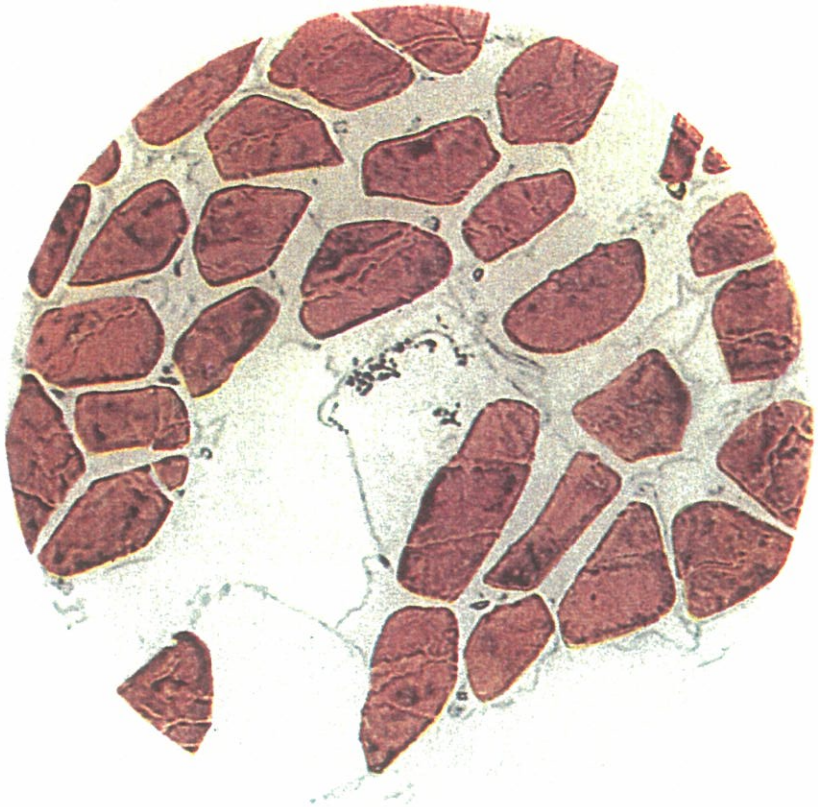


FIGURE 358. A CROSS SECTION OF MUSCLE FIBERS WHICH WAS DISSECTED FROM THE TRAPEZIUS MUSCLE OF THE NECK OF A PATIENT WITH ACUTE TORTICOLLIS, WHICH SHOWS THE STREPTOCOCCI AND DIPLOCOCCI WITHIN THE SHEATH OF THE MUSCLE FIBER. CASE NO. 455.

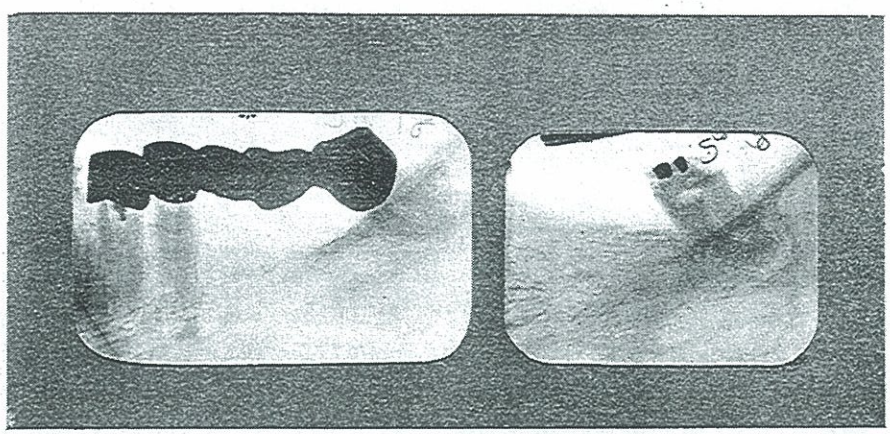


FIGURE 359. ROENTGENOGRAPHIC APPEARANCE OF A TOOTH WITH CARIES BENEATH A BRIDGE WHICH TWO YEARS LATER PRODUCED TORTICOLLIS ON OPPOSITE SIDE OF NECK OF CASE 455.

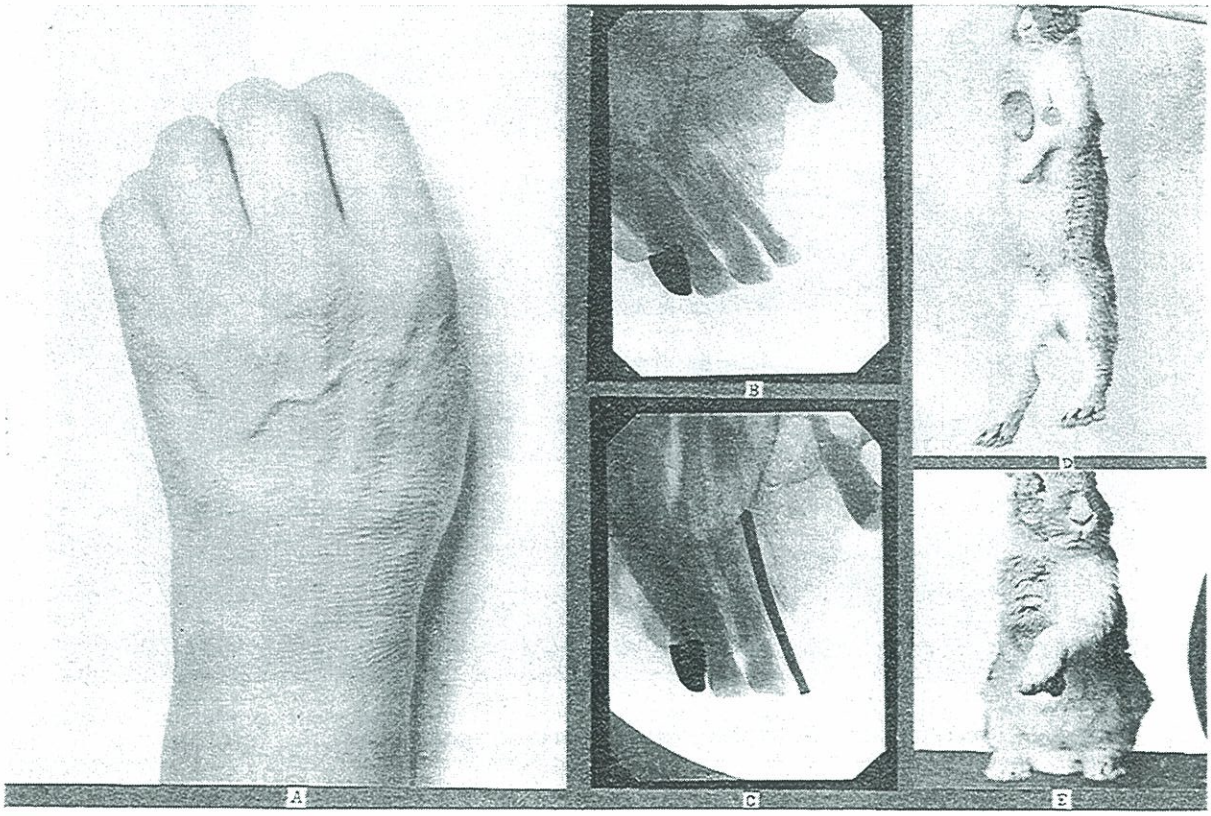


FIGURE 360. ABOUT TWO YEARS LATER, PATIENT AGAIN SUFFERED FROM TORTICOLLIS AND RHEUMATISM. B SHOWS PUTRESCENT LATERAL INCISOR APPARENTLY PRODUCING SAME; A, THE PATIENT'S SWOLLEN WRIST JOINT. D AND E, RABBITS WITH SWOLLEN FEET AND JOINTS WITH ACUTE RHEUMATISM, INOCULATED WITH CULTURE FROM PUTRESCENT LATERAL. C SHOWS A LEAD BAR IN THE TOOTH SOCKET. NOTE THE DECEPTIVE APPEARANCE OF APICAL AREA OF LATERAL IN B.

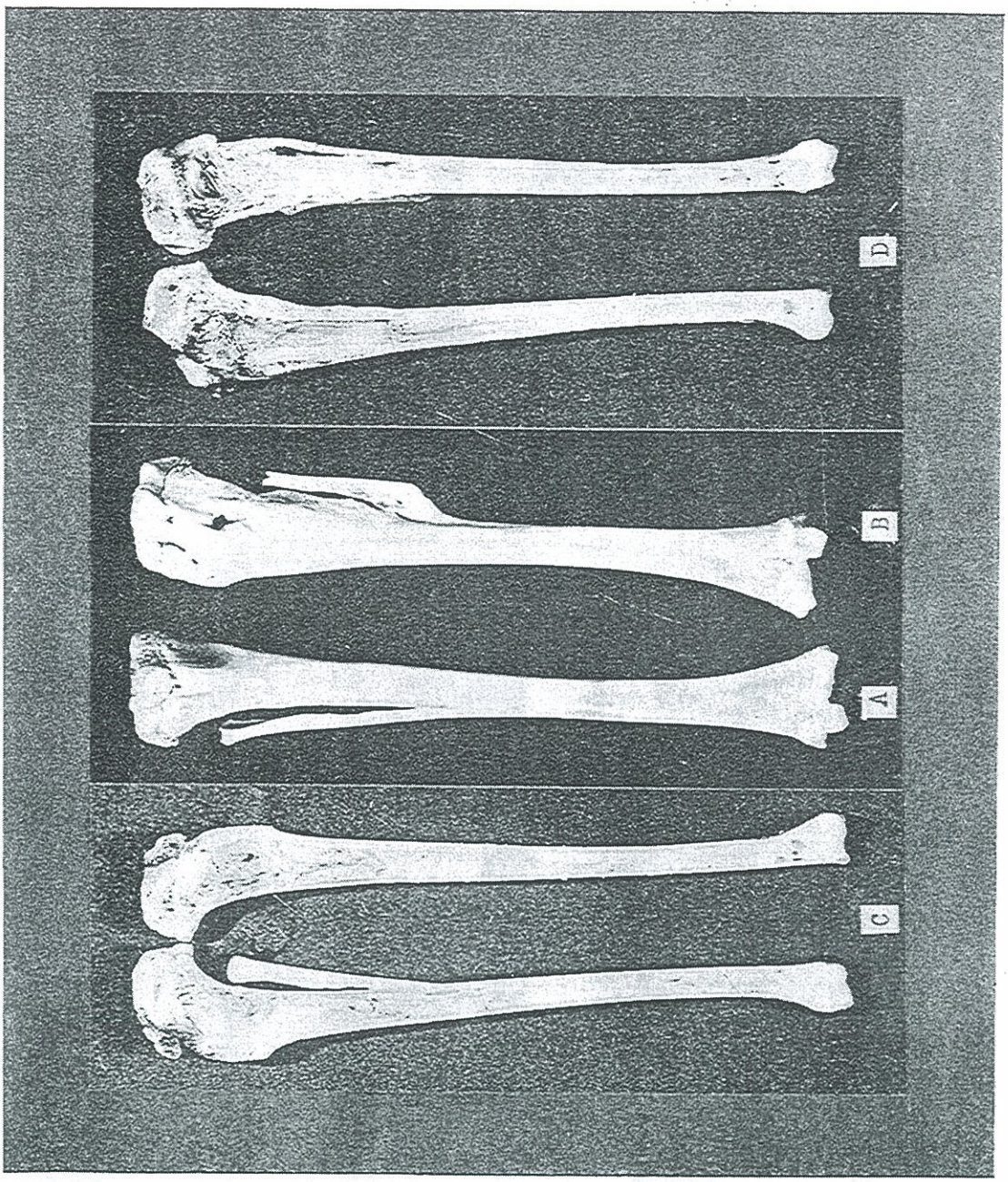
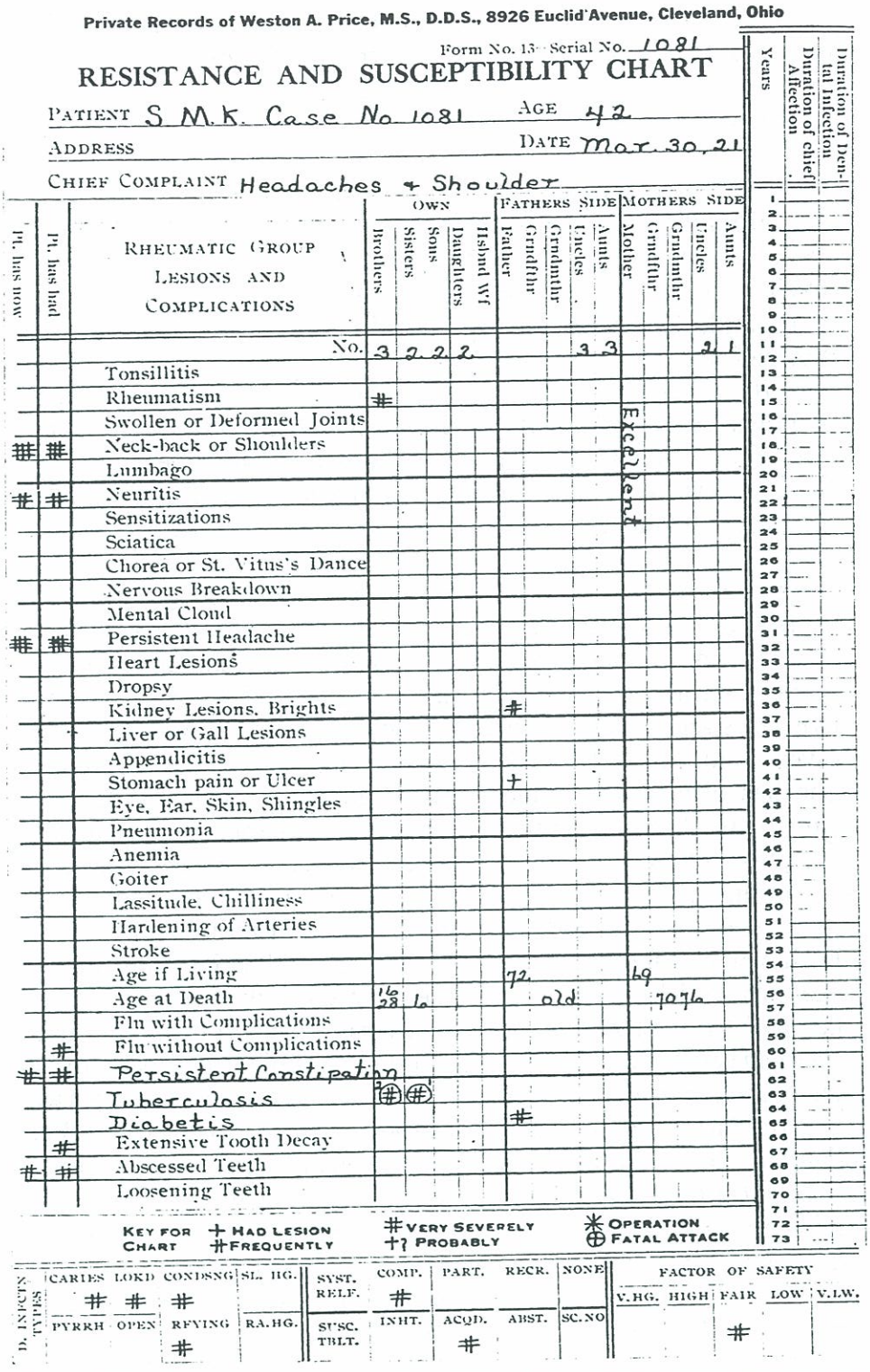


