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OF THE

PERIOR MAXILLARY BONE.

BY

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EXCISION OF THE SUPERIOR MAXILLARY BONE.

J. M'T., aged 50, two months ago had his attention first directed to his present disease, by a severe pain in the gum over the left molar teeth of the upper jaw, one of which was diseased. He supposed it to be a gumboil, and had the decayed tooth removed. This afforded some relief to the pain, but caused no diminution of the swelling, which continued to increase rapidly till it interfered with deglutition and articulation. It now gives him great uneasiness, and frequently prevents sleep at night.

At present the appearance of the disease is somewhat as follows :— The left side of patient's face is completely distorted by a large tumour, which protrudes the cheek at least an inch beyond that of the opposite side, and encroaches considerably on all the facial cavities. It bulges somewhat into the nasal fossæ, and raises the eyeball above its natural level. It can be felt in the zygomatic fossa behind the malar bone. The anterior wall of the antrum is completely absorbed by the pressure of the growth which protrudes in nodules underneath the cheek. The posterior half of the alveolar process on the left side is invaded by it, and it can be partly felt behind the velum. It causes the patient great pain and discomfort, and he is anxious for relief.

On the 16th of May 1863, I performed excision of the upper jaw in the following way :—The patient was put deeply under the influence of chloroform, and though he occasionally became so far conscious during the operation as to assist in spitting out blood, and turning his head as desired, he assured me afterwards that he felt no pain at all. An incision was made from the angle of the mouth to the prominence of the malar bone in the line of the zygomatic muscle. This divided the cheek into the mouth. Next I cut through the upper lip in its centre, and dissected it along with the ala of the nose from its attachments, and so turned off a flap consisting of the whole of the left cheek. With a narrow saw I divided the zygomatic arch, the outer wall of the orbit, the nasal process of the superior maxillary bone, and completed this part of the operation by separating the intermaxillary suture with the cutting pliers. By placing the thumb on the lower wall of the orbit, having previously divided the attachment of the eyeball, and pressing firmly

downwards, the bone was easily dislodged from its position, and came away, carrying with it the greater part of the tumour which bulged from it on all sides. A part, however, remained attached to the back part of the cavity which was left by the removal of the bone. I scooped and tore away all that was within reach, and succeeded in removing everything which seemed of a suspicious nature, so that when the wound was sponged out, the anterior aspect of the pterygoid process was clearly in view. To prevent the chance of leaving any tissue of a morbid kind, I applied a small actual cautery, and destroyed the soft parts at the bottom. The cavity was filled with folded lint, and the wound stitched with silver wires.

The patient recovered without a bad symptom, and was dismissed on the 29th June, the wounds being entirely cicatrized.

He returned occasionally to show himself at the infirmary, and when I saw him last, in May 1864, a year after the operation, there were no signs of any return of the disease. The cheek was retracted with the cicatrization of the wound, but he could speak, eat, and swallow with facility. A band of elastic hard substance could be felt under the skin, stretching from the prominence left by the section of the zygomatic arch, across the cheek. This seemed to me to be formed by a band of partially ossified periosteum which may have been pushed out by the tumour, and had been dissected off with the cheek flap. The most careful examination of the cavity of the mouth, fauces, and glands adjoining failed to detect any symptoms of a return.

When the tumour was examined after removal, it had all the appearance of epithelial cancer, and the place of its first appearance confirms this view. It sprung from the gum, and first attacked the alveolar process, then extended into the antrum, and projected from it wherever it found readiest egress,—that is, into all the adjoining cavities. The manner in which it broke under the fingers, the nodulated character of its protrusions, and the everted and thickened edges of its ulcerated part in the mouth, point to the same conclusion, which was confirmed by microscopic examination.

The case is interesting as affording proof that this form of disease, even when it attacks a part so extensively connected as the upper jaw, can be removed with success, provided the incisions are made free of the diseased tissue, and sufficient care be taken to eradicate every trace of morbid structure.

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