

half of the anterior pillar of the fauces to the most prominent part of the tonsil and this has been called the *plica triangularis*. If these two *plicæ* are well developed the tonsil may be almost completely hidden. The lingual tonsil is produced by a proliferation of lymphoid tissue from an accessory nodule at the base of the faucial tonsil.

Now from slight developmental peculiarities different clinical varieties of tonsils may be described.

(a) The imbedded tonsil. This is the normal type of tonsil in a child up to the age of three or four years. Looking into the throat you can scarcely see any tonsillar tissue, but on making the child retch, two globular masses come out below the soft palate and nearly touch in the middle line. This type of tonsil is hidden by the anterior pillar of fauces and by the two *plicæ*, namely *semilunaris* and *triangularis*.

(b) Sessile or flat tonsil is the normal type of tonsil found in middle life. If the tonsillar tissue of the young child is not subject to much inflammation it begins to atrophy after about the fourth year of life, so all that remains in middle life of the large tonsillar mass of the child is a few scattered masses of lymphoid tissue.

(c) If, however, the tonsils are subject to considerable inflammation after the fourth year of life, they enlarge instead of atrophying and this may go on until adult life. This inflammatory enlargement produces what is known as the prominent tonsil. It is due to a proliferation of the lymphoid tissue at the outlet of the tonsillar sac. These tonsils are easily seen when looking into a patient's throat. They stand out as if they were on a pedicle.

(d) Another type of tonsil is where the lingual prolongation is very well marked. The faucial and lingual tonsils seem to be one continuous mass of lymphoid tissue.

*Anatomy*:—The tonsils are masses of lymphoid tissue partially surrounded by a capsule and situated between the pillars of the fauces. The capsule is absent on the pharyngeal surface of the gland. Areolar tissue separates the capsule from the Superior Constrictor muscle of the pharynx. The pharyngeal surface of the tonsil is perforated by a number of orifices which lead into the tonsillar crypts. These crypts vary in number from eight to twenty. They are usually separate and pass completely down through the tonsillar tissue to the capsule. Rather more than half these crypts open in towards the pharyngeal isthmus, but the remaining ones open into the supratonsillar recess. If the *plica semilunaris* is well developed it is very difficult for this cryptic secretion to get free from the supratonsillar recess. Tonsillar calculi occasionally form from this retained material. Quinsies are also frequent in such