FIGURE 361. OSTEOMYELITIS PRODUCED IN RABBITS FROM CULTURE FROM TOOTH IN PREVIOUS FIGURE: A, NORMAL; B, PATHOLOGICAL; C, SECTION NORMAL; D, SECTION PATHOLOGICAL.

the lead wire placed in the alveolus after the extraction. Rabbits inoculated with the culture from this tooth developed acute rheumatism so that they carried a foot or hopped with great difficulty. Two of these are shown in D and E. One of these rabbits would cry with pain when the other rabbits in the cage would crowd it, making its rheumatic infection painful. There was no tendency to depositions in the joints of the patient; and the infection, when placed in rabbits, tended to produce an osteomyelitis, a striking illustration of which is shown in Figure 361, A normal, B diseased, C sectioned normal, and D sectioned diseased femur.

In the cases of this and the preceding chapters, discussing the practical cases, we have given the detailed history of the case and the findings, including animal reactions first, and then followed these with the physical and susceptibility studies. Let us reverse this order and proceed as we would were the patient presenting for study.

Case No. 1081 —The case in question, a woman forty-two years of age, presents very much underweight with the complaint of acute pain in the right shoulder just below the inner lower border of the scapula, which had been troubling her for about five years and which, at times, during the past two years, was so severe that she had to have medical aid on different occasions. She has also been troubled with headaches. The problem is: Are her teeth probably related to her disturbance, and what are the prospects of improvement from interference or surgical procedure in that line? One of the first steps of course, is complete roentgenograms and the making of the susceptibility chart which is shown in Figure 362. It will be noted that her pain in the shoulder and headaches have been the chief disturbances. She has had three brothers and two sisters, one brother having had rheumatism. Two brothers and one sister died of tuberculosis. Her father and mother are both living, the former seventy-two and the latter sixty-nine. The father has diabetes. The mother has had excellent health and has not been afflicted with any of the rheumatic group lesions. Her father has had some kidney and digestive tract disturbance, but no neuritis or rheumatism or headache in the father and his three brothers and three sisters, or the mother and her two brothers and one sister. It, therefore, is not a family characteristic. The roentgenograms of her teeth,



Private Records of Weston A. Price, M.S., D.D.S., 8926 Euclid Avenue, Cleveland, Ohio

Form No. 15 Serial No. 1081

RESISTANCE AND SUSCEPTIBILITY CHART

PATIENT S.M.K. Case No 1081 AGE 42

ADDRESS DATE Mar. 30, 21

CHIEF COMPLAINT Headaches + Shoulder

Pt. has now	Pt. has had	Rheumatic Group Lesions and Complications	Own: Brothers	Own: Sisters	Own: Sons	Own: Daughters	Own: Husband Wf	Fathers Side: Father	Fathers Side: Grandfthr	Fathers Side: Grandmthr	Fathers Side: Uncles	Fathers Side: Aunts	Mothers Side: Mother	Mothers Side: Grandfthr	Mothers Side: Grandmthr	Mothers Side: Uncles	Mothers Side: Aunts
		No.	3	2	2	2					3	3				2	1
		Tonsillitis															
		Rheumatism	#														
		Swollen or Deformed Joints											Excellent				
##	##	Neck-back or Shoulders															
		Lumbago															
#	##	Neuritis															
		Sensitizations															
		Sciatica															
		Chorea or St. Vitus's Dance															
		Nervous Breakdown															
		Mental Cloud															
##	##	Persistent Headache															
		Heart Lesions															
		Dropsy															
		Kidney Lesions, Brights						#									
		Liver or Gall Lesions															
		Appendicitis															
		Stomach pain or Ulcer						+									
		Eye, Ear, Skin, Shingles															
		Pneumonia															
		Anemia															
		Goiter															
		Lassitude, Chilliness															
		Hardening of Arteries															
		Stroke															
		Age if Living						72					69				
		Age at Death	16 28		1o			old					70 76				
		Flu with Complications															
	#	Flu without Complications															
#	##	Persistent Constipation															
		Tuberculosis	⊕	⊕													
		Diabetis						#									
	#	Extensive Tooth Decay															
#	##	Abscessed Teeth															
		Loosening Teeth															

Years: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73

Duration of chief Affection

Duration of Dental Infection

KEY FOR CHART: + HAD LESION; # FREQUENTLY; #? PROBABLY; # VERY SEVERELY; ✳ OPERATION; ⊕ FATAL ATTACK

PRESENT STATUS	CARIES	LOKD	CONDSNG	SL. HG.	SYST. RELF.	COMP.	PART.	RECR.	NONE	FACTOR OF SAFETY: V.HG.	HIGH	FAIR	LOW	V.LW.
	#	#	#			#								
	PYRRH	OPEN	RFVING	RA.HG.	SUSC. TBLT.	INHT.	ACQD.	ABST.	SC.NO					
			#				#					#		

FIGURE 362. SUSCEPTIBILITY STUDY OF CASE 1081. NOTE ABSENCE OF INHERITED SUSCEPTIBILITY FACTORS.

Figure 363, indicate that much dental work has been done. There are two gold crowns with long standing apical involvements and no periodontoclasia. None of these teeth are painful or uncomfortable. An analysis of the oral pathology and systemic susceptibility, which is shown on the bottom of the susceptibility chart, (Figure 362) shows as the dental infection types a previous tendency to caries, locked and condensing osteitis, also rarefying osteitis; the systemic relief after dental operation—complete; classification of susceptibility—acquired, factor of safety—fair. A more careful study of the roentgenograms, shown in Figure 363, will reveal that the long standing apical involvements which earlier in life had expressed themselves in extensive rarefying osteitis, as shown particularly in the upper right second bicuspid, right central, upper left first bicuspid, lower left first bicuspid, lower right molar, have been followed by the development of a zone of condensing osteitis. (See particularly the upper right second bicuspid and upper left second bicuspid, also shown other places in less marked degree.)

What diagnosis and prognosis are suggested (by these data) on the presumption that the data herewith presented and the basis of interpretation are based upon fact? My interpretation of this case on this information is as follows: Her normal defense by inheritance should be expected to be high and there is evidence that it was high until recent years. Her overloads have been the raising of her family of four, two of whom were twins, the two pregnancies following closely. This woman's classification in regard to inheritance is acquired, and my investigations have shown (See Chapter 4) that when individuals with normally a high defense for rheumatic group lesions do break because of a combination of dental infections and overload, of which the dental infections may be a very large part, the break tends to be in the nervous system. We have also shown that when people with an acquired susceptibility, whose defense normally should be high, have their overloads removed, when they are chiefly dental infections, they tend to rebound splendidly; in other words, the prognosis is particularly good. These conditions must always be considered in conjunction with all other factors, one of the very important of which is the menopause in women. The structural changes about the roots of her teeth suggest that she has changed from a condition of good reaction at the apices to one of poor reaction, the former being an expression and therefore somewhat of a measure of the activity of the extent of some of the processes

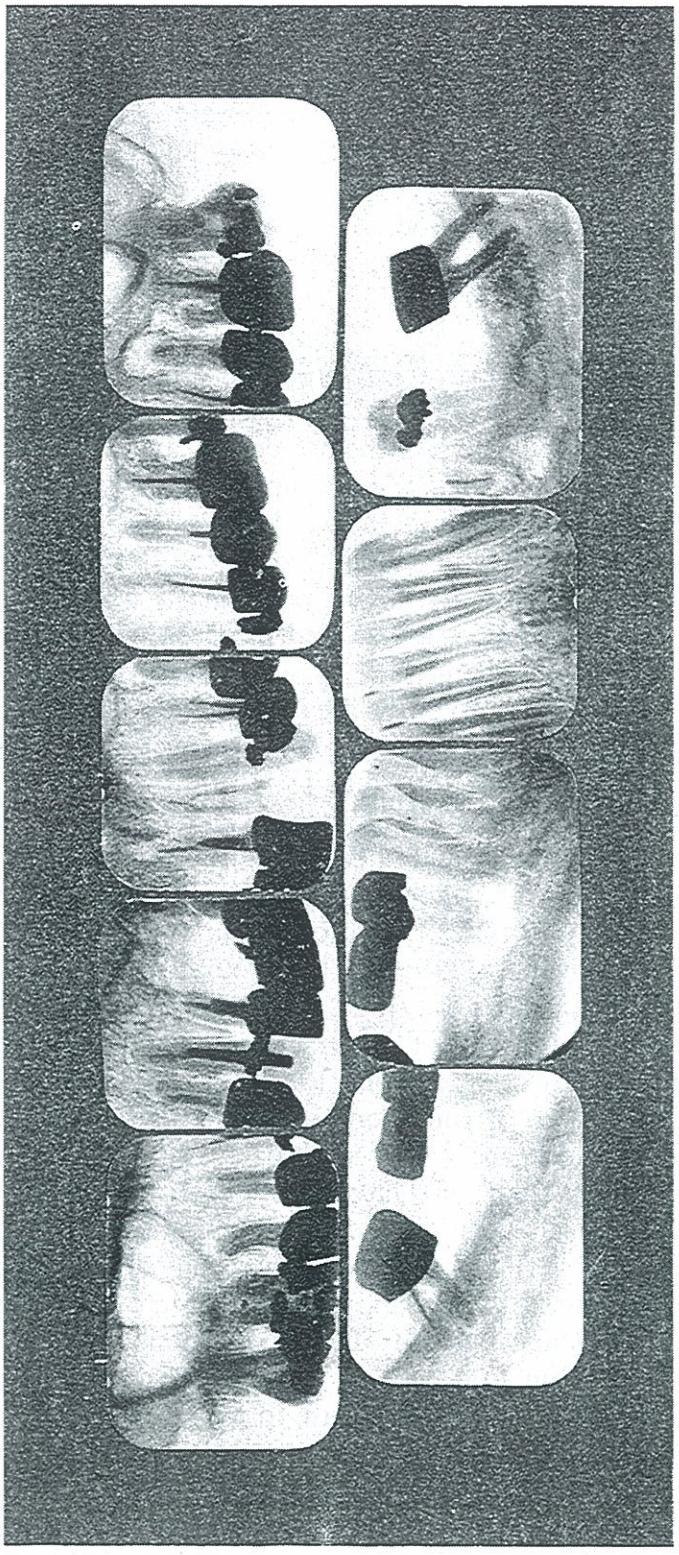


FIGURE 363. ROENTGENOGRAPHIC APPEARANCE OF TEETH OF CASE 1081. NOTE ZONE OF CONDENSING OSTEITIS SURROUNDING RAREFYING, PARTICULARLY OF UPPER RIGHT SECOND BICUSPID, CHARACTERISTIC OF A HISTORY OF A BROKEN HIGH DEFENSE. PATIENT SUFFERING FROM ACUTE PAIN AND LAMENESS IN RIGHT SHOULDER.

and the completeness of the quarantine. I do not interpret the condensing osteitis surrounding the rarefied areas as being a part of Nature's defensive mechanism. Nature does not have that type of intelligence. Tissue cells react to various changes of environment in all stages of irritation, stimulation, depression, and exhaustion, and the same irritant may only bring the response of stimulation at one time, which, under more perfect reacting conditions, will produce sufficient irritation to produce the taking up of lime salts instead of their deposition. Therefore, the building of a zone of condensed bone about the area of rarefaction is an expression of the change in cell membrane permeability and function. The toxic substances developed in these teeth not only are not escaping through a fistula, neutralized by the blood plasma and exudate furnished as a part of an efficient local warfare, but are passing the first defense without ample obstruction and are going to all parts of the system in the fluids of the tissues through the hematogenous and lymphatic circulations. We would, therefore, expect from the change in pathology, evidencing a change in the defensive efficiency about the tooth, that the patient has lost the ability to establish and maintain the quarantine about the infected teeth; and if she is not already breaking in some tissue, she is in great danger of doing so. The fact that she is already breaking, as shown by the history, is just what we should expect.

PROGNOSIS. Since this individual's history, as shown in her own and her family record, and her history, as written in the bone changes revealed in the roentgenogram, indicates that her normal defense has been high, that it has been broken, that there is an ample source of dental toxin and bacterial infection, and that there has been a contributing physical overload, therefore, if the various overloads can be removed, she should be expected to come back to her normal which is high, and, therefore, since the dental infections form an important part of the overload and can be removed, the prognosis is good.

