ing ramus and the skull. On account of some oozing from the divided bones the cavity was packed with iodoform gauze. The wound was closed with horse-hair, except at the posterior part where the gauze was brought out. Gauze was removed the next day and wound healed by first intention. There was considerable swelling of the cheek for some weeks, which seemed to be due to obstruction of Stenon's duct. There was also some paresis of the orbicularis palpebrarum, but this he now entirely recovered. The teeth can now be separated in front to the extent of ⅜ of an inch. I think the inability to open the mouth wider is due to shortening of the masseter and temporal muscles of the other side—for the jaws can be separated an inch under chloroform. The patient is able to eat meat and other solids, and seems to masticate well. The operation was in the main after that of Bottini, done originally in 1872. This is, I think, the best operation of those cases of bony ankylosis of the temporo-maxillary joint without involvement of the soft parts. When the jaws are fixed by cicatricial contraction in the soft parts due to noma, lupoid ulceration or burn, the section of one must be in front of the cicatrix, and for these cases Esmarch's operation—that is, the removal of a wedge near the body of the jaw—should be done.

It is not always easy to discover on which side the ankylosis exists. The history may help. Then the jaw should be examined, and there may be lateral displacement, as there was in this case, due to loss of cartilage in the process which destroys the jaw. Cabot mentions another method of determining this. If the fingers are pressed in on the teeth on each side, and at the same time the patient makes a vigorous attempt at mastication, a spring of the bone on the free side will be noticed in quite distinct contrast to the fixity on the ankylosed side.

In looking over the literature of the subject, sixty-seven operations on cases of bony ankylosis of the temporo-maxillary articulation have been reported. Of these, forty-seven were done by Bottini's method, and this would seem to indicate that surgical opinion favored the operation being done close to the zygoma.

Dr. Bruce then presented the patient for examination.

Dr. Grasett said that this was the first case of the sort he had ever seen. He thought the result was very satisfactory.

Dr. Peters said that he had seen the case at both operations, at which time there was very little movement. His recollection was that the coronoid was not ankylosed by bone to the skull. The first week after the second operation the patient would voluntarily open the mouth so that there was a distance of an inch between the jaws.