TOOTH CYSTS.*

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It is not our purpose to transgress upon the domain of the dentist, but rather to report a few cases of interest to the rhinologist.

Tooth cysts may be divided into periosteal and follicular cysts. Periosteal cysts have their origin in the covering of the root, and consist of granulation and epithelial cells. They appear to be more frequent in the upper jaw than the lower, although they are many times overlooked in the lower jaw, owing to the thickness of the bony cortex limiting their growth.

It has been my experience that the lateral incisor and bicuspid are especially affected. The sack gradually increases in size, encroaching upon the surrounding parts, and many times, owing to the bony covering being absorbed, extends into the antrum and nose. It contains a straw-colored fluid, often rich in cholesterin crystals. Not infrequently the contents are infected and a pus sack results.

The treatment of the periosteal cyst is simple and efficient. Incision is made into the cyst wall, thoroughly draining it. If necessary, a counter-opening is made and very mild packing is used for several days, after which time washing of the cyst with antiseptic solutions is all that is required. A cure is usually obtained in from three to six weeks.

The Follicular cysts originate in normal or supernumerary retained tooth germs. They are much slower in growth and not at all dependent upon pathological changes in the tooth itself. The diagnosis is sometimes difficult, but with a swelling in either jaw, together with the absence of the permanent tooth, a Dentigerous cyst should be suspected. The use of the x-ray photograph is especially useful for diagnostic purposes.

The Follicular cysts are the true Dentigerous cysts—that is, tooth-bearing cysts. A root is never developed from these germs, but a tooth crown is often found in the sack.

Treatment of Follicular Cysts.—An incision is made through the mucous membrane and periosteum and a large flap is dissected

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loose. After chiseling away the bony cortex, the inner cystic wall should be most thoroughly dissected out and the mucous membrane of the periosteum crowded into the cavity by a compress. If the sack is not thoroughly removed, there may be a recurrence. Not the least of the dangers of a dentigerous cyst is the possible occurrence of a rarifying osteitis which may destroy the entire jaw.

Case I.—Miss R., age 25, presents herself with marked facial deformity. There is a swelling underneath the upper lip, on each side of the median line, so prominent that the nose is displaced forward. Upon examination, a cyst on each side is easily detected, at the junction of the alveolar and buccal mucous membrane. Examining the nose internally, a cyst is seen along its floor and underneath the anterior portion of the inferior turbinate body. This is a very plain case of double Periosteal cyst connected with the right and left incisor. This is the first case of double Periosteal cyst that I have ever seen. Two incisions were made into the sack, one in the nose and one in the mouth, giving good drainage. This was followed by gentle packing, stimulation with a mild solution of iodine and washing. Both cysts were cured within five weeks. After the operation the cosmetic effect was very striking.

Case II. Mrs. R., age 35, presents herself with a swelling at the right of the median line, causing a displacement of the wing of the nose. It has been coming on for some months and has been painful during the last week. Intranasal examination shows a swelling on the floor of the nose extending to the outer wall. By direct palpation in the nose and under the lip, a cyst is diagnosed. An incision under the lip liberated pus. Another incision was also made on the floor of the nose. The usual treatment was followed out, resulting in a prompt cure.

Case III. Exactly like *Case I*, occurring in a woman, age 40. The sac contained pus and was unilateral.

The above are all illustrations of the ordinary Periosteal cysts.

In conclusion, I wish to report two cases of Follicular or Dentigerous cysts.

Case I. Boy, age 11, presents himself with a swelling in the upper left maxilla which is firm and painful. Immediately above the sixth-year molar a Dentigerous cyst was suspected, and we operated upon him a few days afterward. With a good labial retractor, the parts were well exposed and incision made from the

canine fossa posteriorly to the malar ridge. The membrane and the periosteum were carefully dissected loose, followed by two incisions at right angles to the original one, and the bony cortex removed. The cyst was then dissected out as thoroughly as possible, followed by curettage. The membrane, with its periosteum, was then pushed back into the cavity and held in position by means of tampon. Suppuration followed, but after eight weeks of careful washing and stimulation the entire cavity closed. In this cyst an inverted tooth crown was found, probably a supernumerary bicuspid.

Case II. Young woman, age 22. A diffuse hard swelling is found over the second bicuspid. She reports that she was operated upon previously and the bone scraped. There is a large fistula opening into the antrum. This fistula has discharged for over a year. There has been no discharge of pus from the nose. An incision was made from the median line to the malar ridge. The membrane was then carefully dissected up. In this case it became necessary to remove the entire anterior wall of the antrum. The cyst wall was removed and the extensive removal of bone was made necessary by the existing osteitis. The walls of the antrum were also curetted. The subsequent treatment consisted in the packing and washing of the antrum. A drainage tube was soon introduced and the washing continued through it. Healing was complete in about seven weeks.

No doubt every rhinologist sees many of these cases, but as all of these had been overlooked, I hope that the recital of my experience will be of some interest to you.

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