The subsequent history of her case is as follows: These dental infections were removed by the removal of the teeth and curettement of the sockets. This was done eighteen months prior to the writing of this text and during this time she has not had a single recurrence of the disturbance in her right shoulder, which had been almost continuous for the two years previous and, at times, very severe. Her headaches have also dis-

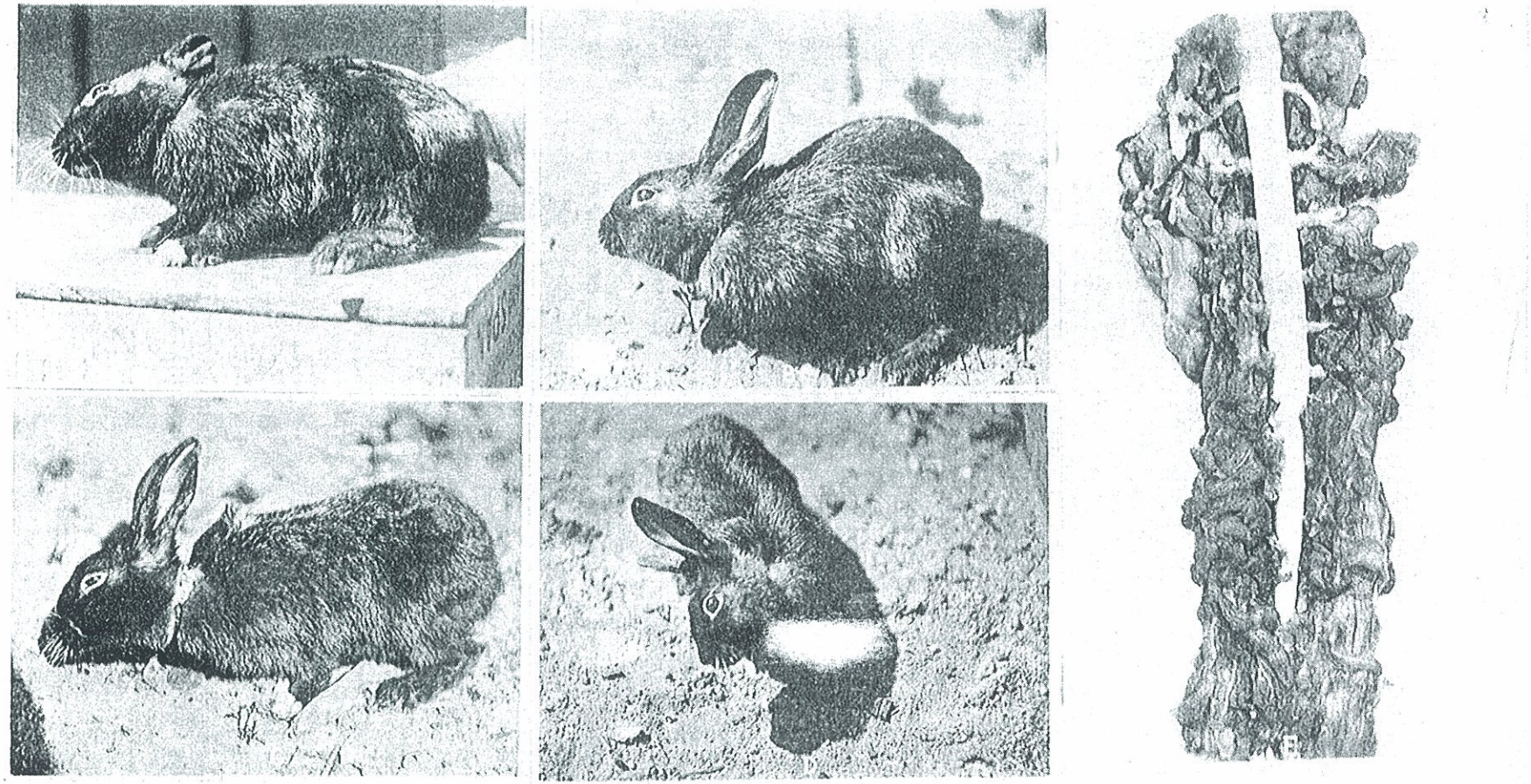


FIGURE 364. FOUR VIEWS OF A RABBIT INOCULATED WITH CULTURE FROM THE TEETH OF CASE NO. 1081. UNDER ANESTHESIA THE NECK MUSCLES RELAXED. AT RIGHT, SECTION OF THE CORD AND CERVICAL NERVES.

in the roentgen-appeared. When the teeth were removed, they were cultured and rabbits were inoculated, one of which is shown in Figure 364. This rabbit developed this involvement of the neck and shoulders in six days after the inoculation of a very small quantity of the culture. It gained ten grams in weight and was very little disturbed in its habits in eating. When placed under an anæsthetic, which was done for experimental purposes, the muscle spasm entirely disappeared and its head ceased to be drawn to the side. As soon as it would come out of the anæsthesia, the muscle spasm would return and the head would go back into that position. The different head positions are shown in the illustration. Figure 364-E shows a dissection of the neck and spinal cord with some of the cervical nerves. Definite pathology was found in the muscles, as shown in Figure 364 and also in the nervous system, as shown in Figure 365. It is significant first that this rabbit, when alive, maintained its head continually in a rotated position after the development of the lesion except when under the influence of a general anæsthetic which unhitched the nervous system temporarily, in which condition there was no physical evidence of a lesion. The lesion was, therefore, quite in the nervous system. It is, therefore, important in this connection to review the microscopic pathology of this condition, which is shown in Figure 365. The histological description and microscopic diagnosis of the pathologist were as follows:

"Rabbit 291. Spinal Cord. Microscopic Study.

"*Inverted Ocular* shows a small circular-shaped piece of tissue of the spinal cord, stained with a pinkish blue color. There are apparently no changes to be seen.

"*Low Power.*—The spinal cord is cut transversely. In the gray matter there are no changes of any kind to be noticed except at the proximal ends of the motor roots, there can be seen here and there small vacuolations, especially of the interstitial tissue. The blood vessels do not show any changes. The central canal with its ependymal lining does not show any abnormal changes.

"*White Matter.*—All around the border of the section there can be seen here and there many vacuolations in the interstitial tissues, also some changes in the nerve fibres. The axis-cylinders in many cases are seen to be pushed out from their central locations and in many instances only wide clear spaces can be seen, without any axis-cylinders. There are no changes to be seen in the blood vessels of the periphery of the cord.

"*High Power* shows the same changes as above.

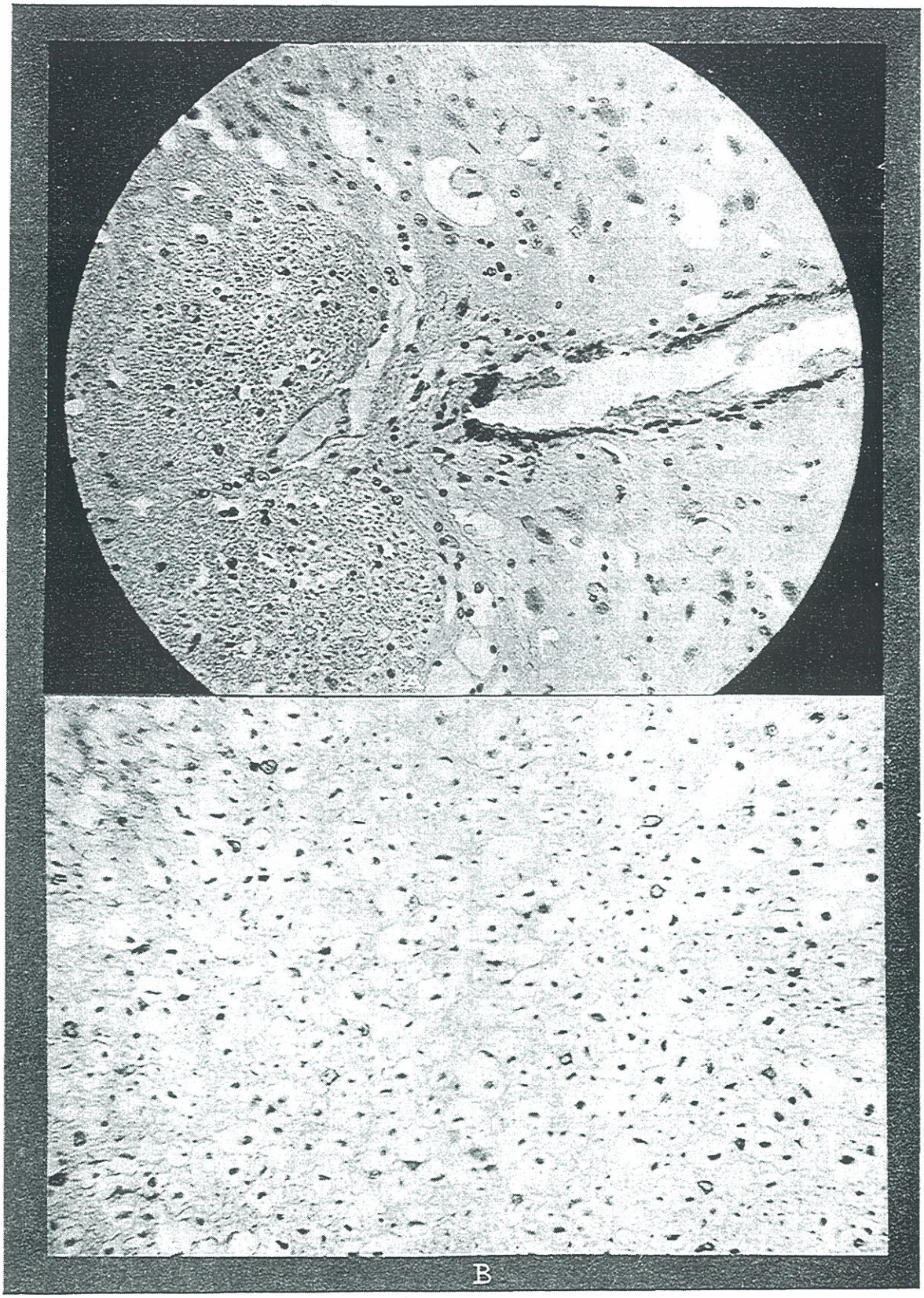


FIGURE 365. CHRONIC DEGENERATIVE MYELITIS OF THE SPINAL CORD OF RABBIT OF PREVIOUS FIGURE.

"*Diagnosis.*—Chronic degenerative myelitis (focal) of the spinal cord."

This patient had also suffered from catarrhal and maxillary sinus involvement of the right side of her face, which has not recurred since the removal of the dental infection. This case has responded just as we should expect it to do in accordance with these interpretations, and it is because of the many hundreds that have responded in accordance with these interpretations that I feel sufficiently confident now to present them as the most logical explanation for the observed data. Whether our interpretations will be found correct in all details must be left for extensive observations by many competent observers. However, there are so many contributing factors that those who observe must have a very wide knowledge of dental and general pathology. Whereas in the last case with neck involvement, the lesions were strikingly in the nervous system, in other instances we have found them chiefly in the musculature. In Figure 366, A, B, and C, will be seen sections of the muscle of the neck of a rabbit also suffering from rotation, in which three different areas of muscle tissue are used, each of about equal width. In the photograph they blend as pieces of a veneering of mahogany would tend to blend. In each of these there is marked degenerative and destructive involvement. In some muscle cells the nuclei do not stain well. The picture was one of acute myositis with degeneration of the muscle cells. In high power the organisms can be seen in some of these cases, as, for example, in Figure 358.

CYST AND MUSCLE SPASM.

Another type of dental lesion, which frequently contains toxic substances which seem to have very marked reaction on certain muscle and nerve tissues, is the dental cyst. We have seen a very large variety of systemic disturbances produced by these. A typical case is shown in the following.

Case No. 978.—Figure 367-D shows the location of the disturbance in the muscles of the neck and back where it had been becoming progressively more severe for two years, the last nine months of which the patient could not raise his hands higher than his shoulders. The trouble began seven years previously as rheumatism acutely in his right arm. Roentgenograms of his face showed a large cyst below the lower left bicuspids and molars, apparently, directly related to mesial root, partially root-filled, of the first molar. Its extent is also clearly shown in the roentgen-

FIGURE 366. THREE SECTIONS OF MUSCLE TISSUE FROM NECK OF ANOTHER RABBIT SUFFERING FROM TORTICOLLIS.

