

sutures were removed within a week; no trace of suppuration having ever been seen in connection with them. The local treatment of the wound consisted in frequent irrigation with a weak permanganate of potash solution. It is needless to say more than that the patient made an uninterrupted recovery, and returned home in excellent health and spirits in March, 1899. Having regard to the fact that almost the entire of half the lower jaw was removed, it must be admitted that the result was satisfactory.

The tumor is an example, and a signally well-marked one, of the comparatively rare condition, multilocular cystic disease, formerly known as cystic sarcoma. It is, as already stated, similar in its growth and structure to the remarkable examples of the disease described and illustrated in Mr. Christopher Heath's work on "Diseases of the Jaws." The case recorded above, however, differed in one respect from these—one which in no small degree added to the difficulties in the technique of the operation—and that was the extension of the disease so far posteriorly, involving as it did not only the coronoid process but also the cervix and condyle of this bone. This feature or peculiarity in the case, which added so largely to the difficulties of the operation, made it differ from any of the specimens I have read of, operated on, or seen in any pathological museum.

The diagnosis of these tumors is at times surrounded with difficulty, and if the contents be fluid or partially so, the characters of chronic abscess, dental cyst, dentigerous cyst (follicular odontome), and multilocular epithelial cyst (epithelial odontome) will have to be differentiated. In Smale and Colyer's work it is stated that the last (epithelial odontome) "may be suspected if the swelling shows a tendency to be nodular. This form of tumor is likely to be mistaken for a medullary sarcoma, and the diagnosis between the two is often very difficult; but with the former there will nearly always be an absence of a tooth or teeth from the series."¹

There is much obscurity in connection with the origin of these bone cysts, and much difference of opinion exists among some acknowledged surgical authorities. Mr. Heath states that this origin is probably in the cancelli of the bone, and due to irritation caused by neighboring teeth, and also that the multilocular form of bone cyst seems to be more closely connected with the teeth than the single cysts.

Distension and absorption of the alveoli go on as the cysts increase in size, so that the walls at length become membranous, and the macerated bone shows great gaps in its outline.—*Heath*.

At variance with these views we have Mr. Pollock's statement that these cysts appear to be independent of either any tooth irritation or of any previous cartilaginous deposit.

The theory of tooth irritation has also an advocate in Mr.