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- Removal of a portion of lower jaw, for neuralgia. Series XXII.
976. Transverse and recent fracture of the sternum, just below the cartilages of the third rib. 1855.  
*Dr. J. B. S. Jackson.*
977. A second specimen; at the junction of the middle and lower thirds. From a case of laceration of the heart. 1868.  
*Dr. C. Ellis.*
978. The two upper bones of the sternum, completely separated, except so far as they are held together by the fibrous expansion posteriorly; and without fracture. 1861.  
*Dr. H. G. Clark.*
979. Ten lower ribs, from the right side, showing very numerous fractures. Prepared in connection.  
From a sailor (hospital, 83, 195), who fell from the third story of a house, and lived about seven hours. Extensive laceration of the lung, and emphysema. 1859.  
*Dr. C. Ellis.*
980. Old fracture of a rib near the angle. 1847.  
*Dr. J. C. Warren.*
981. The same; toward anterior extremity. Union quite regular. 1847.  
*Dr. J. C. Warren.*
982. The same. Union quite regular. Probably from a dog. 1847.  
*Dr. J. C. Warren.*
983. Recent and complete fracture of the coracoid process of the scapula. 1847.  
*Dr. J. C. Warren.*
984. A scapula, showing a defined circular perforation through the body of the bone, as by a rifle-ball. 1863.  
*Dr. J. W. Foye.*
985. Comminuted, and somewhat recent fracture of the clavicle; not yet united. Preserved on account of the exuberant growth of new bone at the seat of injury. 1866.

COUNT DE BOURNON on the *Laumonite*,

79

*Specific Characters of the Laumonite,**Essential Characters.*

## A. CRYSTALLOGRAPHICAL.

1. *Primitive Crystal.* A rhomboidal tetrahedral prism with rhombic bases, the sides of the prism meet at angles of  $92^{\circ} 30'$  and  $87^{\circ} 30'$ ; the bases are inclined upon the edges of  $92^{\circ} 30'$ , so as to form with them angles of  $55^{\circ}$  and of  $125^{\circ}$ , fig. 1. The height of the prism is to the edges of the terminal faces, in the ratio of eight to seven. This prism divides in a direction parallel to all its planes, but much more easily longitudinally than on its terminal surfaces; this division takes place also with greater facility on two of the opposite sides than on the two others. It is likewise more readily effected, but at the same time less neatly, when the substance has undergone alteration.

2. *Integrand Molecule.* This slightly rhomboidal tetrahedral prism is besides divisible parallel to its axis, and to the greater diagonal of its rhombic terminal planes. I have not perceived any natural joints in the direction of the other diagonal. This second division shews that the integrand molecule of the laumonite is a trihedral prism, the exact half of the rhomboidal tetrahedral prism, fig. 2.

3. *Fracture.* Lamellar.

## B. PHYSICAL CHARACTERS.

1. *Specific gravity.* Taken with a piece slightly changed, but still preserving in some degree its transparency 22,34.\* The variety

\* Water being considered as 10,00.



times occupies even a wider range than has been mentioned above, more than two-thirds of the neck of the bone occasionally disappearing; so that the head of the bone is as if it were forced in the direction of its axis towards the base of the trochanter major.

Superadded to the simple absorption of the neck of the thigh-bone, we frequently observe extensive osseous depositions on the surface of the bone; the lower part of the neck of the bone seeming as if it were incased in a sheath of osseous matter, which is sometimes of a spongy texture, and sometimes of a dense structure, and presenting an irregular stalactitic surface. In the Medico-Chirurgical Observations of CORNELIUS TRIOEN, two excellent delineations are given, which illustrate this form of the affection\*. It is those cases of interstitial absorption which are combined with exostotic deposition, that are apt to be confounded with fracture of the neck of the thigh-bone †.

\* Lic. citat. p. 143. tab. xi. & xii.