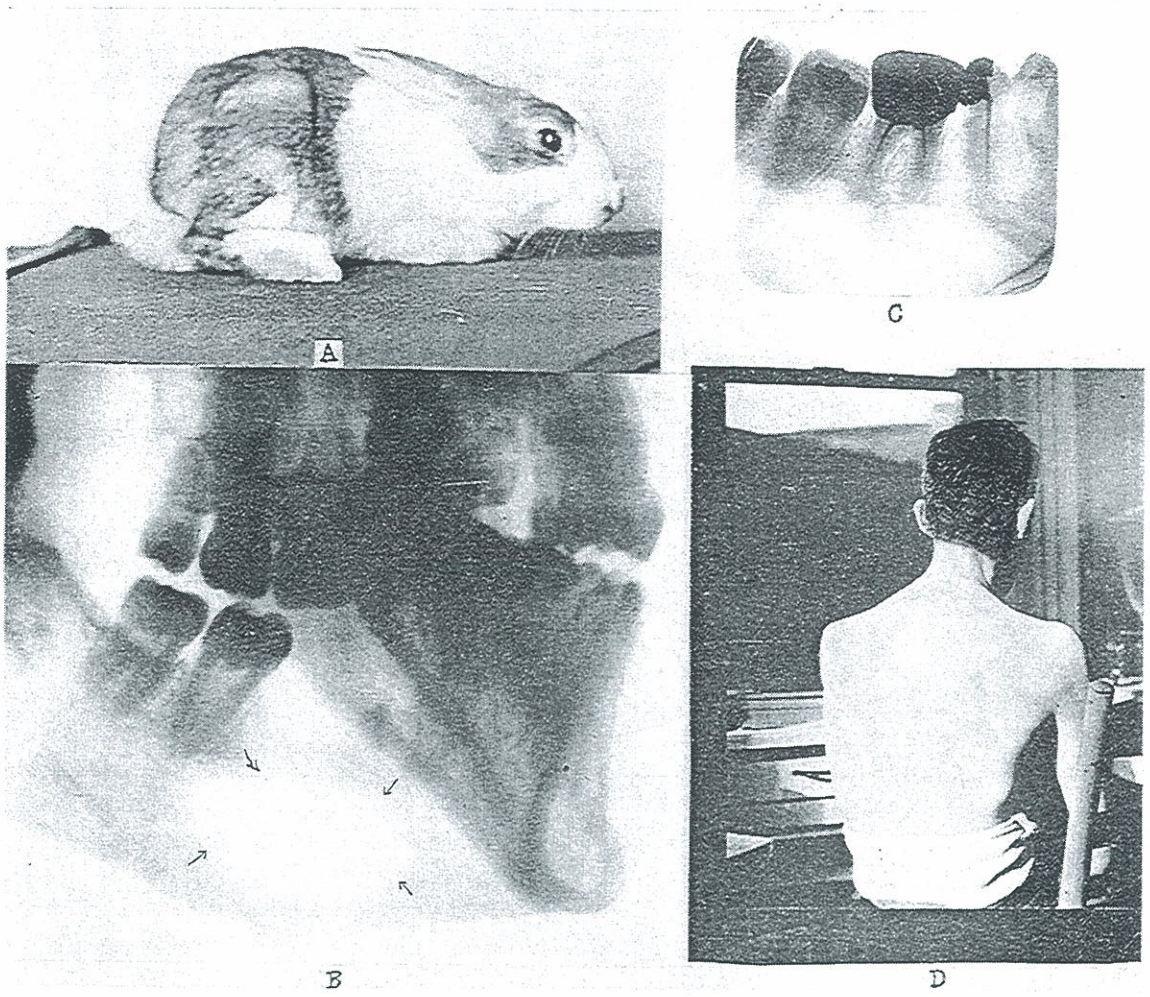


FIGURE 367. AN ACUTE INVOLVEMENT OF THE MUSCLE OF THE NECK AND SHOULDERS SHOWN IN D, RELATED TO THE CYST SHOWN IN C AND B. OPERATION FOLLOWED BY RAPID AND MARKED IMPROVEMENT. A, A PARALYZED RABBIT INOCULATED FROM CULTURE OF SAME.

ogram of the mandible, made after the extraction of the teeth. The surgical treatment of this case was as follows: Owing to the involvement of the inferior dental nerve and the blood vessels which would, of necessity, be injured, if not destroyed, by a complete curettement of the cyst chamber, a liberal section of the alveolar wall was removed and the membrane of the mouth allowed to develop into the cyst chamber and replace the cyst membrane. Where the cyst wall was trephined, the tissue and membrane were removed intact for sectioning, shown in Figure 368. The pathological picture is very interesting. Where the cyst membrane is in contact with the alveolar bone, extensions are

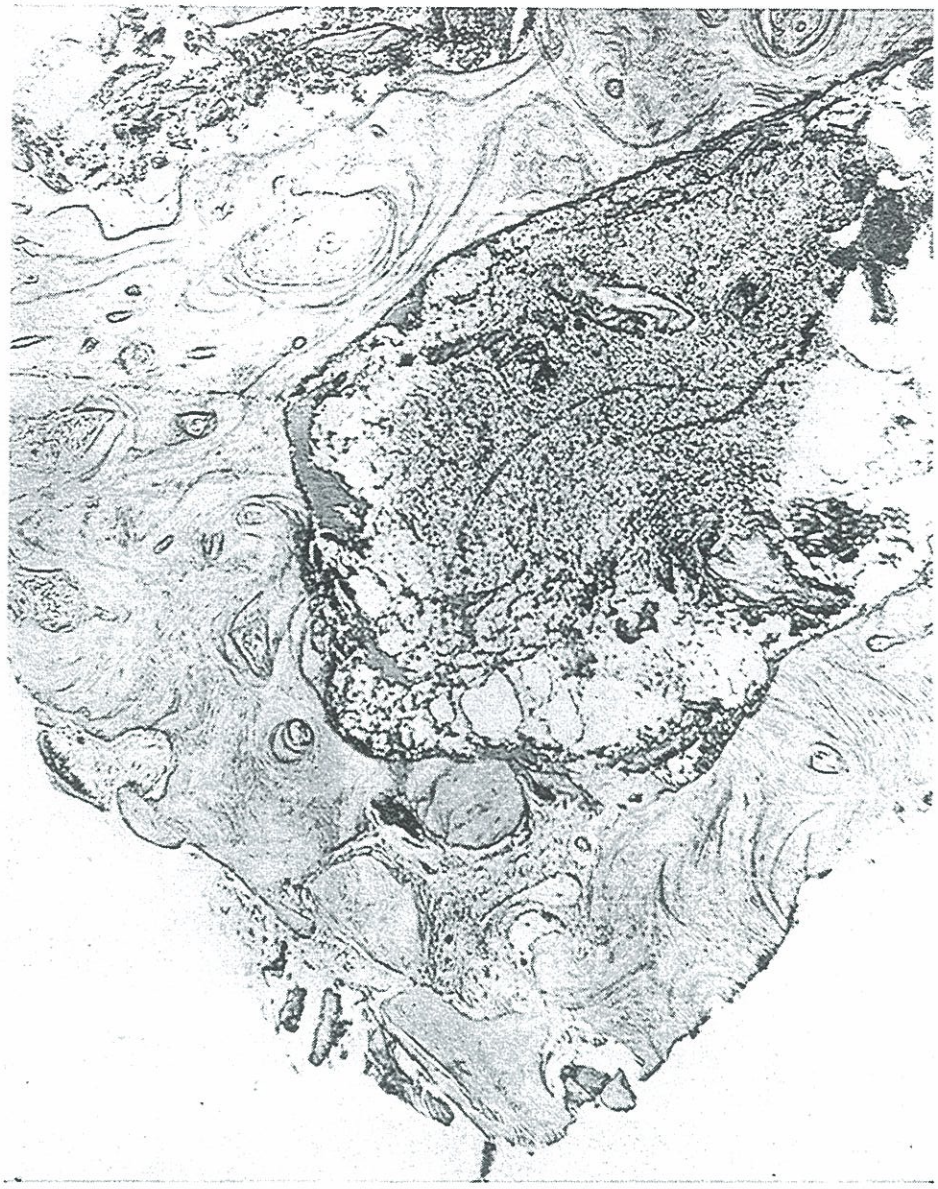


FIGURE 368. A SECTION FROM THE CYST WALL OF PREVIOUS FIGURE. NOTE OSTEOCLASTIC ACTIVITY.

seen thrusting themselves into the bony structure in the process of undermining and absorbing it. Osteoclasts and giant cells are seen, in the higher powers, in the act of taking down the bony structure. The detailed pathological interpretation is as follows:

"*Inverted ocular* shows a circumscribed area of bluish stain,

surrounded with a narrow zone of a red color. The greater part appears to be composed of a dense, compact tissue and a swollen portion, resembling very much gland tissue. *Low power* shows a great portion of the section to be composed of a large number of connective tissue fibres, arranged in a wavy manner. A large number of blood capillaries, distended and filled with blood, can be seen. The tissue, which resembles a gland under inverted ocular, shows the epithelium stratified. The papillæ show degenerative processes with many young blood vessels. At some places, there are areas of proliferative cells accumulated around blood vessels."

The pathological studies of the cyst are discussed under Chapter 69. A very important factor of this case is the following: Within five hours after the opening and draining of the cyst chamber, the patient felt the distinct relaxation in the tension and spasm of the muscles of his shoulders. He could already raise his hands higher than for some time previously. In twelve hours there was a marked improvement, and by the next day he could place his hands high over his head. It is now two years since this operation was made; and while his trouble was not entirely corrected, his condition was very greatly improved and has remained so with but one marked recurrence, the details of which are particularly important and were as follows: In order to protect the cyst chamber and its delicate tissues, for the inferior dental nerve and arteries and blood vessels were clearly visible passing along the floor of the cyst, a removable restoration was made replacing the missing teeth by supporting on clasps on the teeth adjoining the space. This not only restored occlusion, but prevented the food from getting into the cyst chamber which for some days after the operation was packed and irrigated with normal salt solution daily. This became so comfortable that the patient forgot to remove the denture and irrigate the cyst chamber twice daily, as directed, and it received no attention for several days. He presented at the office with considerable alarm because of evidence of return of the old distressing symptoms. When asked if he was irrigating the chamber with a special wash as directed, he realized that he had not done so for several days. The symptoms promptly and entirely disappeared again with the reëstablishment of the irrigation, which emphasizes the importance, as we have seen in many other cases, of maintaining com-

plete freedom from retention of the fluids of the cyst until Nature has replaced the cyst membrane with the extended mucous membrane of the mouth. A culture was made from the cyst fluid which was inoculated into a rabbit which is shown in Figure 367-A, carrying its hind leg.

A photograph showing the cyst contents is seen in Figure 369. The large crystals are cholesterol. These cyst fluids are discussed in Chapter 69 under Cysts.

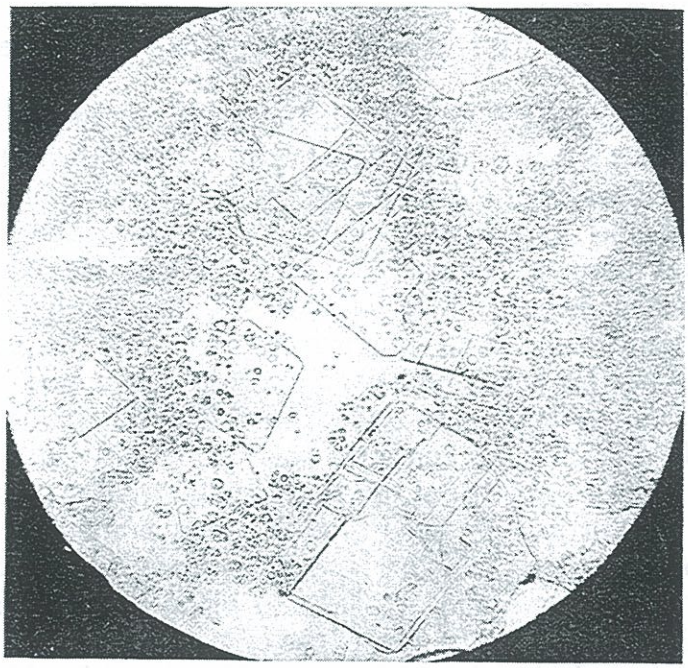


FIGURE 369. A PHOTOGRAPH OF THE CONTENTS OF THE CYST SHOWN IN FIGURE 367. LARGE CRYSTALS ARE CHOLESTEROL.

RETAINED GRANULOMA AND RHEUMATISM.

In former years, owing to the little knowledge of dental pathology, little or no attention was paid to the sockets after the extraction of teeth. If the granuloma remained attached to the tooth, the tooth was considered particularly dangerous because it had the so-called pus sac. If it chanced to remain in the alveolus, its presence was not discovered. The accumulating evidence of these old cases strongly suggests that many individuals have suffered serious harm because of the lack of proper curettage at the time of extraction and the proper treatment of the sockets.

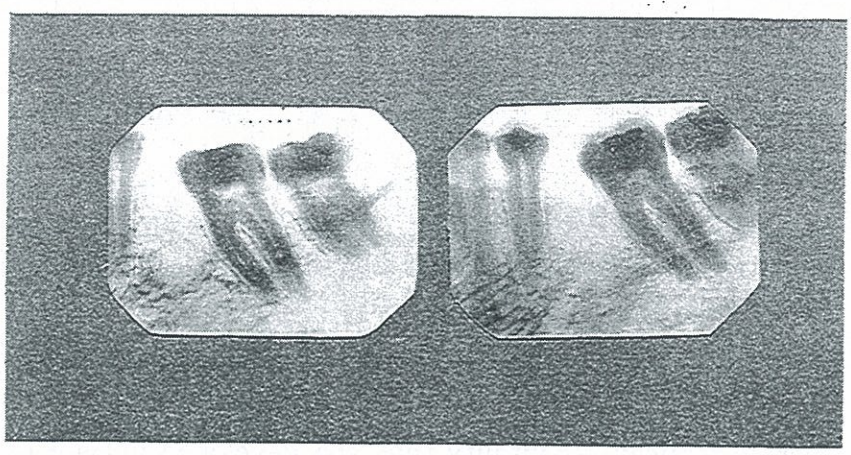


FIGURE 370. A SMALL DENTAL CYST BEFORE AND AFTER OPERATION, POSSIBLY ORIGINALLY A DENTAL GRANULOMA.

Such a case is shown in Figure 370. A shows an overgrown granuloma in the position formerly occupied by the right first permanent molar, which was extracted thirteen years previously, and which, during the patient's memory, was abscessed. Of late years, the patient had suffered from rheumatism. An operation was made by me to remove this overgrown granuloma by trephining a section of the dense alveolar bone from directly over its point of nearest approach from the buccal aspect. The bone surrounding the granuloma was exceedingly dense and the bony chamber, when it was enucleated, had a dense glistening surface that to a sharp pointed instrument felt almost like glass. After the removal of this granuloma and the curettement of the surrounding condensed bone, this patient's rheumatism, the cause of which had been obscure, disappeared and has not returned as such for four years.

