practice if the growth be large enough to snare it off otherwise use caustic and spirit. Yet one must not too lightly snare an aural polypus as is illustrated in a case occurring in the practice of an eminent London aural surgeon last summer when in an old ottorrhoea case a large polypus was thus removed. Septic meningitis immediately followed and death ensued in a few days. This case suggests the remark that it is questionable as to the advisability of removing aural polypi through the external auditory meatus but preferably to do so from their origin the mastoid antrum. But practically all cases will continue to be attacked from the outer ear, so in whatever manner whether by snare or forceps, a preliminary course of antiseptics should be used to eliminate sepsis as well we can and thereby add to the safety of our operation.

Of cauterizing agents probably those most frequently used are phenol, chromic acid, silver nitrate and the galvano cautery. Phenol is probably the best since, while possessing as much escharotic action as is necessary it is not followed by any inflammatory reaction. Frequently however in cases of small granulations the use of absolute alcohol with or without sulphate of zinc is followed by good results.

Should we have granulations existing on the posterior wall of the bony canal or on the posterior superior especially with sagging down of the superior wall we must strongly suspect mastosid involvement. Some authors say in such cases the mastoid is always involved. Here the case demands a radical operation at once delay being useless and dangerous. In cases where we can detect roughened bone either by a cotton tipped probe or a blunt one, we have a very tedious case to deal with.

At times the character of the discharge assists us in diagnosing caries. The discharge is frequently thin, brown and copious, especially when a sequestrum exists while persistence of foul odor after thorough use of antiseptics points strongly to caries. Presence of asseous particles is of course pathognomonic.

Granting we have no evidences of granulations or dead bone what course of procedure are we to adopt. Here again each case must be treated according to the conditions found. The general rule above mentioned which says remove the cause is the one to follow. If the discharge be associated with naso-pharynygeal trouble this must be corrected especially adenoids. The removal of this apparently innocent pad of adenoid tissue in the vault of the pharnyx will often work wonders. In children when practically all have adenoids my rule is to clean the pharyngeal vault in every case where there are even slight evidences of adenoid hypertrophy previous to doing anything to the ear whatever. In many cases I have completely cured a running ear of months duration by simply cleaning the pharyngeal vault of its mass of adenoids. (Case No. IV.) Maintaining the patency of the eustachian tube and the injection of various antiseptic sprays frequently add success to our treatment. The practice of injecting irriating antiseptic liquids in any quantity through the eustachian catheter should certainly be condemned.

Now comes the use of remedies applied through the external auditory meatus. Let us consider what our object is in using remedies here. I take it to be as follows: (1) Dissolving of the discharge; (2) its removal; (3)