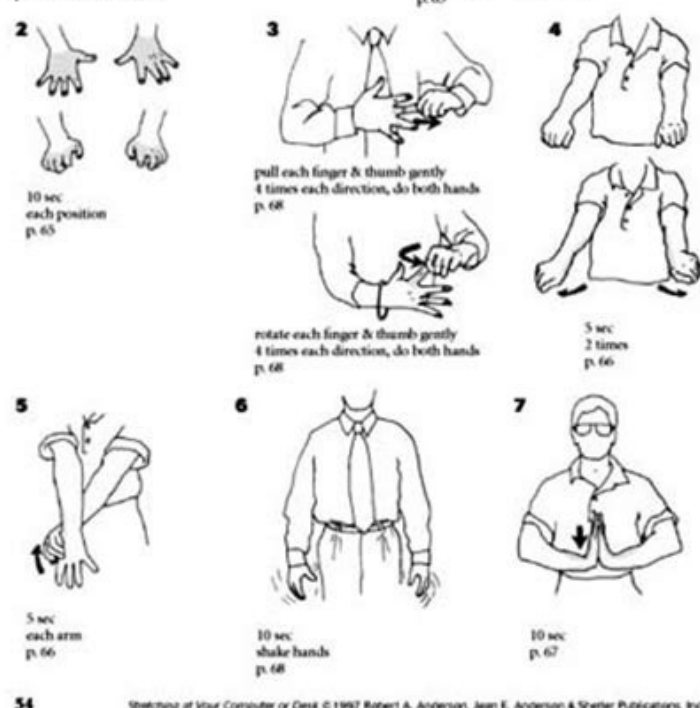
† In confirmation of my views relative to the nature of interstitial absorption, I have received communications from numerous correspondents in different parts of the island.

### Hand, Wrist & Forearm Stretches

#### (To Prevent Repetitive Strain Injuries)

Here is a series of stretches for the hands, wrists and forearms. If you have RSI-type problems, do not do any of these that cause pain. Proceed with caution.

If you do not have an RSI-type problem, we recommend you follow this routine as preventive medicine.



Working at your Computer or Desk © 1997 Robert A. Anderson, Jean E. Anderson & Walter Publications, Inc.