In the light of my various studies I would be inclined to interpret this patient as having a low factor of safety from other causes, and the removal of the granuloma might relieve the system of the source of infection to complicate the general picture, but would not relieve it of the other contributing factors. Indeed, this is borne out in this very patient's history in the fact, that she developed nephritis; and while her nephritis may have been related to other dental conditions, (I think, however, here again they were only contributary,) the granuloma that we removed probably was not an important contributing factor in the development of her nephritis, since it apparently developed after the

removal of the granuloma. There probably is great danger that, because of our limited knowledge of the symptom complex of a patient and of either normal or abnormal tissue reactions, we will look for causes as being more simple and isolated than are the facts.

In Chapter 60, under Circulatory System, I cite a case of very marked muscle atrophy, rheumatism, and heart, associated with a type of rheumatism which is very painful. This patient, Case No. 1009, had, as I noted, suffered an attack of infantile paralysis in childhood, from which she quite completely recovered, had a normal life as a girl and young woman, married, and had several pregnancies and miscarriages close together, which so reduced her vitality that she developed a type of arthritis which I have discussed as degenerative in form. In Figure 289 will be seen the roentgenograms of the teeth of this patient.

I wish to call attention particularly to the fact, that, whereas, I have said over and over in this book that people with strong rheumatic tendencies tend to have very slight rarefying osteitis either at apices or at gingival margins as the result of irritations, yet, in this case there is very marked evidence of periodontoclasia. This will be particularly noted about the molars and bicuspids of the lower jaw and the incisors of the upper. I wish to stress that this is not a contradiction, but an illustration of the exception to which I have referred in several chapters as the type with the degenerative form of arthritis instead of the proliferative form, and which is accompanied by a normal or even high ionic calcium of the blood in contrast with the depressed ionic calcium of the proliferative type. It seems very probable that the type of calcium metabolism disturbance associated with this lesion is distinctly different from that of the other type. I have discussed this in relation to the role of calcium in neutralizing acid products of the blood when the blood itself is carrying these imperfect products of oxidation and when bases less costly to the organism or to the individual are not available.

The following items should be noted in this case, which is typical of a group containing many individuals: The process of sacrificing bony structures, when the available supply of calcium is not adequate, with the development of periodontoclasia and the degenerative types of osteitis about joints, is in keeping with this general group of symptoms. In this connection it is also of interest to note that while this patient had suffered from atrophy

of certain muscles, as a result of her infantile paralysis of childhood, these had not been structurally conspicuous and inconvenient handicaps until the development of this degenerative type of rheumatic arthritis. During this process the muscle atrophy developed to such an extent that if her head would accidently swing back too far, she would be entirely helpless to raise it again unless someone would come to lift it to a balanced position above her shoulders, due to the almost complete loss of function of the sternomastoid and associated muscles. After the removal of her dental infections, by the removal of the teeth with the periodontoclasia pockets, and the use of the vaccine, which, as I previously noted, produced so marked a change in all of her symptoms, including the improvement in her badly infected heart, and although she had been an invalid for a couple of years, she was restored to very comfortable health and capable of walking distances where previously she had to be carried or taken in a wheel chair.

I would stress again that we must not think of calcium metabolism disturbances as being so simple as that a depressed ionic calcium is directly a measure of the disturbed metabolism. In Chapter 66, I have discussed in detail a case (No. 484) of very extreme muscle atrophy, involving the right arm so that it was only about one-half the size of the left and was so nearly helpless that the individual could not carry five pounds with it. After the removal of the dental infections, this man's arm so greatly improved that he could swing a pail full of water over his head and could use a heavy sledge hammer, a thing he had not been able to do for twenty years. The relation of this type of muscle atrophy to the enervation of these muscles is discussed in detail in that chapter; and we must think of the muscle lesions, which we are discussing in this chapter, as being very frequently related to involvements of the nervous system.

A discussion of the lesions of the muscular and skeletal structures would not be complete without the inclusion of a discussion of the relationship of the systemic involvement, expressing itself in general deforming arthritis, and the health and comfort of the teeth of the individual. In Chapter 40 on Dental Involvements Caused by Arthritis, I have presented researches directed specifically to the disclosing of this relationship. These revealed that in a manner quite similar to that in which arthritic processes involve and destroy synovial membranes and adjacent structures of

joints, so that same systemic involvement may injure and involve the supporting structures of the teeth and their pulps. I have cited in that chapter several cases illustrating this direct expression of the systemic disturbance in the dental conditions.

One of the most striking of these is Case No. 355, in whose mouth a number of teeth have become involved in succession, some of them coming finally to have non-vital pulps, without that destruction process being related to caries, trauma, or other natural causes. To save repetition I will not repeat here the illustrations, but will refer to them in Figure 29, Chapter 3. I do, however, feel it necessary to repeat the important substance that the roentgenogram of the upper right second bicuspid, shown in Figure 29, which was made in 1901, revealed a zone of very definite radiolucency, indicating a periapical absorption. I, at that time, treated the tooth and filled its root in accordance with the best knowledge of that period. Kindly note that from the standpoint of usual interpretation, there is every evidence that my operation was a success, since the rarefied area became normally radiopaque by the year 1914. By 1916, when my researches had advanced to a point where I was fearful for the safety of patients carrying such conditions, it is important to note that the periapical bone had become more than normally dense. During these fifteen years this patient had been getting progressively more and more involved with deforming arthritis, having come to a condition in which she was almost helpless, having to be carried or move herself with very great difficulty on crutches. It is also important to note that when this tooth was extracted by a method which was deemed adequate to destroy all living organisms—namely, the use of an electric cautery to sear as deeply as it could reach into the tissues about the neck of the tooth before its extraction—the periapical tissues showed, on culture, the presence of a diplo- and strepto-coccus, which organism was also found in the bone for a distance of one-fourth of an inch beyond the alveolus. These cultures, when inoculated into rabbits, produced joint lesions, which, in itself, is not strikingly significant, since streptococcal infections from various types of dental sources tend to produce involvements of joints. The percentage, however, is much higher when the culture is taken from patients suffering from acute processes.

With the removal of this patient's involved dental conditions, which existed at that time and which have developed since, there

has been, continually, evidence of a direct relationship, both demonstrating that the teeth were causative in her case in making the systemic involvement worse, and also that her systemic condition attacked the teeth with structural and functional changes in the peridental membrane, with absorption of cementum and fibrosis and calcification of the dental pulps. In one of the last teeth extracted, also illustrated in Chapter 40, the pulp chamber was practically entirely obliterated by one huge pulp stone, with the remarkable coincident condition that the tooth was not only still hypersensitive to thermal change, but to instrumentation and irritation of the dentin at its gingival border. This patient has been so confident that the removal of her involved dental conditions has improved the systemic, that no compensation in the world could induce her to have one of these teeth back if she could. Her marked systemic improvement following these dental involvements has seemed to justify this confidence on her part.

That dental infections are directly related to osteomyelitis seems to be abundantly illustrated by the many instances of progressive involvement of the medulla of the bone. On culturing, these usually show streptococcal involvement. Their progressive invasion of normal tissue may be so rapid as to involve the entire mandible or one or both maxillary bones, or any part thereof. That these are related directly to streptococci has, as I suggested, been very frequently observed and reported. I wish to present here a case which, however, seems very definitely to be related also to a spirochete invasion.

Case No. 1417.—This young man, age twenty, presents with the following symptoms and history. Following the extraction of the left central incisor, because of an apical abscess, a very acute infection spread to and involved the maxilla and all the teeth, including the first molars, and so violently that he was taken to the hospital instead of returning to the exodontist who made the extraction. He lost twenty-five pounds in a week, and when brought to me by his dentist, while he was sufficiently improved to walk, pus was discharging from the roof of the mouth and from five fistulæ on the buccal and gingival surfaces of the alveolus between the central incisor and the left first molar. Several of the teeth were so loose that it seemed they could be picked from his mouth with the fingers. These are shown roentgenographically in Figure 371, and some were made with flexible gutta-percha points to aid in the differentiation. The bone seemed non-

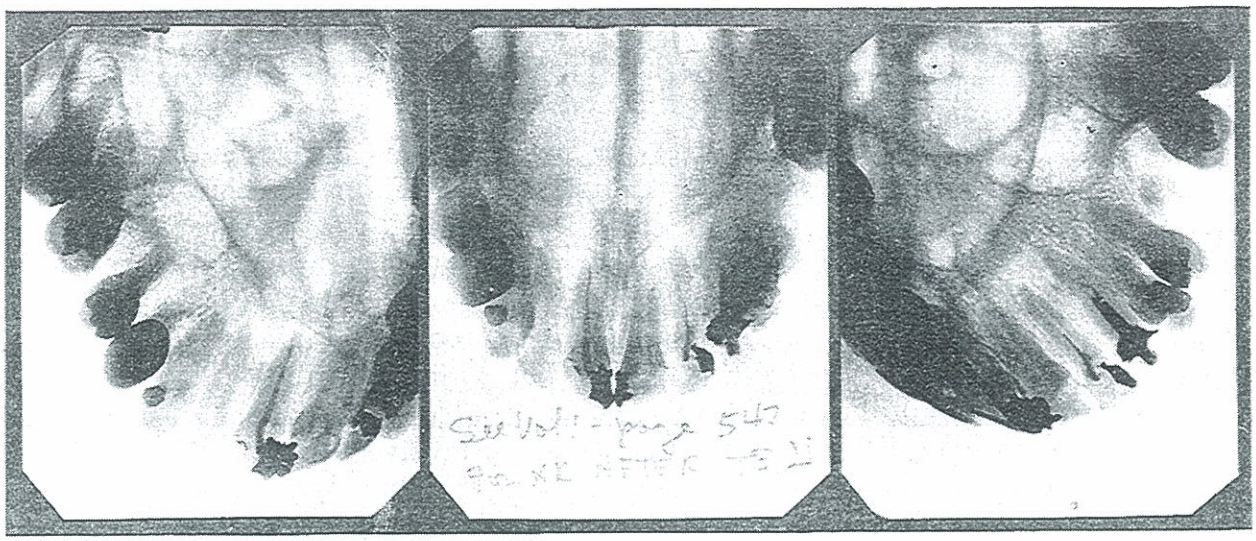


FIGURE 371. ROENTGENOGRAPHIC APPEARANCE OF AN OSTEOMYELITIS OF THE MAXILLA FOLLOWING AN EXTRACTION. SEE CHAPTER 43, VOLUME ONE.

vital for some distance about several of these fistulæ. The smears from the aspirated material revealed under the dark field a profuse culture of spirochetes in addition to the streptococci. This has suggested immediately the possibility, if not probability, that his infection had been an extension of a periodontoclasia to the alveolus. A bacterial examination of his gingival infection revealed an abundance of a similar spirochete.

It is interesting to try to visualize what has taken place in this young man's condition. Both his age and the type of reaction about his teeth would suggest a good capacity for defense. Why, then, did his invasion become so rampant? When we review his clinical history we find that an effort had been made by treatment and root filling to save this tooth which had an infected pulp and which latter produced the violent apical involvement immediately following the placing of a gold inlay. When infection is retained under pressure, there must either be a tremendously active reaction and inflammatory combat in the immediate vicinity, with an adequate vent for discharge, or the toxic substances will enter the system. If the high defense shall be maintained, the toxic products of the warfare will be discharged into the lymphatic and hematogenous circulations. But in this young man's case, his abscessing incisor was retained long enough for his eye to be swollen nearly shut before the extraction of the

tooth. There was, accordingly, a great deal of local and therefore, of necessity, systemic involvement with the toxic substance of this warfare.

We also note from the history that he lost twenty-five pounds in eleven days, 17 per cent. This again suggests just such a reaction in loss of weight as we have demonstrated to occur in rabbits when the infection of planting the tooth is permitted to overwhelm them, for his percentage loss per day was approximately 2 per cent, which was the amount we have shown to occur in rabbits, and represents such an infection and toxic invasion as will very greatly reduce the defensive powers of the blood and very greatly reduce the ionic calcium. It is, therefore, of interest to note that just as a reduction of 15 to 20 per cent in the weight of a rabbit will usually represent a reduction in the ionic calcium of the blood of at least 10 per cent, just so this young man's ionic calcium was reduced approximately 10 per cent. But even more important, there was a pathologically combined calcium of 3.35, which is very unusually high for even pathological cases. The alkalinity index of his blood was reduced to 2.66, and in a few days' time had increased to 34.

We have, then, a suggested means for reinforcing his defense; and it is also of interest to note, that placing him on a regime for the increasing of his ionic calcium and the reinforcing of his defense, has almost immediately checked the activity and spreading of the infective invasion. He was placed on parathyroid extract with quite rapidly diminishing dosage, three-tenths the first twenty-four hours, two-tenths the second twenty-four hours, and one-tenth per twenty-four hours daily for a few days, together with calcium lactate, three tablets with each meal, and in a week's time his ionic calcium was back to normal and his general systemic condition practically normal.

But a matter of perhaps greater interest is the following: Whereas, in this type of case the usual procedure would be to extract all the involved and loose teeth and make extensive curettage, no teeth were extracted, thorough and frequent irrigations being used through the fistulæ in order that such of these teeth as might remain vital and be retained, could do so. This program was adopted, based on my experience of several years, in which I have found that, frequently, teeth, that would be considered so

seriously involved as to be utterly incapable of reattachment, have been retained and their vitality retained. This program, however, would not be adequate unless there accompanied it a very careful interpretation of the reactive capacity of the patient, by studying the bactericidal properties of the blood *in vitro*, as well as determining the ionic calcium and the other factors such as blood morphology. I present this case to illustrate how that with a better knowledge of the pathological processes involved, and a study of the efficiency of the mechanisms of defense, very much more conservative programs will not only be justified but urgently indicated, for fundamentally this bush-fire type of infection is primarily dependent upon a temporarily broken defense.

