within the upper pole of the tonsil; it is covered in by the plica tonsillaris, which is prolonged from the anterior pillar of the fauces. It is bounded above and in front by the capsule of the tonsil covered by a layer of lymphoid tissue, while the posterior boundary is formed by the tonsil itself. Some of the crypts of the upper part of the tonsil, and of the mucous glands in the soft palate, open into this fossa. The prolongations of the tonsil to the tongue can be seen by firmly depressing that organ with a spatula.

On rare occasions a congenital perforation is seen on each of the anterior pillars of the fauces; they should not be mistaken for syphilitic lesions.

The posterior wall of the pharynx can now be inspected. Tortuous veins are not infrequently observed coursing over its surface, but they have little clinical significance, and may be disregarded. Larger pulsating vessels are occasionally detected; they do not give rise to symptoms, but cutting operations should obviously be avoided in their neighbourhood. Granules of lymphoid tissue may frequently be found, scattered irregularly over this area, and their presence should not be overlooked, as they may cause a certain amount of irritation and discomfort.

When abnormal conditions have been found in the pharynx, the state of the lymphatic glands should be investigated, for this is frequently of no little importance in modifying prognosis and treatment.

Fig. 1.—Holding a refractory child.

Some children refuse to allow their throats to be examined peaceably; it then becomes necessary to use force. The most satisfactory way to do this without hurting the child is to have him held according to the German method (*Fig.* 1) when proceeding to operate for enlarged tonsils. A nurse takes the child