

months previous to the date of the operation.

An incision was now made through the periosteum, beginning as high on the condyloid portion of the neck as my field would permit, carrying it down to that portion of the neck below the base of the new formation of bone, then by means of a small periosteal elevator I removed as much of the periosteum as possible, all the time keeping the point of the elevator close to the bone so as to avoid injuring the internal maxillary artery and the seventh pair of nerves.

Two small retractors were placed in position and the edges of the wound separated. Then by means of a small chisel and mallet I removed the bony bridge extending from the seat of fracture to the zygoma. The chisel was now placed below the callus on the neck of the bone, a few vigorous yet guarded blows of the mallet sent the chisel through the bone, separating the neck and condyle from the ramus proper.

I now found upon examination an ankylosed condition between the head of the condyle and the glenoid fossa, being caused by the callus of bone thrown around the seat of fracture through the condyle. The chisel and mallet were again brought into use and the condyle was tediously removed in sections, without any injury to the seventh pair of nerves, the temporal and internal maxillary arteries, the three important structures which occupy dangerous positions in the field of this operation.

After the removal of the neck and condyle, I made use of slight forcible extension upon the lower jaw, and its normal movements were readily produced. The transverse-facial artery was ligated after the first incision, the remaining bleeding vessels, which were small, were very easily checked by means of torsion and pressure. The wound was thoroughly irrigated with a solution of bichlorid of mercury, 1 to 2,000. The wound was now dusted with iodoform. Three deep and three superficial silk sutures closed the wound, with the exception of the lower corner, which was left open for the introduction of a small rubber drainage tube.

A large layer of iodoform cotton was placed over and in immediate contact with the wound; over this was placed a layer of bi-chlorid gauze, another layer of iodoform cotton, then a final layer of bi-chlorid gauze; a head bandage was applied, the anaesthetic was withdrawn, and the patient recovered from its effects without any mishaps.

On April 27th, 10 a.m., the day following the operation, the thermometer registered 102.5° F., pulse 120 full and bounding. Administered four grains of phenacetine. At 4 p.m. temperature had fallen to 100° F., with a proportion decrease of the heart pulsation.

April 28th, 10 a.m., temperature 99.2° F., pulse 96. At 4 p.m., temperature 99.6° F., pulse 96. April 29th, 10 a.m., temperature 98.5° F., pulse 96; 4 p.m., temperature 98.2° F., pulse 98.

April 30th, the fourth day after the operation, I removed the dressings; the wound had united by first intention; no evidence of puss on the dressings; three of the sutures were removed and the drainage tube withdrawn; the wound irrigated with a bi-chlorid of mercury solution, 1 to 5,000. The drainage tube was shortened about an eighth of an inch and reintroduced. Two layers each of iodoform cotton and bi-chlorid gauze completed the dressing.

The dressing was not again disturbed until May 3rd, the seventh day after the operation; the remaining three sutures were removed; the drainage tube withdrawn, no evidence of puss. Used 1 to 5,000 bi-chlorid mercury in washing out the sinus left by the drainage tube. Iodoform was blown along the tract left by the tube; the toilet was completed with dressings of iodoform cotton and bi-chlorid gauze.

On May 15th, eighteen days after the operation, the dressings were again removed. The sinus and aperture left by the drainage tube had filled with healthy granulations.

This aperture I covered with a small piece of isinglass court plaster and discontinued any further dressings. At this date the boy can make sufficient use of the jaw to eat anything set before him on the table.