Another indication of the toxic phase involved in this case is the fact, that his polymorphonuclears were 59 per cent, his small lymphocytes 30 per cent, with his total leucocyte count 8,400, which relationship was changed in one week's time to polymorphonuclears 70 per cent, small lymphocytes 20 per cent. The bactericidal efficiency of his blood was approximately 50 per cent of normal at the time of his serious involvement and one week later had increased to 80 per cent.

He has been saved the serious deformity which would have attended the extensive extractions and curretage of all involved tissue, for the palate and alveolar ridge have been permitted to rebuild in its original form, and whether the teeth are retained for most of his lifetime or not, the ridge is retained, and therefore his facial expression has been conserved, and this to no disadvantage. Later one tooth was extracted and the sequestrum surgically removed, the teeth being supported by a splint while new bone was being formed.

In Volume I, I have discussed in various chapters, factors that are involved, and which contribute to determining the type of expression of dental infections, particularly the changes that develop in the hard structures. These involve variations in defensive factors of the patient, which modify the local expression directly and indirectly by modifying the organisms involved since the organism tends to develop characteristic qualities dependent upon the pabulum or culture medium furnished by the host. The arthritides may be expressed with extensive proliferations with osseous hypertrophies, or may be characterized quite largely by degenerative destructive wasting processes which later involve not only the involved surfaces but a decalcification of the body of

the bone. In some instances both of these conditions will be in progress at the same time in different parts of a joint or in different joints.

It is remarkable how rapidly these progressive degenerative processes may develop and progress. This can be illustrated by reference to many of the illustrations in these two volumes, most of which, however, have not been sectioned or presented to illustrate this point. It can well be seen in Figures 372 and 373, which show the articulating surfaces of the knee joint of a rabbit in each the normal and the arthritic involvement, and are larger views of the frontispiece of this volume. Twelve days after the rabbit was inoculated with 1 cc. of the anaerobic strain grown from an infected tooth of Case No. 1414, it developed a swelling of the left knee joint and favored that limb. Twelve days later it was chloroformed and the tissues taken for section, Figure 372 showing the normal right knee and Figure 373 the involved left knee. By reference to the normal, it will be noted that the articulating surfaces of the heads of the femur and tibia have smooth even surfaces, supported by the well developed trabecular structure of the epiphyses. The joint capsule, medial meniscus and the synovial membranes are all in excellent condition and can readily be differentiated.

In comparison with this it will be seen by referring to Figure 373, that the arthritic knee has undergone very extensive change. First, it should be noted that there is slight difference in the plane from which the sections are taken, which does not, however, modify the pathological picture. The difference in size is due to swelling. In the arthritic joint there has been very extensive inflammatory destruction of the joint capsule, with its rupture. The pus escaped when the tissues were prepared. The trabeculæ of the epiphyses are undergoing decalcification and the articulating surfaces and their cartilages have been very seriously mutilated by the inflammatory process. The posterior cruciate ligament appears in this section though but slightly in the former. Its attachments have been seriously injured and its body is undergoing necrosis.

It can easily be understood how such an inflammatory process, destroying the synovial membranes, joint cartilages, ligaments, and capsule, would in a proliferative process tend to throw down a deposit of bone quite regardless of form and function, and would tend to produce a condition which would be entirely im-

FIGURE 372. NORMAL ARTICULATING SURFACES OF RABBIT'S KNEE. NOTE EXCELLENT CONDITION OF CARTILAGES, CAPSULE, AND JOINT STRUCTURES.

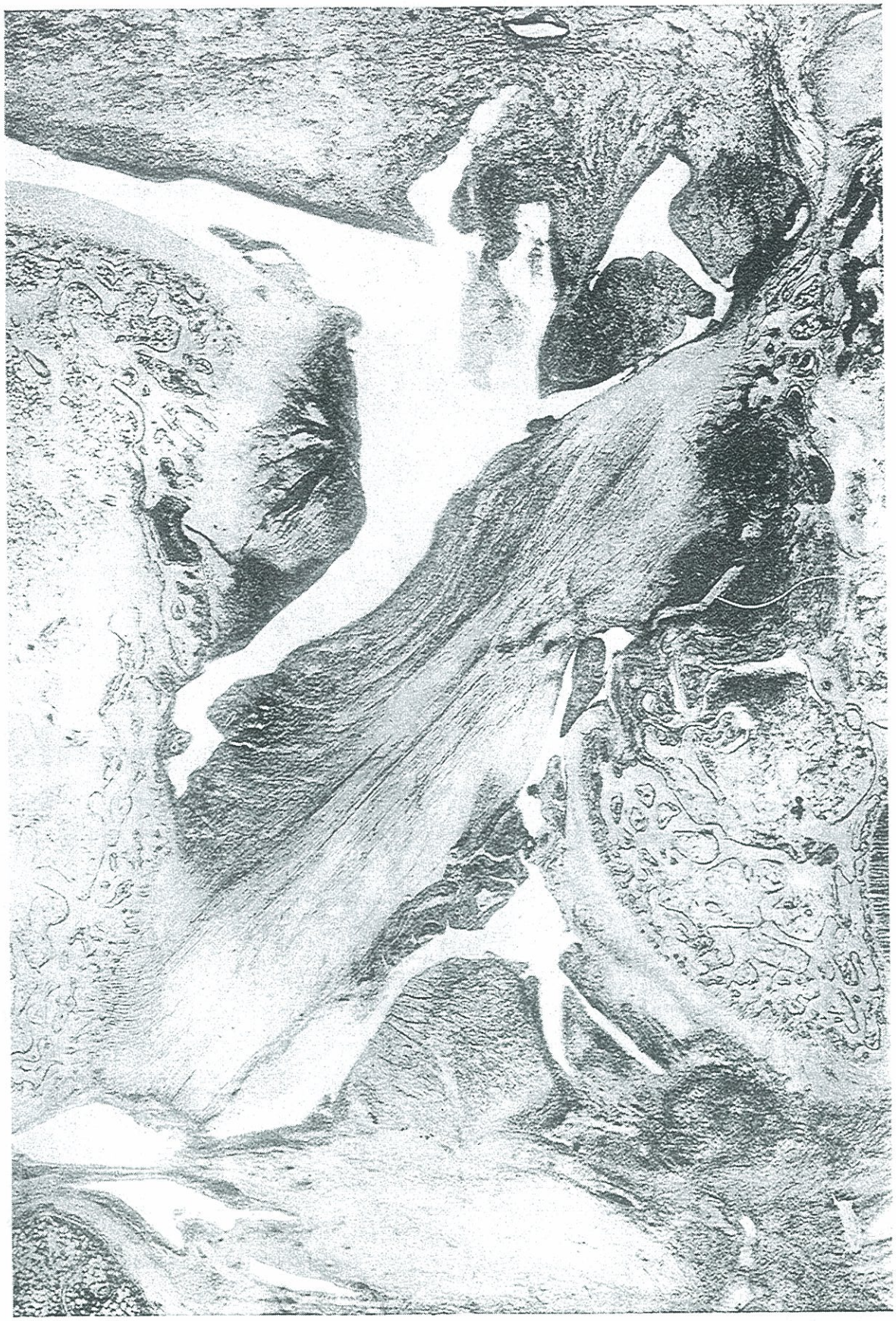


FIGURE 373. PATHOLOGICAL ARTICULATING SURFACES OF RABBIT'S KNEE WITH ACUTE RHEUMATISM. SLIGHTLY DIFFERENT PLANE FROM PREVIOUS FIGURE. NOTE NECROSIS OF POSTERIOR CRUCIATE LIGAMENT AND CARTILAGES.

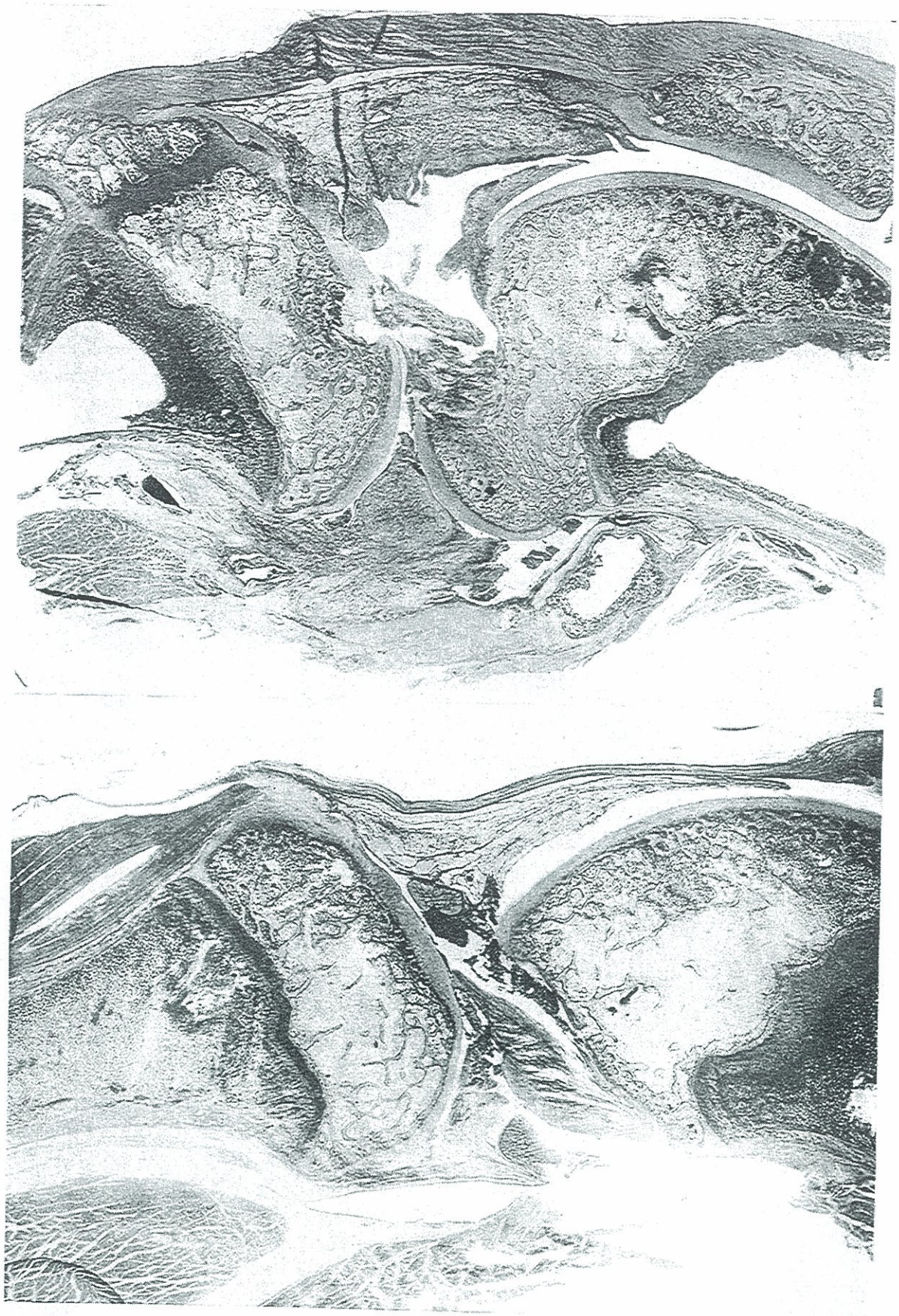


FIGURE 374. COMPARISON OF NORMAL AND ARTHRITIC KNEE JOINTS OF RABBIT IN NEARLY CORRESPONDING PLANES AND DIFFERENT PLANES FROM THE PRECEDING FIGURES: UPPER, PATHOLOGICAL; LOWER, NORMAL.

mobile, if not a continuous dense bone from one long bone to the other. When we realize that this degenerative process which would with certainty have destroyed the function of this knee was produced from the inoculation of a quantity of germs, which, when separated from the solution in which they were suspended, would not have a bulk half as large as the head of a pin, and which would weigh approximately one or two thousandths of a gram, we realize somewhat of the potential possibility of these organisms, particularly when we realize that they were thrown into the entire blood stream with its relatively large capacity for defensive process. I have shown in Chapter 42 of Volume I, the difference in the defensive qualities of different bloods. The organisms injected into this rabbit would pass by way of the circulation to practically all organs and tissues of the animal's body and would survive in those tissues only, which had the low capacity for attacking them, assuming some of them failed to be killed by the blood stream.

When we realize that this reactive response of the blood may call from the leucocytes the bactericidins within one minute's time after the injection of the organisms, we realize how quickly the germs must get into some protected position if they will ultimately survive. Unfortunately for humanity the streptococcus contains in its protective mechanisms, defenses which are very hard to overcome even under favorable conditions. When, however, these organisms find a lodgment in tissues that have very pure vascularization and deficient in defensive fluids, they tend readily to proliferate. Their method of warfare is not, however, entirely a defensive one, for, as I have illustrated in Volume I, they generate toxic substances which tend to paralyze the leucocytes and thereby incapacitate them for their normal function. The warfare, therefore, may be a progressive one with very extensive degenerative processes, or there may be a truce in which the organisms will be surrounded by bactericidal and physical obstructions which will compel them to limit their activity to a balance between their own toxicity and supply of nutriment on one side, and the defensive mechanisms of the host on the other. The streptococci in this form may take on a very low grade vitality in which they will produce exceedingly little irritation to the host, under which conditions the host withdraws, or fails to develop its defensive fluids to resist the organisms and their toxins. This apparently quiescent process may then become a

new primary focus from which new infections will proceed to attack other tissues near or far, and it is doubtful if an individual so attacked can ever be sure that the infection has been entirely destroyed, for the evidence seems very conclusive that these processes tend to light up again when irritated. Goadby[4] has shown that streptococci in wounds in bone may lie dormant for years, and on so trivial an accident as the bumping of the shin and thereby starting an inflammatory process, the encysted streptococci may begin an active aggressive process and kill the host. Every individual, therefore, who has had an attack of rheumatism or heart involvement, or other streptococcal organ and tissue invasion, may be handicapped for life and always live in the presence of an impending great danger, and on the strength of statistics must be considered to have his or her life prospect and possibly duration definitely reduced. It is therefore not an unimportant matter to wait until a dental infection has produced evidence of harm before eliminating it. No course is a truly efficient one in the treatment of disease which does not prevent it.

