performed on the 3rd of March last, a piece of decaying bone two inches in length was removed, and by the end of April, the wound was entirely healed.

The third case was a healthy looking boy, aged 13 years, who had got his leg hurt by wrestling about a year previous. Usual history of such cases, pain, swelling, suppuration, and open sinuses. Examination revealed dead bone. As the sequestrum here lay upon the outer part of the posterior surface of the femur, I reached it by cutting in from the side, just in front of the tendon of the biceps. The bone was easily reached, the dead portion removed without difficulty. In six weeks the wound was healed, and the boy went home well.

What I claim for these three cases is, that they show the propriety of removing dead bone at the earliest possible opportunity, the ease and safety with which sequestra may be removed from the posterior part of the lower third of the femur, if proper care be exercised, and the frequency of necrosis, in this peculiar site. The first patient had suffered for nearly fourteen years, and was well in about 3½ months after the operation. The second had suffered for 23 years and was cured in about two months by operation. The third case had been going on for a year, but was terminated by a return to health in six weeks after operation. In all of them Esmarch's bandage was used during the operation and bleeding was almost *nil* after removal of the bandage. The drainage tube was inserted into the lower part of the wound and the rest of it brought together with sutures; carbolic oil and lint was applied to the wound and the leg enveloped in a roller bandage from the foot upwards. No bad symptoms followed any of the operations, all progressing favorably to the cure.

ON EXCISION OF THE TONSIL.*

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The question, "When should a tonsil be excised"? is an exceedingly practical one which comes up for discussion almost every day in practice. The answer it would be well if possible to define precisely. The indications for excision I consider to be the presence of symptoms either of impaired nutrition with marked obstruction to respiration, frequent relapsing, inflammation or suffering in contiguous parts.

Marked enlargement of the gland is almost sure to be accompanied by impairment of the general health, partly through the imperfect circulation of the blood, and partly also because of the broken rest at night. It is also probable that the stomach suffers from the constant swallowing of unhealthy mucus. Obstruction to respiration is a serious matter in the young, inasmuch as it causes the deformity of the chest, known as "pigeon breast." These symptoms demand the removal of the offending gland, because there is not time to wait for the slower action of internal and local remedies. The Eustachian tube and middle ear are very apt to suffer from inflammation by contiguity. The nasal mucous membrane also may, and frequently does present symptoms of severe inflammation and consequent obstruction of the nose. These symptoms also demand most urgently the removal of the tonsil.

Tonsils, the seat of chronic relapsing inflammation, should be removed. Also cases of true pathological hypertrophy of the tonsil are best treated in the same way, medicinal treatment being nugatory. The tonsils are frequently enlarged in strumous and delicate children; if there be no symptoms as before related, they are best left and treated by internal remedies, prominent among which are syr. of the iodide of iron and compound syrup of hypophosphites. Local astringents may also be used with benefit. In cases of follicular tonsillitis it is not often necessary to remove the gland. Local treatment with fused nitrate of silver on a probe applied to each follicle is generally successful. Mere enlargement of the gland without other symptoms, I do not consider to indicate its removal.

With regard to the mode of operation, the cases must be selected. For large, prominent tonsils, especially in children, the tonsillitome is, in my opinion, best suited. In moderately enlarged and very hard tonsils, in true hypertrophy and in the long, flat-shaped tonsil, the vulsellum forceps and blunt bistoury should be used. It is almost impossible, however, to use the bistoury in the case of young children, without an anæsthetic. I do not regard the danger of hemorrhage as a very

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