All structures below the level of incision were apparently normal. In about a month of comfort the cicatrisation began to reappear and the man was again incised and given a rubber bougie to pass several times daily. He then was lost sight of for five months, during which time he had failed to use the bougie, and fresh incisions were called for. He was then given metal tubes to use so that the tissue might not re-contract.

Dr. J. H. Bryan commented on the obstinacy of these cases, and had found all plans unsatisfactory. He had tried the flap operation, bringing the upper and lower edges together and trying to form a posterior pharyngeal wall, yet there had been contraction, and his patient was very uncomfortable.

Observations on the Variety of Germs Present in Wounds Following Operations on the Faucial Tonsils.

By Dr. Alexander W. MacCoy (Philadelphia).

Some twenty cases were examined. Of these nine showed mostly staphylococci and streptococci. One showed the predominating organism to be a short, stout, spore-bearing bacillus. In another it was a short, stout, unidentified bacillus, singly and in pairs. In nine of the cultures there was no predominating organism, but colonies of cocci and common mouth bacilli. In four of them, however, a large diplococcus was found, and in two irregularly beaded bacilli. In one culture there were proteolytic colonies which digested the blood-serum; in none of the cultures were the Klebs-Loeffler bacilli found. The author concluded that there was no predominating organism in the pseudo-membranes; that mouth bacteria were to be found in all cases in varying quantities, the cocci being the most numerous, and that cultures would most often show staphylococci and streptococci, due probably in part to their greater hardiness on artificial media.

(*To be continued.*)

Abstracts.

PHARYNX AND NASO-PHARYNX.

Barnes, H. A.—*Hæmorrhage after Tonsillectomy.* "Boston Med. and Surg. Journ.," January 26, 1911, p. 119.

The author thinks the chances of post-operative hæmorrhage after tonsillectomy are no greater and probably not so great as in the old operation. The three spots most prone to bleed are the anterior and posterior pillars at their lower halves and the base between them. He describes the operation as performed by himself. In dealing with post-operative hæmorrhage three methods are available, short of tying the external carotid: (1) Simple pressure; (2) ligation of the bleeding point or points; (3) suturing of the faucial pillars. Any of these methods should be done under ether given in the sitting position.

Macleod Yearsley.

Parish, Benjamin D.—*A Case of Subcutaneous Emphysema; an Unusual Complication Following the Removal of the Faucial Tonsils.* "Laryngoscope," November, 1910, p. 1046.

Swelling of the neck was noticed as the patient was recovering from the anæsthetic (ether). He quickly became cyanosed, and when the author saw him the entire neck was puffed out, the head extended, and both cheeks and the right eyelid were swollen. Crackling on pressure could be felt over these regions and "as far down as the last rib anteriorly." The jaws were prised open, the tongue pulled out, the head and neck bent forward, and restoratives administered. The emphysema could be felt over the chest for two weeks. Recovery.

The author supposes that the dissection, though it was not unusually deep, had penetrated the superior constrictor, and that air was forced through the wound into the neck by the struggling expiratory movements with a closed mouth. During the operation the posterior faucial pillar on the left was button-holed, but the author did not think that this was the point of entrance of the air. *Dan McKenzie.*

Kœnig, C. J.—*Removal of the Faucial Tonsils, followed by Basedow's Disease.* "New York Med. Journ.," December 24, 1910, p. 1275.

The case was one of a young lady, aged twenty-eight, in whom a double tonsillotomy was performed for repeated sore throats. Typical Basedow's disease appeared four to five months later. The author discusses the possibilities as to the connection between the operation and the exophthalmic goître, and suggests that it is quite possible that the repeated throat symptoms for which operation was performed may have been forerunners of the Basedow's symptoms. *Macleod Yearsley.*

Bryant, W. Sohier.—*Epidemic Poliomyelitis.* "New York Med. Journ.," December 17, 1910.

Epidemic poliomyelitis, or infantile paralysis, originates through infection. The author has investigated clinically the disease and believes it is infectious and contagious, the contagion emanating from the naso-pharyngeal secretions. The disease is analogous to cerebro-spinal meningitis, an outbreak of which Bryant saw among soldiers at Savannah, in 1898, which always began with naso-pharyngitis, spread by association, and succumbed to mild nasal antiseptics.

Among diseases other than epidemic poliomyelitis and cerebro-spinal meningitis which enter by the naso-pharynx are lobar pneumonia, true influenza, and diphtheria. Both the latter may cause definite paralysis. The author thinks that in all these conditions the symptoms remote from the naso-pharyngitis are not really pathological entities, but complications.

Admitting all this, treatment should be directed to the naso-pharynx, and should consist of mild antiseptic applications (colloidal silver; argyrol, 25 per cent.; protargol, 30 per cent.; chinosol 1 in 2000). Chronic infections in the naso-pharynx (diseased adenoids, post-nasal catarrhs, etc.) are likely to be serious predisposing factors. The effects of this general and local treatment of infantile paralysis have been (1) restriction of pharyngeal infection; (2) rapid recession of the febrile conditions; (3) prevention of paretic symptoms. In times of epidemic poliomyelitis all cases of naso-pharyngitis should be regarded with suspicion and treated promptly. *Macleod Yearsley.*