thing in these operations is wide local dissection, and Heidenhain's rule of cutting at least 3 cm. away from the visible disease is now considered too narrow for safety. The second principle is the removal of the tributary lymphatics, and the third is to avoid traumatic dissemination of malignant cells during the operation and preventing the possibility of postoperative grafting by proper prophylaxis.

DIAGNOSIS, PROGNOSIS, AND TREATMENT OF CERVICAL ABSCESSES OF AURAL ORIGIN.

Deodato de Carli in the *Jour. of Larnygology Rhinology, Otology,* gives as the pathognomonic finding the fact that gentle pressure on the neck forces out pus from the external auditory canal or from some mastoid fistula. Prognosis is guarded, even in superficial abscesses; extremely so in lateral sinus thrombosis and perisinus abscesses. Untreated, these abscesses tend toward the mediastinum; they may spread via the lymphatics and may even end in the axilla or the back. Treatment should include mastoid operation, simple or radical, except when the mastoid is not involved, as in adenitis or abscesses about the pharynx. Used early, rest, hot application, and antiseptics about the infected area may abort them. Carbolic injections, in three per cent, strength, into a lymphoadenitis will at times arrest its development. After suppuration, incision (with or without mastoid operation, *v. supra*) must be done. Cauterization may supplement early free incisions in adenophlegmon. In lateral sinus or jugular suppuration, the vessels should be opened and ligated below the thrombus. Ligation of the jugular is done by incision about three inches long in a line running from the angle of the lower jaw parallel with the anterior border of the sternomastoid toward the clavicle, the patient's shoulders being raised, neck extended, and face turned toward the opposite side. Beneath the skin and superficial fascia the anterior border of the muscle is found, and by blunt dissection, the vascular packet is opened, the vein lying behind and opposite the artery. Double ligature is passed beneath the vein, which is then cut; the pus escapes or the thrombus is removed. The wound is allowed to close by second intention. Superficial cervical abscesses may be simply incised. Deep submastoid abscesses require removal of the mastoid tip. Lateral pharyngeal abscesses may result from extension from the neck, or may extend from the middle ear via the Eustachian tube. These should be opened externally, either premastoid or retromastoid. The premastoid method means incision along the lateral border of the muscle, and blunt dissection through the apon-