beautiful plates. Ferreri contributes an interesting article on the voice of eunuchs and castrati, Torrini a long account of naso-pharyngeal fibromas, and Bilancioni one on the syrinx of birds. Torrini in his article reports four new cases of naso-pharyngeal fibroma, three of which were treated by radium with great success. One of the cases had an enormous growth which protruded from the right nostril and had displaced all the bones of the face, causing very great deformity. Operation, which would have been attended by great risk, was refused and the patient was treated by applications of radium at fairly long intervals from April 1916 till December 1918, resulting in complete disappearance of the growth. Two other cases were also treated by radium and one by operation with perfect results. The whole subject is discussed at great length by the author. Many of the papers show an amount of painstaking research, to a great extent experimental, which reflects great credit on their school.

J. K. Milne Dickie.

LETTERS TO THE EDITORS

To The Editors,

The Journal of Laryngology.

Dear Sirs,—From the description given of my experiment on the human larynx intended to indicate a possible, nay probable, mechanism of the production of the air-sac in Dr Frederick Spicer's remarkable case of Laryngocele, and which is quoted by Dr Irwin Moore, it is obvious that I have not made the experiment as clear as I thought I had done.

On page 387 of the August issue of the Journal, Dr Irwin Moore refers to me as "showing how an artificial 'emphysema' of the right half of the larynx could be produced by the forcing of air under the mucosa of the subglottic space, by puncturing the subcordal mucous membrane with a needle attached to a syringe," and "this," he says, "cannot satisfactorily explain the condition in the case under discussion."

My experiment was briefly as follows:—I fixed the vocal cords in close apposition by means of a needle passed through the arytenoid cartilages, and "tensed" them by traction backwards on this needle and forwards on the hyoid bone (bringing the thyroid cartilage with it). I thus placed the cords under the *natural* conditions for phonation. I then blew air in the *natural* way up through the trachea from below, as in phonation, and produced a vocal tone. In the next place I passed a recurved knife from above through the glottic chink, and

made a cut in the mucous membrane below the edge of one cord. The blowing was then resumed and a swelling developed in the ary-epiglottic fold, the ventricular band and the floor of the ventricle.

The appearance, if not absolutely identical with that seen in Dr Spicer's case of "laryngocele" (laryngeal pneumatocele), was so very like it as to warrant the opinion that the same mechanical factors might have operated in both, and that the existence of an opening in the mucous membrane below the edge of the vocal cord, whether traumatic or ulcerative, could "satisfactorily explain the condition in the case under discussion."

The swelling commencing as an emphysema, may by the breaking down of the connective tissue be reasonably expected to develop into a pneumatocele, the wall of which is formed in part by the everted saccule and ventricle, when these ultimately become detached from their moorings by the pressure of the air.

I hope to prepare a more detailed account of my experiment.—Yours faithfully, JAMES DUNDAS-GRANT.

LONDON.

THE EDITORS,

The Journal of Laryngology.

DEAR SIRS,—I wish to draw attention to the fact that nearly all text-books on Ear, Nose, and Throat Diseases repeat the old diagram indicating the site of incision in peritonsillar abscess. The incision is made by means of a knife, or sharp-pointed forceps, through the substance of the palate. I do not think this is right and I always approach the abscess, by suitably curved tonsil pressure forceps—long artery clamps—through the inner wall of the abscess between the pillars and above the tonsil. Here the tissues perforate like wet blotting paper. Following this, I insert a gloved finger and break down any septa and push down the upper pole of the tonsil partially detaching it. This drains well. As I believe the tonsil should be enucleated at a subsequent date, there are fewer adhesions to encounter and the operation is more successful. Again, incision of the palate, to me, is bad practice.

In evacuating intra-tonsillar abscesses I insert the forceps between the anterior pillar and the tonsil, and pass them down to the capsule, withdrawing them with the blades open. My finger is here also inserted to break down loculi.

Needless to say a general anæsthetic is used and the patient is immediately turned over on his face so that the mouth is facing the floor, free of the table. The head is not bent on the neck or trunk at all.