the linear cicatrix which results can hardly be discovered. I am not an advocate, however, of making the superficial incision at a remote point and dissecting up the tissues until the gland is reached. This method has been recommended in the neck in order to avoid the appearance of a scar on the exposed portion of the neck; the connective tissue is opened up very extensively and a very large subcutaneous wound made, through which infection may readily occur over a wide area. I believe this to be an exceedingly dangerous procedure.

When the gland is reached and exposed it is best removed by a clean dissection. When early attacked the gland may be dislodged by enucleating it with the finger nail, but if there have been any strong adhesions formed to the surrounding parts these are best divided by means of knife and dissecting forceps. Occasionally the gland is so mattted to the surrounding tissue that it cannot be defined; the only method of proceeding in such cases is to scrape out the central caseous mass and remove by scraping, and possibly by aid of the dissecting forceps and scissors, as much of the gland and capsule as can be thus detached. If an abscess exists, its relation to the gland must be made out. It will not do to simply open the abscess and drain; we must remove the cause of the suppuration here as in the other cases of pus formation. Evacuate the contents, then scrape the walls thoroughly, then hunt for the gland, and not infrequently we will find the gland outside the abscess wall,and communicating possibly with the cavity by a small opening. I was able to demonstrate this to my class of students a short time ago when, after opening a tubercular abscess in the neck, and thoroughly scraping and cleansing it, I found on careful examination a gland about the size of a hazel nut lying outside the abscess wall, and communicating with the abscess cavity by a small flask-like opening. The condition was, of course, due to the fact that the abscess had developed, not in the gland, but in the tissue round about it, and the gland formed practically part of the abscess wall.

The use of lint or gauze, introduced on a pair of pressure forceps, will be found very useful to swab out the cavity of an abscess or of a caseous gland; the caseous detritis may thus be removed very efficiently. After thus thoroughly cleansing the cavity, further caution is required in order to secure a good result. We must remember that the pus and the caseous material may be entirely removed, and yet the actively tubercular tissue *immediately under the capsule* may be left. We have removed it as far as possible by scraping, but a further safeguard should be employed, and this is best done by the use of pure carbolic acid. This may be introduced on a little piece of absorbent wool held in a dressing-forceps, and the interior of the cavity thoroughly swabbed with it. After such treatment, if we feel confident that we have an aseptic wound, we may unite by