1). J Craniofac Surg. First, internal fixation and reduction in the condylar area are challenging owing to the lack of exposure. Degala S, Sundar SS, Mamata KS. Facial asymmetry, which was observed in two patients of each group, showed no significant difference in the final treatment outcome. In both groups, the patients attained good occlusion, and no statistically significant differences were found for mouth opening between the groups. [4] have compared the bottom-to-top and inside-out sequences (5 patients) with the top-to-bottom and outside-in sequences (6 patients). Plast Reconstr Surg. Manson PN, Clark N, Robertson B, Slezak S, Wheatly M, Vander Kolk C, et al. 2013;24:e479-e481. Comprehensive management of pan-facial fractures. 2014;42:e51-e56. J Korean Cleft Palate-Craniofac Assoc. Wenig BL. They suggest starting with the mandibular symphysis for several reasons. (D, F) Water's view and zygomatic arch view at 3 weeks after operation. However, if comminuted fracture exist in naso-ethmoid-orbital area, stabilization of frontal bone near the nasofrontal junction area cannot be continued to stabilization of nasomaxillary buttress. When these principles were applied, the sequence of alignment restoration was influenced [10]. (C, E) Water's view and zygomatic arch view prior to operation. A clinical experience and treatment of panfacial fracture. Markowitz BL, Manson PN. 2015;14:986-994. [Google Scholar]9. Department of Plastic and Reconstructive Surgery, Yonsei University Wonju College of Medicine, Wonju, Korea. Find articles by Jiye Kim Department of Plastic and Reconstructive Surgery, Yonsei University Wonju College of Medicine, Wonju, Korea. Find articles by Sug Won Kim Received 2016 Apr 18; Revised 2016 Jun 25; Accepted 2016 Jun 25. Copyright © 2016 The Korean Cleft Palate-Craniofacial Association This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (CC BY-NC), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited. Panfacial bone fracture is challenging. [PubMed] [Google Scholar]4. [PubMed] [Google Scholar] Articles from Archives of Craniofacial Association (A, B) Our fracture reduction sequence. The "bottom-to-top and outside-in" approach is the most widely used method in the panfacial bone reduction [2,4,5,7,9]. However, a single sequence cannot be applied to all cases of panfacial fractures because of the variations in panfacial bone fracture patterns. 2000;38:472-476. 1999;103:1287-1306. [PubMed] [Google Scholar]11. In cases without comminuted fracture in nasothmoid area but open wounds near the frontal bone fracture site, we start the reduction from the center of frontal bone through the laceration and with rigid fixation of fracture segments to frontal bone that would be a reliable landmark. zygomaticomaxillary segments were reduced (Fig. Panfacial fractures: an approach to management. On the contrary to most cases, we prefer the inside-out approach in special cases that have frontal bone fracture near the nasofrontal junction. 2003;4:1-8. Role of surgical reduction of condylar fractures in the management of panfacial fractures. Curtis W, Horswell BB, Kim JH, Youn CY, Park ES, Tark MS, Lee YM. [PubMed] [Google Scholar]14. 3). Subunit principles in midface fractures: the importance of sagittal buttresses, soft-tissue reductions, and sequencing treatment of segmental fractures. To restore the facial contour, surgeons usually follow a general sequence for panfacial bone reduction. Even experienced surgeons find restoration of original facial architecture difficult because of the severe degree of fragmentation and loss of reference segments that could guide the start of facial reconstruction. 2). 1995;1:43-56. Panfacial fractures: organization of treatment. The decision on which sequence to use depends on the pattern of facial fractures with respect to the "immobile to mobile" and "simple to complicated" principles. No potential conflict of interest relevant to this article was reported. 1. Manson PN, Clark N, Robertson B, Crawley WA. The mandibular symphysis as a starting point for the occlusal-level reconstruction of panfacial fractures with bicondylar fractures and interruption of the maxillary and mandibular arches: report of two cases. In Korea, the incidence was reported to account for 6.59% of all facial bone fractures [8]. J Craniofac Trauma. 1974;2:187-200. Oral Maxillofac Surg Clin North Am. 2013;25:649-660. 1986;78:9-22. There was no severe naso-ethmoid-orbital area fracture, and the midface fracture did not affect the occlusion. Medial fractures such as NEO or symphysis, parasymphysis fractures should be followed according to frame that is decided by projection and height. Degala et al. Using the reconstructed maxillary framework as a template, the lower face was reconstructed last (top-to-bottom sequence) [11,12]. Following the advent of rigid internal fixation, surgeons started reduction of facial fractures with the mandibular condyle [13]. Merville L. J Craniofac Surg. We started the segment reduction from the frontal bone through the laceration wound. J Maxillofac Oral Surg. Only a single four-hole plate is most commonly used to fixate the condyle neck because of the small amount of bone and lack of exposure in the condyle neck area. For panfacial fractures involving the NEO, Merville [15] suggests initially managing the NEO fracture [4,5]. Management of panfacial fractures. Gruss JS, Mackinnon SE. Between the inside-out approach and outside-in, most craniofacial surgeons recommend the outside-in sequence because the approach has a great advantage in restoring the outer facial frame and projection. As both sequences yield similar clinical outcomes, the decision of which sequence to use depends on the fracture pattern and surgeon preference. We reviewed a total of 53 patients who received open reduction at a single academic institution (Wonju Severance Christian Hospital) between January 2011 and December 2015. J Oral Maxillofac Surg. [14] suggest inverting the order of repair from the outside-in sequence (Fig. As a result, this sequence is often combined with either the bottom-to-top sequence or top-to-bottom sequence. [PubMed] [Google Scholar]7. Complex maxillary fractures: role of buttress reconstruction and immediate bone grafts. However, the efficacy of inside-out or outside-in sequences have not been assessed independently of bottom-to-top or top-to-bottom sequences [4,5,7,9]. (B) Most studies have advised starting facial bone reconstruction with the reduction of zygomatic arch and malar projection to establish the outer facial frame and to provide upper facial width and projection before nasoethmoid-orbital (NEO) region. (A) Preoperative three-dimensional computed tomography imaging of a patient with a panfacial bone fracture. Numerous studies have compared combinations of these reduction sequences. Panfacial bone fractures are often accompanied by soft tissue trauma and destruction of the bony framework, which may result in malocclusion or facial deformities, including "dish" face deformity, loss of facial height or projection, increased facial width, and enophthalmos [6]. [PubMed] [Google Scholar]6. (C) As the NEO fracture fragments are fragile, it is difficult to find a stable fixation point in this area. Few authors have recommended the inside-out sequence in favor of the outside-in sequence. [PubMed] [Google Scholar]2. [PMC free article] [PubMed] [Google Scholar]5. de Melo WM, Sonoda CK, Shinohara EH, Garcia IR, Jr Using the "bottom-up and outside-in" sequence for panfacial fracture management: does it provide a clinical significance? Fractures of the frontal bone, maxilla, zygomatic complex, nasoethmoid-orbital (NEO) region, and mandible are the most common [1,2,3]. Clin Plast Surg. In simpler terms, panfacial bone fractures involve the midface and mandible [4]. A Comparative Prospective Study of Two Different Treatment Sequences i.e. Bottom Up-Inside Out and Topdown-Outside in, in the Treatment of Panfacial Fractures. Second, symphysis could be fixed more stable than condyle, and with two-point rigid fixation of symphysis, condyle could be stably corrected following symphysis. The sequence of reduction and fixation in special condition like the panfacial bone fracture involves the bilateral condyle fractures. 2007;65:2459-2465. J Maxillofac Surg. However, he also emphasizes the importance of the outer facial frame and that the NEO fracture should be treated within the fronto-maxillary and zygomatic frame. In cases of bilateral condylar fractures, Pau et al. Frontal bone, bilateral naso-maxillary and zygomaticomaxillary fracture and mandible parasymphysis fracture was observed. [PubMed] [Google Scholar]8. Single fixation of condyle fractures are may become unstable during symphysis correction. Therefore, experts often recommend the outside-in sequence for reconstruction of panfacial bone fractures. (A) An example of a panfacial bone fracture. Yang R, Zhang C, Liu Y, Li Z, Li Z. 1989;16:105-114. As NEO fracture fragments are fragile, it is difficult to find a stable fixation point in naso-ethmoid-orbital area. Medial frontal bone could be a suitable starting point to manage the multiple



