anæsthesia is sufficient for the removal of adenoid tissue, and in my experience cocaine saccharinate is preferable for use in all affections of the upper passages. It is decidedly sweet in taste, always antiseptic, causes less pharyngeal discomfort, and equals other preparations of cocaine in anæsthetic properties. Antipyrin and cocaine may be combined when a prolonged anesthesia is required. The forceps and curette should both be employed, and if the amount of tissue is considerable, several sittings should be given for its removal. Care must also be exercised in the use of instruments, and some antiseptic haemostatic applied after each sitting.

(*b*) Oro-Pharynx. The treatment of diphtheria has been so thoroughly discussed in all the journals, that the writer will only state that in his opinion antitoxine serum cannot yet be accepted as the final remedy for the treatment of diphtheria.

FOLLICULAR TONSILITIS.—Early treatment is desirable, as many of these cases subsequently become peritonsillar and suppurate. Cleansing sprays and the application of any good antiseptic will cause the disappearance of the follicular secretion and membrane in from 5 to 7 days. This period may be considerably shortened and the constitutional symptoms modified by local applications of creasote carbonate and the administration of two-drop doses of guaiacol every 4 hours. Whiskey and 1/100 of a grain of strychnine sulphate should be given at the same time, as they relieve the extreme exhaustion which is so marked in all cases of acute follicular throat trouble.

Mycosis of the tonsil and pharynx resists many forms of treatment. The cautery point introduced at a white heat destroys the growths in many of the follicles, and twenty-five per cent. solution of pyrozone is also very satisfactory. Occasionally a short change of climate succeeds when all other methods of treatment have failed.

QUINSY OR PERITONSILLITIS.—Unless the patient is seen early it is almost impossible to prevent suppuration. Rest, with external and internal heat, a brisk application of cocaine and arterial sedatives may abort some cases. If the history is rheumatic, full doses of sodium salicylate should be administered, as it frequently limits suppuration and modifies the whole course of the disease? Occasionally the acute symptoms subside leaving a fullness in the pharyngeal wall and tonsil and some bulging of the soft palate. This is really an abscess deep in the tissues which may remain quiescent for several weeks unless incised; sooner or later inflammatory symptoms reappear, and the abscess discharges of its own accord. After incising a tonsillar abscess the cavity should be washed out with hot water. If the opening is large, solutions of pyrozone or peroxide of hydrogen may be used to thoroughly cleanse the cavity. Peritonsillar inflammations are usually dependent on diseased tonsillar tissue in which the follicles are large and deep, also on adhesions of the pillars to the tonsils, leaving deep pockets, which are receptacles for all kinds of decomposing materials. Occasionally the tonsils are completely encapsuled by their pillars, which prevents the escape of tonsillar secretions. Preventive measures should therefore be taken in all cases of recurrent peritonsillitis, the adhesions loosened and the follicles kept free.