The following are the steps of the operation: First of all, tracheotomy must be performed, and the canula of Trendelenberg introduced; then an incision is carried from the body of the lower jaw, midway between the symphysis and the angle, toward the greater cornu of the hyoid bone, and thence along the anterior border of the sterno-mastoid as far as the upper extremity of the tracheotomy incision. Next, the submaxillary gland must be removed, the lingual artery tied, the stylo-hyoid and the digastric muscles detached from the hyoid bone; the pharynx is then laid bare and can be dissected out, the larynx meanwhile being drawn to the opposite side.

The principal dangers to be apprehended are peri-œsophageal phlegmon extending into the mediastinum, and pneumonia from the introduction of foreign bodies in the air passages. At the same Congress, Professor Billroth stated that six weeks previously he had removed from a woman, aged forty-two years, *the pharynx, the cervical portion of the œsophagus, the larynx, a part of the trachea, and all the thyroid gland*, for a cancer of the pharynx, involving the posterior portion of the larynx.

He first performed a preventive tracheotomy, and nine days later proceeded to operate, after introducing the canula tampon of Trendelenberg. The incision was made along the anterior border of the sterno-mastoid. In the course of the operation, Professor Billroth found that the tumor extended much further than had been supposed, and as he advanced, step by step, he found himself compelled to remove successively all of the larynx except the epiglottis, the upper rings of the trachea, a large portion of the pharynx, the œsophagus as far as the sternum, and the whole of the thyroid body. An elastic tube was placed in the œsophagus for the introduction of aliment.

During the first four weeks the patient did well, the wound gradully contracting, and the elastic tube was then removed in the hope that the pharynx would unite with the lower portion of the œsophagus and form a permanent canal for the passage of food.

After the removal of the tube, however, deglutition was accompanied by suffocative attacks and vomiting, and the canal contracted, rendering the passage of bougies necessary. In the sixth week a false passage was made in the peri-œsophageal tissue. Pericarditis and death followed.

Kolaczek, of Breslau, removed a cancer of the posterior wall of the pharynx, by a supra-hyoidean pharyngotomy, eight weeks before the Congress met.

The patient was still living at the date of the report, and was nourished through a tube placed in the œsophageal fistula. Kœnig of Göttingen, and Gussenbauer, of Prague, have also removed cancers of the pharynx, and, like Langenbeck, lost their patients through pneumonia due to the introduction of food into the lungs.

To avoid this danger, Thiersch has proposed the preliminary establishment of a gastric fistula.—*Le Progres Medical*, Aug. 30, 1879.—*Maryland Medical Journal.*

TREATMENT OF TINEA TONSURANS.—In a clinic, reported in the *Lancet* for November, 1879, Dr. Robert Liveing says:—

Nothing is easier to cure than tinea tonsurans of the trunk, or more difficult to deal with than the same disease when it is well established on the scalp. It is important that you should understand how the remedies in common use act. They may be conveniently divided into two classes—(1) Those which act by setting up sufficient inflammation in the skin to lead to the destruction of the disease; (2) Those of a milder kind, which act as antagonistic to the development of the Trichophyton tonsurans. To the former class belong such remedies as acetum cantharidis and strong acetic acid; to the latter belong sulphur ointment, the white precipitate ointment, and sulphurous acid lotion. Many remedies combine, as it were, these two properties; as, for example, chrysophanic acid ointment, iodine liniment, and strong carbolized glycerine. How are you to choose between all these and many other remedies? You must be guided by circumstances, and take into consideration both the age of your patient, and also the extent of the mischief. *Strong remedies are always contra-indicated in very young children;* a little tincture of iodine painted on twice a day, for a few days, followed by the use of the white precipitate ointment, is all that is necessary. In older children, stronger treatment must be used, but even then you must be guided in your choice by the extent of the mischief. It is very unwise to make a large sore place on the scalp, as it will very likely give you and your patient more trouble than the ringworm itself. If, however, the disease is in an early stage, and consists of one or two small circumscribed spots, your best plan is to cut the hair short all round the spots, and apply with a brush Coster's paste, acetum cantharidis, or iodine liniment. At this stage a few applications will sometimes arrest the mischief. A single painting with pure carbolic acid is thoroughly effective, but is a strong remedy and gives some pain. Always bear in mind that it is very unwise to trust strong remedies to unskilled hands. When the disease extends over a large surface, you must be content with using milder measures—tincture of iodine of double strength, painted on every day, is a good and safe mode of treatment. This may be followed up by the use of the nitrate of mercury ointment, diluted according to circumstances, or an ointment containing the red and white precipitate of mercury (10 per cent). For many years I