When the wall of the sinus has been profoundly altered, it will be judicious to keep the external orifice open for some weeks. This should be wide enough to allow introduction of the index-finger, and easy exploration of the whole cavity in a dark chamber, with the help of a suitable mirror. We tampon the nasal orifice, which must be permanently maintained, and utilized for irrigations of the cavity. The opening in the canine fossa usually closes spontaneously. When it remains fistulous, we close it by stripping off the mucous membrane, and drawing it by a sliding movement of displacement in front of the orifice, and suturing it in that position to the adjacent gingival mucous membrane.

Fistulæ. The treatment of fistula of the maxillary sinus, whether by origin—traumatic, spontaneous, or surgical—by location—cutaneous, gingival, alveolus, or palatine—demands in every instance the preliminary establishment of a communication between the antrum and the inferior meatus. The fistula is closed by extirpation of its tract, followed by an autoplasty by sliding displacement. The technique must be suited to the individual case.

OPERATION. *First Stage.* We trepan both walls of the maxillary sinus with the cylindro-spherical burr of 16 millimetres (see Fig. 1031) in such a way as to open widely into the inferior meatus (*vide supra*).

Second Stage. Extirpation of the fistulous tract: autoplasty.

TUMOURS.

Benign Tumours.

Mucous Cysts of the Sinus—Hydrops of the Cavity—Dental Cysts—Mucous Polypi. A large opening is made in the wall of the sinus through the canine fossa after incision of the gingivo-labial fold (*vide supra*). A large opening is established leading into the inferior meatus of the nasal fossa.

Fibroma—Osteoma. Solid, voluminous tumours may require invasion of the sinus by the cutaneous route. The incision should follow the naso-genial groove, and curve outward below towards the canine fossa.

Malignant Tumours.

Sarcoma—Epithelioma—Carcinoma.—These tumours demand early electro-coagulation, applied on a wide scale. We operate through either the cutaneous or the buccal route, according as the position of the tumour demands resection of the external or the inferior wall of the sinus.

Operations on the naso-pharynx will be described in connection with operations on the pharyngeal region.

END OF VOL. I.

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