In adolescents and adults the operation can be done under gas alone in most cases; indeed, a rapid operator will frequently remove in the time allowed by N_2O anæsthesia tonsils, adenoids, and the posterior ends of the inferior turbinals. What a rapid operator will do under gas only an average operator will do easily under gas and ether.

Gas and oxygen is perhaps slightly better than gas or gas and air, but for these operations the apparatus is rather inconvenient, and, as a matter of fact, he finds that gas or gas and ether meet our demands. The purified chloride of ethyl used as a general anæsthetic is still under trial.

What do the critics of these methods say? Their first objection is that the operation cannot be satisfactorily and completely done under this form of anæsthesia. Now, this method has been in vogue at the Metropolitan Throat, Nose, and Ear Hospital and at the Central London Throat Hospital for twelve years, during which time 20,000 cases have been so operated upon. Is it seriously suggested that the surgeons attached to these two hospitals have not learnt in twelve years whether or not they can clear a naso-pharynx of tonsils and adenoids in the time allowed by a gas or gas and ether anæsthesia? If at these hospitals these operations were habitually only half done would there not be an ever-increasing backflow of recurring cases? As a matter of fact, the percentage of recurrences is very small, and certainly not greater than that of cases done under chloroform elsewhere. The second objection which is raised is that gas and gas and ether cause more hæmorrhage than chloroform. Even supposing that they do so, unless it can be shown that they cause *dangerous* hæmorrhage the objection ought not to be taken into account against the risk to life entailed by the employment of chloroform; but the objection is purely fanciful. Amongst the several thousands of these operations which the author has seen and assisted at he has never seen a case of alarming or even of serious hæmorrhage. *StClair Thomson.*

CORRIGENDUM.

Dr Dundas Grant, the writer of the portion of the Retrospect of Otology in our last number dealing with the discussion as to the value of intranasal operations in the treatment of chronic non-suppurative disease of the middle ear, desires to amplify certain statements made in that paragraph. To the sentence, "Dr. McBride advanced the opinion that chronic catarrh of the middle ear was never benefited by the removal of a nasal obstruction," Dr. Grant would wish to add the words, "as distinguished from an obstruction in the naso-pharynx." Dr. McBride also stated that it was quite probable that very marked obstruction of the anterior nares might cause catarrh of the naso-pharynx and Eustachian tubes, but that in such a case the obstruction would be so marked as to warrant interference for other reasons. Dr. Scanes Spicer advocated the rectification of nasal stenosis in the early stages of catarrhal otitis, especially when this is recurrent, and before permanent hyperplasia and adhesions in the middle ear had ensued, and not in advanced cases of catarrhal hyperplastic disease with adhesions, or in sclerosis, or in labyrinthine disease, with the idea or promise of curing deafness.

The writer regrets that in the Retrospect the views of these speakers were not more clearly set forth.