superior meatus to keep patent the opening to frontal sinus if possible, and placed an astringent tampoon well to the floor of the nose.

Very shortly my patient, within an hour, was a great deal easier—he said he was a hundred times better, in fact, also no pain whatever. Next day still free from pain, and tenderness over the orbital wall of the frontal sinus was very much lessened, while the edema of the lids and protrusion of the eyeball was somewhat reduced. Antiseptic and astringent sprays for a few days were used, together with frequent catheterization of the frontal sinus. I was much inclined to look upon the case as one of malignant disease, the eye trouble being due to cellulitis caused by infection from the frontal sinus or infection through the orbital plate of the ethmoid bone. The patient was anesthetized in order that I could more thoroughly explore the cavity, and if possible scrape away more of the mass and get a passage to the pharynx Again I removed a great deal of necrotic debris, pus and blood, the latter being very copious. Exploring with my finger I found a very large cavity situated in the posterior part of the nostril, containing at the bottom a large pulpy mass, through which it was necessary to go to reach the posterior nares; from the size and direction of the cavity it probably communicated with the orbit through the orbital plate of the ethmoid bone. I was able to feel bare bone except above the region of ethmoidal cells. With one finger in the pharyngeal vault, I could feel a probe passed through the mass to the posterior nares. I finished clearing out the superior meatus, and left the larger mass alone.

I had sent some of the large scrapings to Dr. H. B. Anderson, who on pathological examination proved my suspicions correct. Dr. Anderson writes me as follows:

"Microscopic examination of the tissue removed from the nose shows a small round-celled structure, supported by a small amount of delicate and exceedingly vascular struma. The walls of the blood vessels are thin and poorly developed. I consider the tissue to show decided evidence of malignancy."

I should have mentioned also that there being a history of an ulcerated second bicuspid of the right side, followed by facial neuralgia, I decided to explore the antrum of Highmore. On attempting to open through to the antrum under the inferior turbinate bone, I was met with a plate of bone exceedingly hard, so I desisted here and secured easy access to the cavity through an alveolus of a second bicuspid, which had on some former occasion been removed. The lotion I irrigated with came away perfectly clear, though none came through the nostril. Following the last nasal curettage there occurred for the first time a continuous oozing of pus from the nostril, which