A very serious and frequent effect produced by cultures taken from teeth, when inoculated into rabbits, is the production of osteomyelitic processes of the spine. One of the very distressing disturbances which the surgeon encounters, is a Pott's disease involving the vertebral column so seriously as to produce gross deformity and grave disturbance. In Figure 375 will be seen a number of lesions of the spine which have developed in rabbits so inoculated. B shows a roentgenographic view of the spine of a rabbit in which paralysis was produced, and it will be noted that there is a marked condensing osteitis with a destruction of the intervertebral cartilage and a condensing deformity of the proximating surfaces of the vertebræ. A shows the dissection and the pinching of the spinal cord produced by this bacterial invasion. B shows the roentgenographic appearance from the lateral aspect. E shows the photograph of a ventral surface of a spine of another rabbit. Note the destruction of the intervertebral cartilage and a localized zone of inflammation and hypertrophy. D shows a lateral view of this case after the lateral walls of the vertebræ had been removed, and it will be seen that there is distinct nodule formation on the ventral surface of the cord, involving the bodies of two vertebræ. A cross section of the spinal column and cord, involving the bodies of the vertebræ, will be seen in Figure 348,

4. See bibliography.

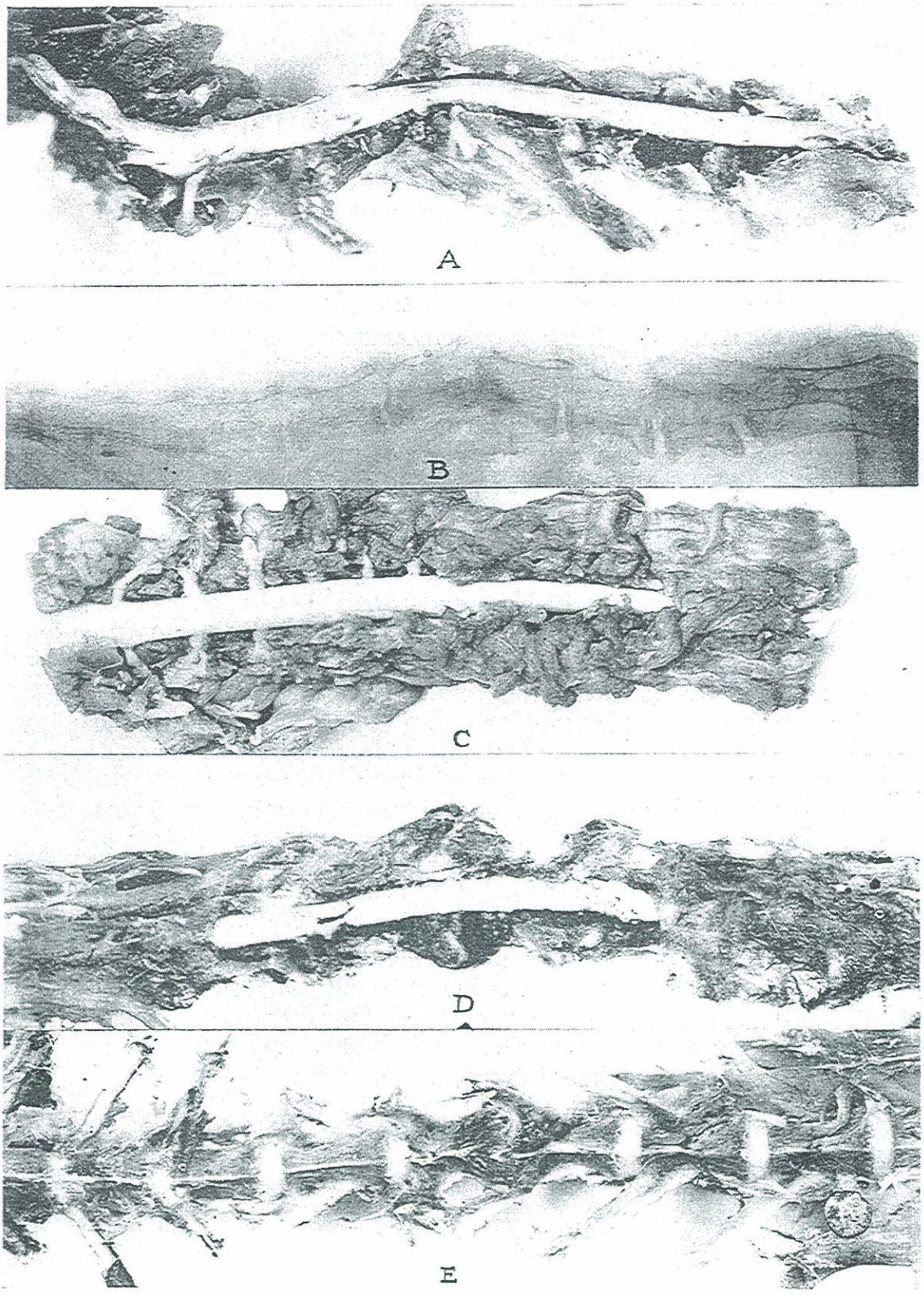


FIGURE 375. SEVERE SPINAL LESIONS PRODUCED IN RABBITS BY THE INJECTION OF CULTURES FROM DENTAL INFECTIONS.

where it is discussed under skeletal and muscular system in deforming arthritis. C shows another spinal involvement.

We have made progressive studies of some of these spine lesions, a typical illustration of which will be seen in Figure 376. This rabbit shows in A the beginning of a distinct condensing osteitis involving three vertebræ and two articulations. This rabbit had been inoculated with the culture from the teeth of Case No. 1178, the rabbits of which case nearly all developed joint and bone, and nervous system involvements. There was a progressive increase of the condensing osteitis, as shown in B and C, the latter being four months later than the first.

This is particularly instructive since many, if not most, of the members of the dental and medical professions, and therefore of the laity who have been instructed by them, expect an infection process in bone to express itself with the removal of bone and the formation of a chamber, and therefore a radiolucent area. In humans, as I have shown, we find the type of bone change that is produced is dependent upon the type of reaction of that individual and will be different in the same individuals at different times in accordance with his or her capacity for reaction, hence a condensing osteitis surrounding a zone of rarefying osteitis, etc. I have also shown that this quality is one that is characteristic of families, and, therefore, in part a mendelian trait and subject to the laws of heredity. In rabbits we do not find a difference in reaction in different litters, which would correspond to the human type of reaction. There is strong evidence, however, that if the organisms are transferred from the human in sufficiently young generations, they will carry over to the new host somewhat of the same tissue elective localization quality which that strain *acquired* in the previous host. Rabbits like most of the biological units tend to adapt themselves to any fixed conditions and environments and, as I have shown in the chapters on blood chemistry, infections, whether introduced by intravenous or subcutaneous injections, readily present changed factors of resistance and therefore of safety, and just as individuals, who have once broken seriously with streptococcal infection, tend to be more liable to infection of the same type in the future, similarly, rabbits that have had developed in their bodies arthritis, seem never to regain again their original defense.

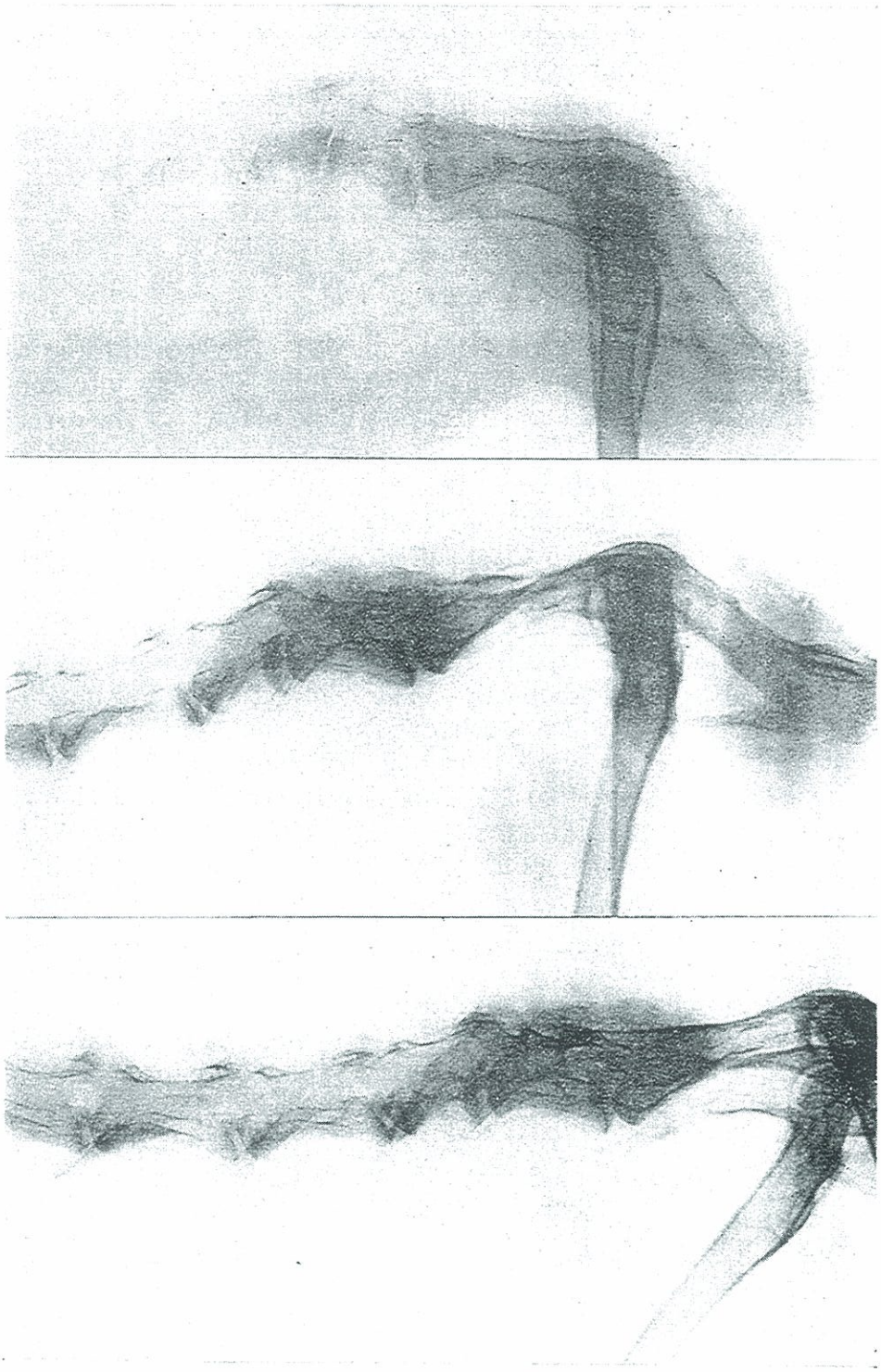


FIGURE 376. PROGRESSIVE DEVELOPMENT OF A SPINAL DISEASE RESEMBLING POTT'S, FROM INOCULATION OF A DENTAL CULTURE.

OSTEOMALACIA.

There are many gradations in degree of the tendency to build up and take down bone in the various pathological lesions, ranging from the extreme arthritides, in which in some instances practically every joint of the body is obliterated and a skeleton becomes one continuous casting of bone, often with extensive hypertrophic deposits, to the gradual and extensive decalcification of bones producing an equally severe lesion as an osteomalacia. In order that this may be more clearly understood, I have presented in Figure 377, three hands representing these two extremes with a normal in the middle. The ages of these individuals do not differ sufficiently to enter seriously into consideration. B is the normal, and it will be noted that the carpal bones are all quite uniformly dense but with distinct separating cartilages. The metacarpal bones, like the other long bones of the body, show a splendid calcification of the shaft and have their epiphyses completely ossified and attached with almost complete obliteration of the junction of the epiphysis with the shaft. In comparison with this will be seen that in A there is a very marked accentuation of the deposition of lime salts, as represented by the greatly increased radiopacity. The contraction of the muscles has tended to produce much deformity, and there are hypertrophic deposits around nearly all articulations. The carpal bones are fused together and have largely lost their unit characters. In C we have the hands of a patient with osteomalacia. In general, there is much less opacity to the Roentgen-rays throughout all the bones. The carpal bones not only have less density but have abnormally thick cartilages separating them. The epiphyseal junction of the shafts of the long bones is still quite visible in many of the ossifications.

The three groups which will be represented by these three individuals have several characteristics. Those of Group A seldom, if ever, have periodontoclasia and but slight reaction about teeth resulting from local irritants, such as crowns and food packs. Those in Group C tend very rapidly to periodontoclasia in its most extreme and obstinate forms. Those in Group B react to irritants with absorption in a moderate degree and respond well to treatment. Almost universally it would be said of the group in A that their teeth extract with great difficulty and are slow in healing, amounting frequently to so-called dry socket. The teeth of the individuals in Group C extract exceedingly easily.

