anterior pillar and extending outwards for about three-quarters of an inch. The tonsil is now forcibly pulled out, and a blunt dissector is pushed behind it from above. It is then systematically teased from its connections. There is no recurrence of glandular tissue after this method of removal, and healing is, as a rule, complete within ten days.

W. Milligan.

Donoghue, F. D.—*Cervical Adenitis with reference to Mouth Infection.* "Bost. Med. and Surg. Journ.," March 28, 1907.

The conclusions of this paper, based on 300 cases, are:

(1) Enlarged glands of the neck are not, primarily, tuberculous, and bear the slightest relation, if any, to general or pulmonary tuberculosis.

(2) They are due to a mixed infection of pus-producing bacilli.

(3) They will quickly resolve if the source of the infection is removed before the glandular tissue becomes disorganised.

(4) If disorganisation takes place the gland should be poulticed until it is practically liquefied. It should then be opened by a stab-puncture, emptied and drained.

(5) Cases seen late, with a large mass of partially calcified and partially disorganised glands present, call for a thorough and extensive dissection.

Macleod Yearsley.

PHARYNX.

Freer, Otto T. (Chicago).—*New Method of Removing Adenoids through the Nasal Fossæ.* "Archives Inter. de Laryngologie, d'Otologie," etc., September—October, 1906.

Dr. Freer advocates the removal of adenoids by means of a special pair of forceps modelled on those of Ingals. He passes the forceps through the fossæ, and with the left forefinger in the post-nasal space engages the adenoid tissue. A general anæsthetic and cocaine locally is used.

Anthony McCall.

NOSE.

Cohn, G. (Königsberg).—*Old and New on Nasal Tuberculosis.* "Arch. f. Laryngol.," vol. xix, Part II, 1907.

The author of this paper discusses some still undecided questions in regard to nasal tuberculosis. After reference to several recent contributions to the subject, he gives the conclusions to which his own observations have led him. He believes that although the occurrence of intermediate forms renders impossible an absolute distinction between nasal lupus and nasal tuberculosis, yet most cases are easily referable to one or other of the following types.

(*a*) Lupus. The patients are usually young and otherwise healthy individuals. The disease, which may be accompanied or not by lupus of the neighbouring skin, at first often presents the appearance of a simple eczema of the vestibule. Later, nodules and granules are found, most

frequently on the anterior part of the septum, but also on the turbinates and the floor of the nose. The progress is slow, and there is little disposition to break down. The tendency to healing under appropriate treatment is considerable, although recurrences are frequent.

(*b*) Tuberculosis. The patients are generally ill-nourished and the subjects of advanced tuberculosis of the lungs, the larynx, and often also of the pharynx. Ulceration is frequent, tumour formation less so; the bone is very rarely affected. Progress is fairly rapid, and death is usually not long delayed.

Lupus of the exterior of the nose originates, in Dr. Cohn's opinion, most frequently at the anterior nasal angle, that is, the point at which the alar and triangular cartilages meet at the anterior margin of the nasal orifice, a small space which can only be satisfactorily seen by rhinendoscopy. For this purpose the author employs Professor Gerber's mirror.

Lupus of the nasal mucosa is very frequently primary, and may persist for months or years, unaccompanied by any other tuberculous affection.

Thomas Guthrie.

Kramm (Berlin).—*To what extent can we depend upon Intra-nasal Treatment in Chronic Suppurations of the Frontal Sinus and the Ethmoidal and Sphenoidal Cells?* "Zeitsch. f. Ohrenheilkunde," vol. lii, No. 1.

