conditions mentioned above. Such signs have given me the clue to appropriate treatment.

The effects upon the nose of chronic intestinal toxæmia also merit more attention than has been accorded to them. Many of the cases of varying turbinal hyperæmia (with or without accompanying septal abnormalities) clear up with remarkable rapidity when the toxæmia is treated. They are really instances of disturbed vasomotor conditions, and are often subjected to the tragedy of galvano-cauterisation.

I am, Sir, yours faithfully,

August 21, 1916. MACLEOD YEARSLEY.

NOTES AND QUERIES.

PULMONARY SUPPURATION AFTER TONSILLECTOMY.

In the *Interstate Medical Journal* Dr. H. Wessler has published a skiagraphic study of the pulmonary inflammation due to aspiration, which sometimes follows tonsillectomy. He applies the term "lung suppuration" as more accurate than abscess or gangrene of the lung, which describe only a possible phase of the process. At the Mount Sinai Hospital, New York, he has examined with the X rays eight cases of pulmonary suppuration following tonsillectomy. These formed as high a percentage as 28 of all the cases of pulmonary suppuration observed in the same period. In all a general anæsthetic had been administered—a procedure which stands in close relation to the complication. After an incubation period of a few days symptoms of broncho-pneumonia begin. Later, evidence of suppuration—chills, high fever, and purulent expectoration—supervenes. In practically all the cases the sputum was foul at some time or other. This is some justification for the designation of gangrene of the lung, but the latter is a subordinate lesion. The putrefactive organisms usually cause small areas of gangrene, and as these are sloughed out the sputum becomes fœtid. Periods of grangrenous sputum alternate irregularly with others in which there is no distinctive odour. Hæmoptysis is a very constant symptom, and varies from a slight brownish discolouration of the sputum to the expectoration of a pint of blood. Pain is frequent, and due to associated pleurisy. A predilection for the right lung was noted (six of the eight cases), and any lobe may be affected. The physical signs are frequently not distinctive, and are of the least value in diagnosis. As a rule, an area of dulness of varying extent is demonstrable with but few changes in the respiratory sounds, which are frequently diminished. In not one case were there signs of a cavity. There is evidently consolidated and poorly aërated lung, sometimes covered by thickened pleura. In six of the cases spontaneous recovery took place in from six weeks to five months. In one case recovery took place after two years—following excision of carnified lung. The remaining case is still unimproved. Skiagrams show an infiltration of the lung of varying extent. In five cases a cavity was demonstrated, in some with a fluid level which shifted on a change of position of the patient. The shape of the infiltrated area varied; in some a lobar distribution was seen; others gave the impression of a residual infiltration involving only the small portion of a lobe. Unless the lower lobe is involved there is no restriction of the movement of the diaphragm. When present, cavities are easily recognised as lighter areas of circular or elliptical shape within the shadow of infiltrated lung. In two cases they were multiple, and in two located at the hilus. When filled with secretion they may be invisible, but come into view after copious expectoration. The process of cure may be followed by the Roentgen rays. The infiltration gradually becomes less dense and fades at the periphery until it disappears, leaving perhaps a few thickened strands for some time. But clinical cure may be associated with persistence of the infiltration. Whether in such cases recrudescence follows cannot be said.

BOOK RECEIVED.

Throat and Ear Troubles. By *Macleod Yearsley, F.R.C.S.* With 12 Illustrations. London: Methuen & Co., Ltd. Price 1*s.* net.

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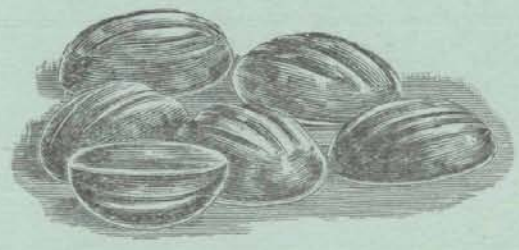

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