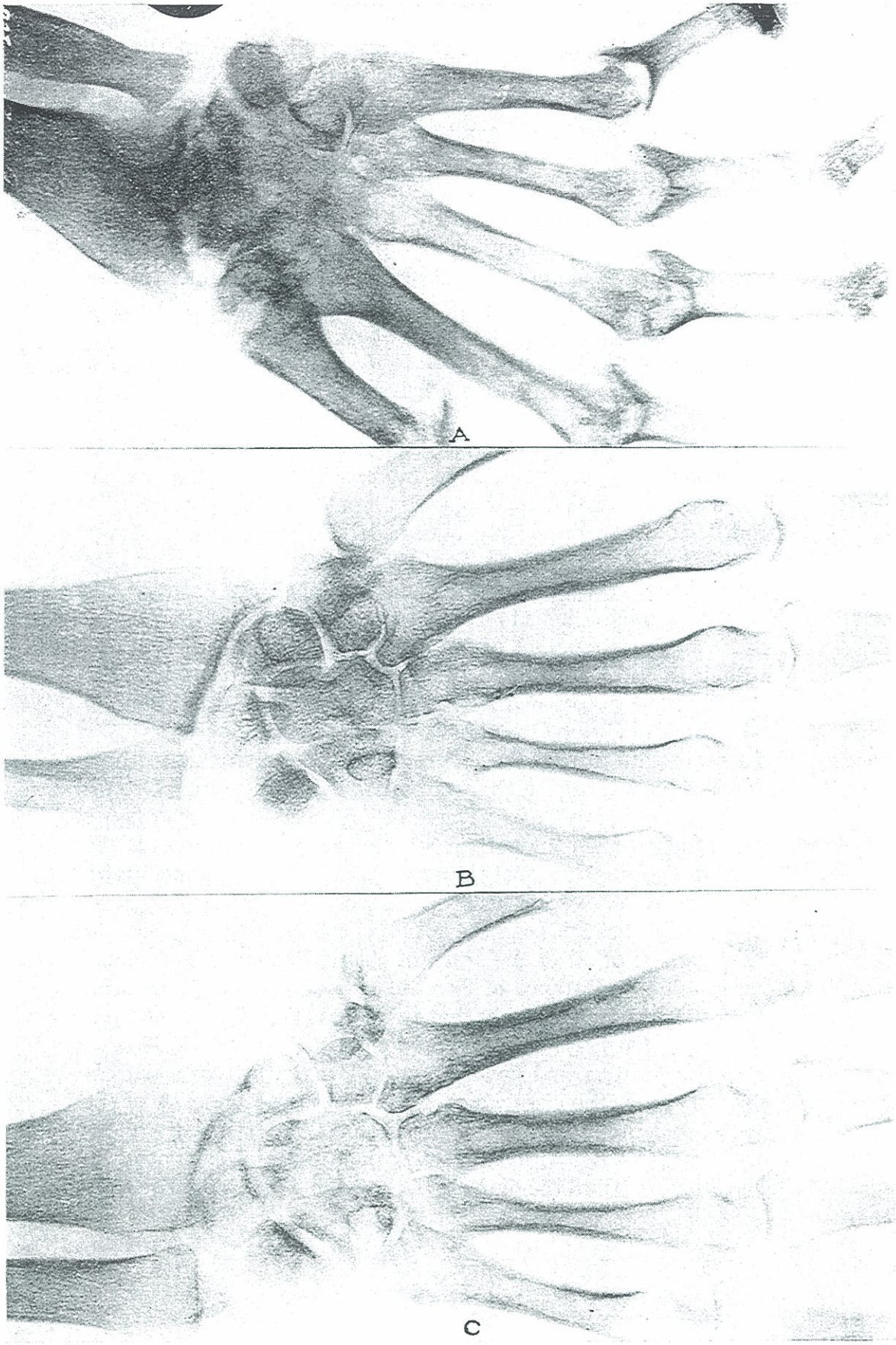


FIGURE 377. THREE TYPES OF OSSIFICATION: B, NORMAL; A, PROLIFERATIVE ARTHRITIS; C, OSTEOMALACIA.

Anesthesia is produced with great ease, and except in the advance stages there is little after-trouble from sockets. The individuals in Group A, whether suffering from deforming arthritis or a mild tendency to it, tend readily to develop excementosis. Those in Group C not only do not produce excementosis but on the contrary produce a marked thinning of the cementum of the tooth, as we shall show later. Those in Group A tend to develop calcifications of the pulp with pulp stones, whether suffering from arthritis or simply of that group classification, not having broken. The individuals of Group C practically never have pulp stones or pulp calcifications while in that state.

At this point I should stress that individuals may have a marked tendency to periodontoclasia as an active process, at which time they will have a characteristic physical condition as expressed in their blood chemistry, and which physical condition may completely change in a few months' time, and they will go into a state in which their reaction would be entirely different from that which previously obtained. To the casual observer so-called pyorrhea pockets would look the same in both these stages, yet, pathologically and clinically, they are entirely different and unlike. This I have discussed in Chapter 28 in Volume 1. From the standpoint of our present information it would be so difficult as to be practically an impossibility to produce the same type of results in the treatment of gingival irritations in individuals of Group C as those of either Group A or B.

To illustrate further the difference in the individuals in these groups, I have shown teeth from individuals representing Groups A and C in Figure 379. The tooth marked A in that figure was extracted from the patient whose hand is shown in C of the previous figure. Note that the cementum has been thinned down to a very thin covering shell and almost entirely destroyed at places. This has not been the action of the bathing pus, but is a characteristic of all of the teeth of this individual. The roentgenographic appearance of her teeth is shown in Figure 378, and it will be noted not only that there was extensive periodontoclasia, but that there was a marked characteristic of slenderness. In contrast with this I have shown in B a tooth from a patient who belongs in the class which I have discussed under A of the preceding figure, and it will be noted that there has been exceedingly extensive depositions of layer upon layer of cementum in this latter case until the diameter of the root a little distance from

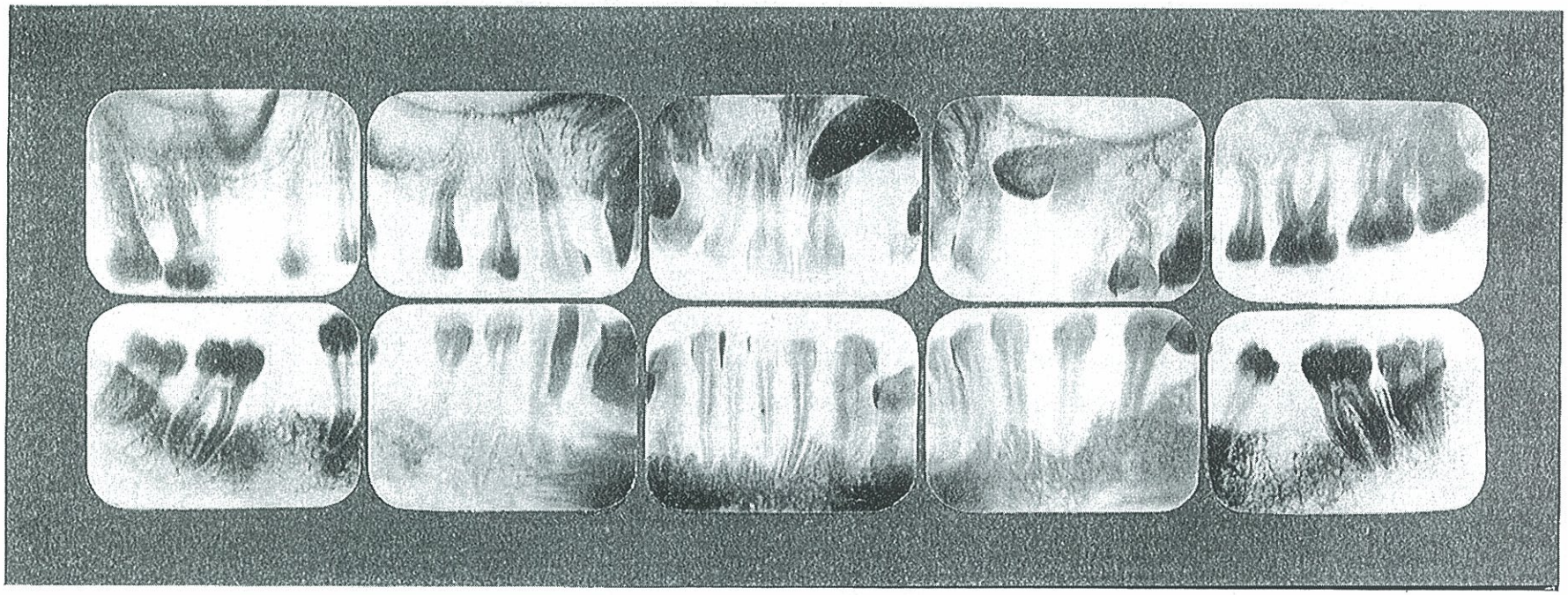


FIGURE 378. EXTREME TENDENCY TO PERIODONTOCLASIA OF PATIENT SUFFERING WITH OSTEOMALACIA. THE SYSTEMIC BACKGROUND MAKES THIS CONDITION EASILY PROGRESSIVE AND THEREFORE RESISTANT TO TREATMENT.

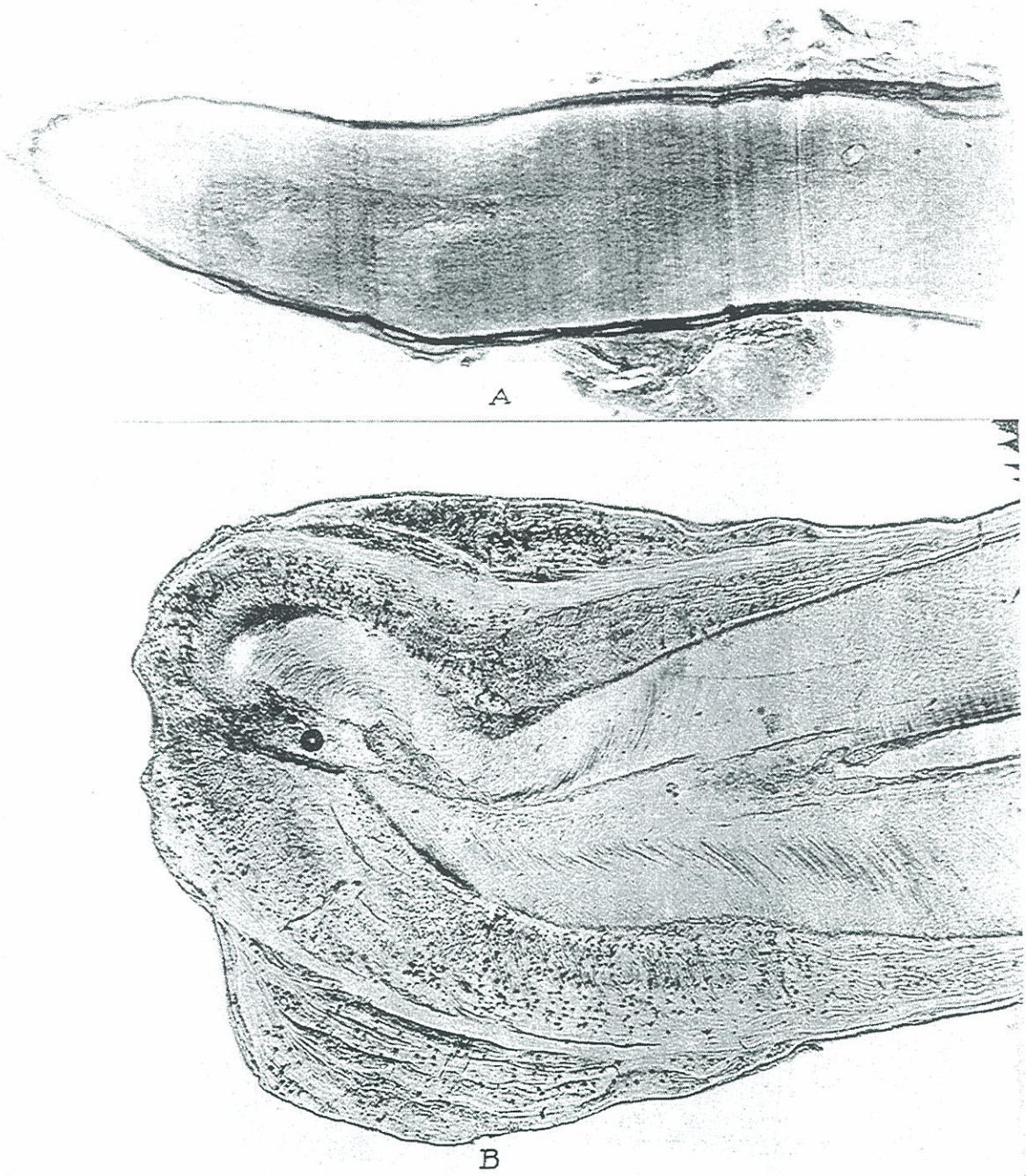


FIGURE 379. TWO OPPOSITE TYPES OF REACTION IN CEMENTUM: A, HYPOCEMENTOSIS WITH DESTRUCTION OF CEMENTUM IN OSTEOMALACIA AND SEVERE PERIODONTOCLASIA; B, HYPERCEMENTOSIS WITH EXTREME EXCEMENTOSIS IN PATIENT WITH BROKEN DEFENSE.

the apex is probably approximately four times that of its original. The roentgenographic appearance of this tooth is shown in Figure 432, the mesial root of the upper right molar. This patient was suffering from very acute eye trouble. It would be a physical impossibility for any form of irritant to produce the effect shown in B on any tooth in the mouth of a patient from which the tooth shown in A was extracted until that patient could be changed from the present physical background to that which obtained in the patient from which B was extracted.

We have, therefore, not only the type and quantity of irritant to consider, but we have always the type of reaction and characteristic defensive mechanisms of the host. In Chapters 43 and 44 of Volume 1, I have discussed the relation of the alkalinity index of the blood of these individuals to the ionic calcium and to the type of systemic reaction. We must come finally to view these patients in terms of their blood chemistries and their capacity for metabolic and catabolic processes. The patient from whom A was extracted and whose hand is shown in C of the previous figure was suffering from osteomalacia. That, however, does not mean so much as does the significant fact which is a background to her condition—namely, that her alkalinity index ranged from 26 down to 20—and it is not surprising that when she, as a seamstress, pricked her finger, she was laid up for weeks with a bush-fire type of infection. She is living all the time on the edge of a precipice and her safety lies continually in an intelligent effort to restore normality in so far as possible, first by reducing the acidosis, and for this, while drugs may be ultimately called upon for assistance, the diet is, of course, the first and most essential factor.