and we should decide at this juncture whether we have to deal with an enlarged pharyngeal tonsil or a mass of adenoid vegetations.

In very young children I do not favor the digital method, for the very small naso-pharyngeal space, made smaller by the pharyngeal spasm caused by the finger irritation, almost forces one to injure the Eustachian openings and may cause middle ear catarrh. In such cases, if mouth breathing is present I adopt what I have found to be a very useful and sure method of diagnosis, which may be called the "method of exclusion." Continuous mouth-breathing indicates some obstruction. Examine the tonsils, and if they are not or only slightly enlarged they cannot account for the stuffing up. Then examine the nostrils carefully, and if they are free the only way to account for the mouth-breathing is the presence of adenoids. So then, a young mouth-breather without enlarged tonsils or hypertrophic conditions in the nostrils has probably adenoids.

But why not use the posterior rhinoscopic mirror? I have found this means absolutely impracticable in these young cases, nor do the Vienna or London schools use it. I employ it always in older cases. In these very early cases when the tonsils are enlarged sufficiently to impair the breathing, I always take the curette along with the tonsillotome, for in about 100 per cent. of such cases adenoids are present. Then we know that adenoids are more common than enlarged tonsils in the proportion of six to five.

There is another class of cases, however, which I have been very much interested in and which I do not find discussed very often, a class in which mouth-breathing is never or only very occasionally present. The hypertrophy in these cases is very slight and yet sufficient to keep up an inflammatory condition in the naso-pharynx without stuffing up the breathing. The misleading feature in these cases is that they do not present themselves for mouth-breathing or snoring, etc., but we are simply told that they are occasionally troubled with slight dulness of hearing. We recognize the condition as Eustachian catarrh, but overlook the slight adenoid condition which is the causal factor. The chronic catarrhal condition kept up in the eustachian tubes and tympanic cavity by these as it were latent adenoids, is often the cause of a chronic dulness in hearing in after years, and in my opinion is often the forerunner of these almost untreatable cases of stenosis of the Eustachian tubes and of the slow sclerotic processes in the middle ear, chiefly around the base of the stapes. In children having this form one often sees a granular appearance of the lower pharyngeal mucous membrane. No case of ear trouble however mild is properly examined unless a thorough examination for even a slight adenoid hypertrophy has been made.