fracture segments when comminuted nasoethmoid-orbital bone fracture was not combined.Independently measuring the reliability and efficacy of the insideout sequence is challenging because the sequence alone is not sufficient in treating panfacial bone fractures. Multiple dislocations of the facial skeleton. Given that the malar projection is the most important part in panfacial bone reduction, we prefer the outside-in sequence over the inside-out sequence. Even experienced surgeons find restoration of the original facial architecture difficult because of the severe degree of fragmentation and the loss of all reference segments that could guide the start of facial reconstruction [4,5]. Pau M, Reinbacher KE, Feichtinger M, Navysany K, Karcher H. We believe that the frontal bone is strong enough to provide the supported needed for reducing the nasomaxillary and supraorbital rim buttresses.This 61-year-old male was injured by bicycle accident. 1989;16:93-104. [PubMed] [Google Scholar]12. Gruss and Phillips [11] advised starting panfacial reconstructions with reduction of the zygomatic arch and malar projection to establish the outer facial frame and to provide upper facial width and projection before NEO, maxillary, and mandibular reconstruction (Fig. Gruss JS, Phillips JH. Because of this, the bottom-to-top sequence is widely used in craniofacial surgery today.As no clear classification of panfacial bone fractures is available, various sequences of reduction (bottom-to-top, top-to-bottom, inside-out, and outside-in) are used in combination to restore facial contour. (B) The sequence of panfacial bone management was occlusion plane, symphysis/parasymphysis, bilateral condyle, and zygomaticomaxillary fracture.In the absence of bilateral condylar fractures, surgeons generally find the outside-in sequence to be the most reliable sequence for panfacial bone correction because malar projection and condylar height are the most important point to decide the facial contour. However, a consistent sequence cannot be applied because of the wide variations in facial bone fractures. Tullio A, Sesenna E. Among the sequences, the bottom-to-top and outside-in sequence is reported to be the most widely used in recent publications. Herein, we review the efficacy of the inside-out sequence for the reduction of panfacial bone fractures.Panfacial fractures are usually caused by high-energy injuries (e.g., motor vehicle or gunshot injuries) [7]. Complex facial trauma: the evolving role of rigid fixation and immediate bone graft reconstruction. Most of these fractures were suitable for outside-in approach. [PubMed] [Google Scholar]13. He D, Zhang Y, Ellis E., 3rd Panfacial fractures: analysis of 33 cases treated late. The condyles determine the facial posterior height, and restoration of this height allows the mandible, which is the strongest bone of the facial skeleton, to be used as a template for panfacial bone reduction [14]. We have not experienced a complicated case like Pau's report [14], which is presented with fractures of the mandibular symphysis combined with bilateral extracapsular condylar fractures. [PubMed] [Google Scholar]15. [PubMed] [Google Scholar]10. Why should we start from mandibular fractures in the treatment of panfacial fractures? In this article, we intend to find the reference and discuss the efficacy of inside-out sequence in facial bone fracture reconstruction.Keywords: Panfacial. Base sequencePanfacial bone fractures are defined as facial fractures simultaneously involving the upper, middle, and lower thirds of the face. Panfacial fractures account for 4%-10% of all facial fractures. Merville [15] suggest the frontozygomatic suture line should be reduced first in panfacial bone fractures because this important structure determines facial width and projection. Otolaryngol Clin North Am. 1991;24:93-101. [PubMed] [Google Scholar]3. Br J Oral Maxillofac Surg. 2012;70:1386-1392. The most common site of mandibular fracture is the symphysis (33.5%), followed by the condyle (31.1%) and body (17.1%) [9].In the 1980s and early 1990s, craniofacial surgeons established the principles of wide exposure and direct visualization of fracture alignment for accurate craniofacial bone reduction. The concept of facial buttresses was emphasized as the key to restoration of skeletal framework, and panfacial reconstructions began with the reduction of the frontal bone and proceeded with the midfacial bone alignment.

Sialadenitis (sialoadenitis) is inflammation of salivary glands, usually the major ones, the most common being the parotid gland, followed by submandibular and sublingual glands. It should not be confused with sialadenosis (sialosis) which is a non-inflammatory enlargement of the major salivary glands. Sialadenitis can be further classed as acute or chronic.

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