small injections should be given, so as to avoid the risk of a sudden rise of blood-pressure. As soon as it can be retained, water should be given by the rectum; then rectal feeding, and a few drops of water by the mouth, the quantity being gradually increased. But extreme caution is required in commencing to feed by the mouth in these very severe cases, lest the vomiting be brought on again.

In the fourth stage of a severe case—viz., that of peripheral paralysis—if there is difficulty of swallowing, nasal feeding is required, and in the early part of this stage "absolute rest should be the golden rule of treatment." It is doubtful whether medicinal treatment has any effect, but strychnine and galvanism may be tried.

Arthur J. Hutchison.

Cary and Lyon.—"American Journal of the Medical Sciences," September, 1901.

Pseudo-membranous inflammation of the visible mucous membranes and of the gastro-intestinal tract resulting from infection by the pneumococcus is reported. The report is accompanied by an interesting review of the few known cases of this character.

MOUTH, FAUCES, Etc.

Moure, E. J.—*Tonsillar and Peritonsillar Abscess.* "La Presse Méd.," August 24, 1901.

That abscess occurs in the parenchyma of the tonsil itself is now generally admitted. The tonsil is red and bulging, but the pillars, uvula, etc., are not affected—*i.e.*, when the case is seen early.

Peritonsillar abscesses may be divided into three main groups. Most common is the classical or antero-superior group (26 out of 46 cases); next is the posterior group (12 out of 46 cases); least common is the external group. The last group is by far the most serious. Abscesses of this class give rise early to swelling of the neck and of the glands of the neck, to fixation of the neck and of the jaw. Sometimes, having perforated the limiting aponeurosis, they spread into the tissues of the neck, giving rise to so-called lateral pharyngeal abscess. They may produce fatal hæmorrhage.

All peritonsillar abscesses ought to be opened early—within three or four days of their onset. At that time it is foolish to explore for pus with a knife, because (1) considerable, or even dangerous, hæmorrhage may be produced, and (2) the wound closes long before the abscess cavity has had time to heal up. It is much safer to use a cutting galvano-caustic point, which is aseptic, almost painless, and produces a wound that will remain open from eight to ten days. Tonsillar, antero-superior, and posterior abscesses are generally pretty easily opened (details are given in the paper); but to open an external abscess is often both difficult and dangerous. In these the galvanic knife is plunged through the whole thickness of the tonsil towards its upper third, then is drawn from behind forwards, and from within outwards to the bottom of the tonsillar fossa ($2\frac{1}{2}$ to 3 centimetres). If this has not opened the abscess, the pus may be sought for with a cannula. Even if the pus cannot be found, it is most likely that it will find its way to the incision within twelve or twenty-four hours. Hæmorrhage may also occur after ten or twelve hours.

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Sometimes, when called too late to such a case, the surgeon cannot open it through the mouth; he must then open the abscess from without, remembering that the abscess is situated much deeper than in an ordinary suppuration of the glands of the neck. The operation must, therefore, be carried out slowly and carefully under general anæsthesia.

When the abscess has healed, the tonsil and tonsillar fossa must be carefully examined and attended to, to prevent recurrence.

Arthur J. Hutchison.

Dabney, S. B. (Louisville, Kentucky).—*Chancre of the Tonsil: its Symptoms and Diagnosis.* "The Medical Times," September, 1901.

A paper read before the Louisville Clinical Society. After citing various authorities as to the previous hypertrophy of the tonsil, and as to the question of the lesion being unilateral, or even bilateral, the author mentions two cases as illustrating the various ways in which this disease can be acquired. In the first case, that of a male aged twenty-five, the infection had been conveyed by smoking the pipe of a messmate who was being treated for syphilis; in the second case, a girl aged seventeen, was found to be suffering from chancre of the tonsil, due it was supposed to some attachment existing between herself and a youth suffering from syphilis. Various other cases were mentioned in the discussion which followed. *StGeorge Reid.*

Hopkins, F. E.—*Malignant Disease of the Tonsil.* "Boston Medical and Surgical Journal," October 17, 1901.

A paper read before the American Laryngological Association, May 23, 1901. In it the author first refers to the rarity of the disease, and cites various authorities on the subject. He considers that carcinoma of the tonsil recurs at a later period of life than sarcoma, the lymphatic structure of the tonsils having then undergone certain retrograde changes, the epithelial structure persisting. He deals at length with the various symptoms and the question of diagnosis, and mentions several cases. *StGeorge Reid.*

Hopkins, F. E. (Springfields, Mass.).—*General Anæsthesia in Operations upon the Nose and Throat: Nitrous Oxide, Chloroform, and Ether.* "Boston Medical and Surgical Journal," September 12, 1901.

A paper read before the American Laryngological Association. The author, speaking of nitrous oxide, although he recognises how generally it is employed in England, considers that the disadvantages, such as brevity of unconsciousness, struggling, etc., outweigh its advantages with adults or children old enough not to be alarmed by the apparatus. He employs nitrous oxide first, and follows it by ether. He considers that the danger attending the administration of chloroform in these cases precludes its use; ether he has had considerable experience with, and believes that in many cases it has advantages over either of the above. He refers to the method of giving ether by the rectum for operations on the throat and nose as requiring care in its administration, but in some cases being very satisfactory. *StGeorge Reid.*

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