A very important fact noted was that the lesions existed, especially at the bottom of the crypts, at the base of the tonsil, so that were the superficial portion of the organ alone removed the greater portion of the disease would remain in the stump. In conclusion, tonsils should be removed in young children:

(1) When they are much hypertrophied, interfering with respiration and thoracic development, affecting deglutition and speech and favouring infection of the naso-pharynx and middle ear.

(2) When they are small and submerged and clinically of the tuberculous type, accompanied by cervical adenitis.

(3) When chronically inflamed and giving rise to attacks of fever without any other apparent cause.

(4) When suppurating and associated with entero-colitis.

In older children and adults:

(1) When chronically inflamed in rheumatic subjects.

(2) Whatever their size, when the seat of acute inflammatory attacks (relapsing abscess, simple recurrent lacunar tonsillitis, etc.) leading to functional troubles or keeping up relapsing anginas, rhino-pharyngitis, otitis or laryngitis.

The following are given as contra-indications to surgical treatment.

(1) Any inflammatory attack or recent congestion.

(2) During epidemics of influenza, eruptive fevers, diphtheria and mumps, it is better to wait.

(3) In cases of suspected hæmophilia.

(4) During menstruation.

(5) In cases where general anæsthesia is refused but is absolutely necessary for performing the operation.

(6) When the operation is refused.

In the last two cases caustics (chromic acid, trichloracetic acid, and nitrate of silver) are recommended to be applied down to the bottom of the crypts.

Concerning the methods of removal, the merits and demerits of tonsillotomy and tonsillectomy are very fully discussed, and the technique of the respective operations described at length. A copious bibliography is appended. *H. Clayton Fox.*

## LARYNX.

**Monson.**—*Foreign Body in the Larynx; Report of a Case.* "The Cleveland Med. Journ.," April, 1910.

A female child, aged six months, in whom a piece of tinfoil remained lodged in the larynx for three months, the child dying some few days after a low tracheotomy. *Macleod Yearsley.*

**Prota, Prof. G.** (Naples).—*Two Cases of Traumatic Laryngoplegia from Wounds in the Neck.* "Archiv. Ital. di Laring.," 1909, p. 165.

The author contributes an interesting account of the history and literature of this affection. He gives full clinical notes of two cases of his own. In one the left recurrent was wounded either by the weapon itself or by inclusion in the cicatrix of the deep wound. The second man had five stabs, one of which necessitated ligation of the left jugular and common carotid. Owing to necrotic changes the latter vessel had to be tied a second time a few days later lower down. There was hoarseness from the time of the injury, and the laryngoscope showed complete

paralysis of the left vocal cord. After healing there was an ugly cicatrix on the side of the neck, pressure on which or turning the head to the right produced attacks of spasmodic cough. In both cases electrical treatment was tried, but the patients disappeared before any result was attained. *James Donelan.*

## ŒSOPHAGUS.

**Jackson, Chevalier.**—*Œsophagoscopic Removal of Open Safety-Pins by a New Method.* "Laryngoscope," April, 1910, p. 446.

The method is devised for the removal of safty-pins lodged in the œsophagus point upward. A special forceps having sharp pin-like points seizes the safety-pin by the ring in its centre; the forceps and pin are pushed onward into the stomach, in the free cavity of which the pin is easily and safety turned so that the point is now downward. If the pin is small it can be withdrawn through the tube; if large, the forceps carrying the pin and the œsophagoscope are withdrawn together.

*Dan McKenzie.*

## EAR.

**Rolleston, H. D.**—*Rheumatic Nodules on the External Ears.* "Brit. Med. Journ.," August 6, 1910.

Man, aged twenty-one, who developed tophi, during an attack of acute rheumatism, which diminished in size during convalescence.

*Macleod Yearsley.*

**Schwarz, Gottwald.**—*On the Application of the Röntgen Rays to Otology.* "Monats. f. Ohrenheilk.," Year 44, No. 6.

The apparatus for this use, says the author, must be of the highest order so as to minimise as far as possible the many difficulties which this form of investigation presents. It must be furnished with means for taking instantaneous pictures, and the best tubes are those of medium hardness. It is claimed that the following data can be obtained from this means:

The character of the bone (diploëtic, pneumatic, sclerotic), distribution and size of the cells, thickness of the cortex, size and thickness of the labyrinth capsule, size and shape of the mastoid process, of the pyramid, of the ridge of bone separating the two cranial fossæ, of the tympanic ring, of the mandibular fossa, and of the tegmen antri, size and position of the outer and inner meatus, position and depth of the sigmoid sinus; position, and frequently form and size, of the vestibule with the ampullæ. Position of the cochlea. Also often, and in children always, one can detect the antrum (its position and form), the attic (though this seldom), the cochlea, the canals, and the jugular bulb.

Herschel has also utilised the rays to control the decalcification of bone in the preparation of microscopical specimens, which is of course less detrimental than testing the condition with a needle.

Foreign bodies, such as bullets, can of course be localised, but for this the screen is more convenient.

Fractures of the base of the skull may also be detected, though this the author admits may be difficult.

In both acute and chronic inflammation of the middle ear the rays afford great diagnostic help. Pictures are taken in two positions—the one with the head lying on the side and the ear on the plate, whilst the tube is placed vertically over the contra-lateral parietal eminence. The