and transient, and may be disappearing when lesions at a distance are in full pathologic activity.

In the case of tubercle bacilli the primary lesion may be scarcely noticeable, while the secondary glandular infection is accompanied by marked symptoms. A girl aged fourteen of the tuberculous type, but in whom no sign of tubercle had previously appeared, had an attack of tonsillitis which followed the usual course and soon subsided. The lymphatic glands on one side of the neck then gradually swelled and threatened to break down, and were removed by operation. Under the microscope tuberculous lesions were found in the extirpated glands, and guinea-pigs inoculated with the pulp were infected with tuberculosis. The tonsil may be the starting point also of various other infections. The author quotes a rare case recorded by Heubner ("Deutsch. Med. Woch.," August 13 and 20, 1903) of fatal general infection with oïdium albicans of tonsillar origin in a child aged sixteen months.

In view of the possibility of serious infections through the tonsils, the author advocates the immediate use of antiseptic methods for the mouth on the least sign of sore throat in delicate persons, also local applications of iodine to the tonsils; and he advises removal of the tonsils when affected with recurrent acute attacks or with chronic enlargement.

Chichele Nourse.

NOSE, NASO-PHARYNX, AND ACCESSORY SINUSES.

Foucher.—*Interstitial Injections of Paraffin for correcting certain Deformities.* "Montreal Medical Journal," January, 1904.

Foucher reports two cases recently operated upon by him, both being cases of nasal deformity. Photographs being taken before and after treatment, and enlarged by magic lantern, show the details of the deformity, and the perfect correction through paraffin injections.

Price Brown.

Leon E. White.—*Resection of the Nasal Septum with Report of Fifteen Cases.* "Boston Medical and Surgical Journal," April 21, 1904.

This article is the result of two years' work by a new method of operation, described originally by Otto Freer. The advantages given by the author are: (1) Accuracy; (2) Splints are not needed; (3) Rapid recovery; (4) Lack of pain; (5) Short after-treatment; (6) Freedom from sepsis; (7) Free respiration in forty-eight hours; (8) Applicability to both bony and cartilaginous deflections; (9) Creation of utmost possible space; (10) Lumen of concave side is never lessened. The objections are: (1) Adaptability to a limited number of cases; (2) Long and tedious operation; (3) Difficult operation; (4) Hæmorrhage.

The operation and the special instruments needed are fully described. It consists essentially in making a vertical incision anterior to the deflection with, in extensive deflections, a second parallel to the nasal floor and meeting the base of the former cut. The muco-perichondrium is then dissected up and rolled upwards. The cartilage is incised and the mucosa on the concave side separated, and the denuded cartilage removed by cutting forceps. As much of the septal bone and cartilage as is necessary having been removed, the flap is replaced and adjusted with sutures.

passed by special strong curved needles. The nose is cleansed and packed with cylindrical plugs on the side from which the deviation has been removed. The concave side does not need packing. In forty-eight hours all packing is removed. *Macleod Yearsley.*

Wiener, Joseph.—*Operation for Congenital Saddle-nose by the introduction of a Celluloid Plate.* "Med. Record," April 16, 1904.

The author made an incision one quarter of an inch long in the median line in the under surface of the nose. Through this small incision a subcutaneous flap was made over the depressed bridge of the nose. A piece of celluloid an inch long, one half-inch wide, and one-thirtieth of an inch thick after sterilisation was introduced through the incision and pushed upwards to occupy the space made by the subcutaneous flap. It was then moulded into proper shape, and the original incision was closed by one suture.

The author speaks highly of the result obtained, and recommends the procedure. *W. Milligan.*

Percy Fridenberg.—*The Necessity for Supplementary Measures after the Removal of Adenoids.* "Archives of Pediatrics," April, 1904.

The author points out that nasal respiration is by no means automatically established after the removal of adenoids. He insists upon the necessity of coaching the child in nasal breathing, teaching it breathing exercises, ordering cold sponges, and plenty of open-air exercise. Thorough and prolonged mastication, even to "gum chewing" is recommended. Finally, it may be necessary to close the mouth at night. The dentist's aid should be called in to prevent overcrowding of teeth and malformation of the jaw. *Macleod Yearsley.*

Gruening, L.—*Orbital Cellulitis; Empyema of the Ethmoid Cells and the Frontal Sinus; Abscess of the Frontal Lobe; Pneumococcæmia; Death.* "Medical Record," February 6, 1904.

The patient, a male aged twenty-six, was admitted into hospital with swelling of both eyelids upon the left side, impaired mobility, and downward and forward displacement of the eye. The left pupil was slightly larger than the right. Marked tenderness was found to exist over the frontal bone, but not over the frontal sinus. There was a left-sided nasal discharge. Temperature 103·8° F.; pulse 76; respiration 26.

An incision was made along the upper and inner orbital margin, when the periosteum of the os planum and of the roof of the orbit was found to be softened and perforated at several points. The ethmoidal cells were found to be full of pus. The frontal sinus was opened from the orbit and found to contain pus, polypi, and an exostosis. After cleansing the cavity was packed with gauze. Practically no improvement resulted. It was decided to explore the interior of the cranium. This was accomplished by an extension of the original operation. Upon exposure of the dura pus was found to well up through a perforation upon the under surface of the left frontal lobe. This opening was enlarged and was found to lead into an abscess cavity within the substance of the brain. After evacuation of pus and shreds of broken-down brain-tissue, drainage was effected by strips of gauze. Coma, however, supervened, and death resulted. No autopsy was allowed.

W. Milligan.