test that such inflammation may occur and be a cause of orbital disease . It has long been matter of clinical experience that orbital cellulitis may follow infectious disease, such as scarlet fever, measles, typhoid, tonsilitis, etc., and there is strong evidence that in many of these cases the primary involvement was in the antrum. Much information may be derived from an X-ray study of sinus conditions in children and in the diagnosis of disease of these cavities in adults. In all suspected cases of primary sinusitis care should be exercised to exclude the presence of a foreign body in the nose and intranasal syphilis. Syphilis of the superior maxillary, however, is rare in children and when syphilitic periostitis does affect the orbit the diagnosis is rendered easy by the evidence of periostitis elsewhere in the body. Other factors causing orbital cellulitis may be found in suppurating dacryocystitis and erysipelas in very young infants from birth wounds. Posey agrees with Birch-Hirschfeld in considering orbital periostitis from all causes comparatively rare in children. Treatment consists in early evacuation of the pus and establishment of proper drainage, through the body of the superior maxilla if it also is the site of disease. In making the incision the position of the globe should be taken into account as well as the limitations of its movements. The point of election for incision is the lower outer angle of the orbit, the knife penetrating the tissue with the blade in a horizontal direction and as near the bone as possible. Following the knife a grooved director should be inserted and moved all around to open up additional pockets of pus and to determine the condition of the periosteum and underlying bone. Where the diagnosis has been made early simple incision may suffice. Later it may be necessary to remove sequestra. Special attention should be directed to the alveolar border and all loose teeth should be removed. If the autrum is involved early trephining should be tried and proper rhinologic treatment be given. After evacuating pus drainage should be established and the dressing changed daily. If desirable to wash the wound with injections it should be done cautiously to avoid infiltrating the orbital tisues. Prompt healing may follow early incision, and even with necrosis the bone will regenerate if the periosteum is saved. If deformities of the lids occur they should be corrected by plastic operations some months after all acute symptoms have subsided. The article is illustrated.

A HOSPITAL SYMPOSIUM.

In the *Journal of the American Medical Association* for 9th November, 1912, there appeared a symposium of papers on several phases of hospital work. The abstracts of these articles, as prepared for the J. A. M. A., are as follows: