not so the inferior pair, which, in many cases, require luxation of the gland upon the surface before they can be reached and tied without the danger of including the recurrent laryngeal nerves. Rehn, Mikulicz, Reinbach, Rydygier, and Kocher have reported cases successfully treated in this way.

(*d*) Thyroidectomy. The operation which gives the best results is, without doubt, the removal of the lobe of the thyroid gland which is most diseased. The incision may be either a straight one, four inches in length, along the inner edge of the sterno-mastoid, or else an angular one (Mikulicz) or U-shaped (the collar incision of Kocher), along the anterior border of the sterno-mastoid, around the lower part of the tumor, and then up on the anterior edge of the opposite sterno-mastoid. The two latter incisions give free access to the isthmus and do not involve division of any of the deeper muscles, and moreover, the resulting scar is low and not easily seen. This flap, formed of skin, subcutaneous tissue, platysma and deep cervical fascia, is dissected upwards, all vessels cut being immediately tied. The sterno-mastoid is now retracted outwards, and the sterno-thyroid and sterno-hyoid muscles drawn aside or cut, if necessary. The pretracheal fascia, which invests the gland (the capsule of some writers), is now opened by a vertical incision in the median line and the gland is freed from its bed with the finger. This often causes considerable hemorrhage, which can be considerably lessened by first ligating the superior thyroid artery, which enters at the top of the gland, often in several branches, all of which must be separately tied if the main trunk cannot be reached. The true capsule of the gland must, on no account, be opened, or the wound will be immediately flooded with blood and this hemorrhage is with difficulty controlled. The inferior thyroid artery is next dealt with by gradually luxating the gland toward the median line. Care must be taken not to include the recurrent laryngeal nerve with the artery. This nerve, according to Sifton, of Milwaukee, is situated one-quarter of an inch further back on the left side and not so liable to injury. The artery should be secured as far away from the gland as possible to avoid including the nerve. All large veins must be tied to guard against the possible subsequent formation of a large clot in the wound. All pressure forceps may now be removed, as the circulation is fully under control.

On account of the friability and vascularity of the gland, great difficulty is experienced in holding it with any instrument, without causing laceration and hemorrhage. Wither-