The author considers that it is possible, in most cases, to make intra-nasally a wide opening into the frontal sinus and to curette parts of it, as also the edges of a portion of the anterior ethmoidal cells, and to remove almost completely the middle and posterior ones, as well as to make a wide permanent opening in the sphenoidal. Comparing this with Killian's operation, he is of the opinion that the latter is the only one available for the orbital ethmoidal cells, that it is the best one for the treatment of the frontal and frontal ethmoidal cells; it is the more favourable one for the treatment of the most anterior cells covered by the uncinate process and also for the clearance of the sphenoidal, because, by the extra-nasal operation this is attacked from in front, while, by the intra-nasal one it is attacked from in front and below. For the removal of the middle and posterior ethmoidal cells and the extensive opening of the sphenoidal, the intra-nasal operation has completely taken the place of Killian's. It, therefore, appears that both methods are nearly equally good for the treatment of the most dangerous sections of the accessory cavities, especially those parts lying near the lamina cribrosa, with the exception of the orbital ethmoidal cells. In cases in which the intra-nasal operations, carried out as described in this paper, do not succeed in completely removing the patient's discomfort, they are, nevertheless, neither superfluous nor useless, but have the following advantages: (1) the chiselling open of a healthy frontal sinus is almost excluded, as, in view of the large access afforded by the intra-nasal operation, it can, in almost every case, be made out with certainty whether there is suppuration in the frontal sinus or not; (2) before the carrying out of an external operation the internal one renders it possible, by probing from the nose to the wide opening of the frontal sinus, to decide as to the extent, but more particularly the height, of this cavity, whereas the selection of the most suitable extra-nasal operation is facilitated; (3) the indications for extra-nasal operation are more simple and sure; (4) Killian's operation runs a quicker and safer course in cases

of multiple sinusitis, as it involves only the frontal sinus, the orbital cells, and the anterior ethmoidal cells; for the removal of the last, the section of the upper half of the frontal process of the superior maxilla is often sufficient, and this can be carried out with a correspondingly smaller skin incision. *Dundas Grant.*

Carter, W. W.—*Primary Carcinoma of the Inferior Turbinated Body, with Report of a Case.* "Medical Record," March 16, 1907.

The patient was a female, aged thirty-eight. On examination a cauliflower-looking mass attached to the anterior extremity of the right inferior turbinated body was found. Its backward extensions could not be properly determined. There was a serous and non-fœtid discharge from the nasal passage. A piece of the growth was removed, and found, upon microscopic examination, to be a typical columnar-celled epithelioma. After free opening-up of the nasal passage the growth was found to be confined to the inferior turbinated body. The whole of the external wall of the nasal cavity down to, and including a portion of, the floor was removed, together with the inferior and middle turbinates, and a large portion of the anterior wall of the antrum.

The special points of interest in the case are:

(1) The extreme rarity of primary cancer of the nose, and especially of the inferior turbinate.

(2) The age of the patient, few cases having been met with before the age of forty-five. *W. Milligan.*

Coffin, Rockwell A.—*A New Operation for Correction of the Nasal Septum.* "Boston Med. and Surg. Journ.," January 17, 1907.

The author considers the most objectionable features of the "window operation" to be the length of time required to perform it, and the "strain" to patient and operator. He claims to overcome both objections in the operation described.

He performs his operation in two short sittings. At the first sitting a "more or less perpendicular" incision is made anterior to the deviation, and the muco-perichondrium raised as far as the edges of the deviation. The space thus made is injected with sterilised vaseline, and the nose left for one week. At the end of that time incision is made on the opposite side and anterior to the first cut, and the muco-perichondrium raised. The deviation was then removed and a pledget of antiseptic cotton introduced for twenty-four hours. *Macleod Yearsley.*

LARYNX.

Glas, E. (Vienna).—*On Cysts of the Larynx.* "Arch. f. Laryngol.," vol. xix, Part II, 1907.

Dr. Glas distinguishes the following varieties of laryngeal cyst:

(1) *Retention cysts of the infra- and intra-epithelial glands.*—The most common situation for cysts of the infra-epithelial glands is the anterior surface of the epiglottis, but they are sometimes found on one of the four situations occupied by the "glandulæ aggregatæ" of Luschka. Cysts of this nature on the true cords are extremely rare, owing to the