middle ear suppuration and its perpetuation. To an extent, I believe that surgical interference with these structures is being overdone. I believe that the practice of some in removing a normal third tonsil is pernicious. This piece of lymphoid tissue is there for a purpose—the warming and moistening of inspired air, and the lubrication of the mucous membrane of the pharyngeal vault. If not hypertrophied to the extent of causing symptoms, why should it be interfered with?

In the fossæ of Rosenmuller is found the key to the cause of many a persistent middle ear suppuration. F. P. Emmerson, of Boston,* in an admirable paper published two years ago, most clearly presented the pathology of these fossæ, and its clinical bearing. Quite frequently there is present in one or both fossæ degenerated lymphoid tissue or adhesive bands, or both, which escapes detection with the mirror. It is found only on making a digital examination. Such tissue, in even minute amount, excites a sympathetic passive hyperemia in the tympano-pharyngeal tube, with resultant impairment of its function. I make it a practice, in adult cases presenting themselves with a chronic purulent otitis, to make a digital examination of both fossæ—it is easily and quickly done; if the finding be positive it is a simple matter to clean out the fossa with the finger nail. I have had many apparently chronic cases clear up, and that quickly, after performing this simple act.

It is unnecessary to more than emphasize the importance of not overlooking such conditions as hypertrophy of the turbinates (particularly posteriorly), the presence of caries of the ethmoid cells with the resultant polypoid masses, nasal stenosis from any cause, an atrophic condition anywhere in the naso-pharyngeal tract, or a hypertrophy of any portion of the lymphatic ring.

It is necessary to keep in mind the chief anatomical differences in the position of the tympano-pharyngeal tube in the young and in the adult. It is sufficient here to recall that at birth this tube is short, straight, inclining slightly downwards from the naso-pharynx to reach the tympanum. The naso-pharyngeal orifice is on a level with, or slightly below, the floor of the nose, and the bony portion of the canal is exceedingly short. As development takes place the position of the canal changes. At two years of age we find it assuming the adult position, while at puberty this position and shape has been attained. The naso-pharyngeal orifice is now above the floor of the nose, and the tube follows an ascend-

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*Other surgeons who have called attention to the clinical bearing of the fossae of Rosenmuller are: 1. Brunk. Birmingham, Ala., 1906. 2. J. W. Jervey, Greenville, S.C., 1906. 3. F. R. Packhard, Philadelphia, Pa., 1909.