On the Operation for Adenoid Vegetations.

Alfred Decker (*Jour. Lar., Rhin. and Otol.*, April, 1900). Amongst 1,087 children Decker found 138 mouth-breathers, and in 114 of these adenoids were the cause of mouth-breathing. On an average amongst 1,000 patients he found 127 in whom adenoid growths required removal. He usually employs superficial chloroform anesthesia, in the sitting position. He abandoned Gollstein's curette because on one occasion a mass of adenoids fell into the larynx, causing alarming symptoms. [Taking into consideration the position and the anesthetic, one would be surprised if such an accident did not sometimes occur!—*Abstractor.*] He now uses scissors curved to fit the vault, and constructed to catch the detached tissue.

Treatment of Diseases of the Sphenoidal Sinus.

Hermann Cordes (*Monatschrift für Ohrenheilkunde*, May, 1899). The author holds that chronic sphenoidal empyema is generally secondary to some other disease of the nose or naso-pharynx, especially ozena. In this he differs from Grünwald and Michel. To get a good view of the sinus he recommends Cholewa's method. A slender elevator is introduced between the middle turbinal and septum, and the former is simply pressed outward and fractured. Under cocaine this procedure is not painful. Bleeding is slight, and the turbinal is retained and preserves its function. In most cases this manœuvre gives sufficient access to the anterior surface of the sphenoid; but, if necessary, part or the whole of the middle turbinal may be removed by snare or forceps. This is rarely necessary. To freely open the sinus he recommends an instrument on the plan of Krause's double chisel, for removing spurs from the septum.

Case of Fatal Sphenoidal Suppurations.

Samuel Lodge (*Laryngoscope*, March, 1900). The patient, aged 31, when admitted to the Halifax Infirmary, had complained of constant pain in right ear and right side of face for six months. There was also swelling on same side, and copious discharge of pus from right nostril. Had syphilis nine years previously.

The patient lived for three weeks after admission. There was constant fever. Iodides were given in large doses. Exploration of antrum excluded it from the disease. Finally cancer developed and patient died.

Owing to the excessive discharge no absolute diagnosis during life could be made. *Post-mortem* examination revealed necrosis of posterior wall of sphenoidal sinus, with free openings from it into cranial cavity and also into nose. The sinus was full of thick muco-pus. The base of the brain was also