the middle ear and the endocranium were evident from certain well-defined signs. Did it follow from that circumstance that at the first attack, whether localised or diffuse, we ought to open extensively and to extirpate the greater part of the labyrinth? Apart from the fact that it was possible, while desirous of tackling an affection undoubtedly very serious, to provoke an affection necessarily fatal—meningitis, to wit, he believed that it was advisable to act with prudence and to avoid being too radical, all the more so as the results of bold and hasty operating were far from encouraging. And further, generally speaking, the best surgical measure, and that which was most satisfactory to the clinician, was not that which seeks to extirpate as completely as may be the affected organ to the uttermost limits, and even beyond the uttermost limits, of the disease in the hope of curing it. The surest method, in his opinion, was that which followed the clinical indications. In cases of purulent retention setting up septicæmia and pyrexia, and in cases of the hypertension of the humours whereby pain is provoked, simple opening, relief of tension, and drainage of the infectious focus were called for—only that, and nothing more; while at the same time the general powers of resistance were aided and augmented. And in these conditions it was known to all that in the infected labyrinth, in those cases which were capable of being cured, local reactions were sooner or later set up as a natural process which led to the encysting of the focus of disease and to its isolation from the dangerous neighbourhood of the meninges.

Abstracts.

NOSE.

Dickson, T. A.—*In Situ Antrum Trocar.* "Laryngoscope," May, 1910, p. 562.

A curved cannula fitted on to a trocar on the principle of the Lichtwitz trocar. After the antrum is punctured the cannula is left *in situ*, in order to permit of daily irrigation of the cavity without the necessity of puncturing anew each time. The cannula is provided with a "bump" to prevent its being blown out by the patient. The author recommends it in acute cases only. *Dan McKenzie.*

PHARYNX.

Rolleston, J. D. (London).—*Vincent's Angina.* "The British Journal of Children's Diseases," July, 1910.

The author defines Vincent's angina as a faucial lesion, usually of unilateral distribution, characterised by deep ulceration of the tonsil and adjacent structures, a peculiar fœtor, and enlargement of the corresponding lymph-glands, and ætiologically associated with the symbiosis of two organisms—a fusiform bacillus and a spirillum—described by Vincent in 1896 as present in hospital gangrene, and again in 1898 in the lesion to which his name has been given. He summarises the result of his experiences as follows: Vincent's angina is an uncommon disease, occurring in 0·9 per cent. of all cases of sore throat, and in 4·9 per cent. of cases of non-diphtheritic angina. During a five years' period of observation in a hospital population of all ages the affection was confined to children between two and sixteen years. No instance of contagion were observed. Its incidence was greatest in the spring, least in the autumn. It was not found to show any predilection for weakly children or for cases of oral sepsis. There is nothing characteristic in its prodromal symptoms. There are not two distinct varieties of Vincent's angina. The ulcerative is merely a later stage of the membranous form. Constitutional symptoms are slight or absent, but the local affection is more pronounced than in diphtheria. Association with other diseases is uncommon. The prognosis is favourable. Complications are infrequent and usually insignificant. Treatment consists in the local application of tincture of iodine or methylene-blue powder. Internal medication is usually unnecessary.

Dundas Grant.

THYROID.

Mumford, J. G.—*Graves' Disease.* "Boston Med. and Surg. Journ.," June 2, 1910.

The author's conclusions are: (1) Graves' disease is due to abnormal activity of the thyroid gland. (2) In advanced cases degenerative changes in the gland may lead to a shifting symptom-complex, ending at last in the positive signs of myxœdema. (3) The histology of the gland in Graves' disease indicates shifting, advancing, and retrograding symptoms. (4) An enlarged thymus is nearly always found *post-mortem* in patients dead of Graves' disease (5) Advanced Graves' disease may exist without the presence of all the classical symptoms. (6) The disease can nearly always be cured if taken early. (7) The sera of Rogers and Beebe cure a goodly percentage of cases. (8) Through neutral hydrobromate of quinine, as used by Forchheimer and by Jackson, is found a large percentage of improvements and of cures. (9) More than 70 per cent. of patients are cured by partial thyroidectomy. (10) Treat the case early by rest, by sera and hydrobromate of quinine; if no improvement results in two months operate by thyroidectomy, and always regard the operation as the surest cure.

Macleod Yearsley.

EAR.

Randall, B. A. (Philadelphia).—*How far is Heredity a Cause of Aural Disease?* "Amer. Journ. of Med. Sci.," July, 1910.

The writer deprecates the tendency displayed by some authors to ascribe undue importance to hereditary influences in the causation of ear disease. Especially in regard to ostosclerosis he considers it very doubtful whether heredity plays the important *rôle* so often assigned to it, and points out that the proof of genuine otosclerosis being, even in observed cases, far from positive, must in the unexamined relatives rest almost on pure assumption. He attributes some importance to a special susceptibility of the mucous membrane in some families to catarrhal troubles, and holds that some influence should be ascribed to peculiarities of structural configuration which are certainly inherited. He claims, therefore, that predisposition alone can fairly be claimed as a factor in the inheritance of ear disease, and the degree of this is not likely to be agreed upon by the authorities.

Thomas Guthrie.