ried, aged seventy-two, admitted to King'sCollege Hospital, March 27, 1895. Previous history unimportant. In July, 1893, had an operation performed for pain in the abdomen; nature of the operation not known; she says it was about the vagina. Previous to that she had suffered much pain in the right iliac fossa for about eighteen months. She says she was cured as the result of this operation but of late pain has come back in the right iliac region and symptoms of partial obstruction have set in more than once. When she was admitted there was a condition of partial obstruction, but this improved somewhat before she was operated on. On her admission her abdomen was a good deal distended; nothing was felt *per rectum*; *per vaginam* the interior wall of the vagina seemed scarred. On placing the hand on the right side of the abdomen the coils of the intestine are readily felt and great pain is at once felt as the result of the peristalsis set up under chloroform. A hard oval tumor is felt about the umbilicus, which moves freely in the interior of the abdomen. On April 9th the abdomen was opened aud a cancerous tumor of the transverse colon was fouud, together with enlarged glands in the mesocolon and in the neighboring omentum. The bowels were clamped by Maunsell's safety-pin method and the disease was removed. Repair by Maunsell's method. Uninterrupted recovery. Patient well when I last heard." To this Mr. Cheyne adds: "I found Maunsell's method very difficult in this case. The obstruction had evidently lasted a long time, and the longitudinal muscular bands of the intestine above were enormously hypertrophied and formed rigid bands, and the difficulty of invaginating that end of the gut was extremely great. In a case of old-standing obstruction I would not again use Maunsell's method."

9. Dr. Robert T. Morris, professor of clinical surgery in the New York Post-graduate Medical School and Hospital. The operation was performed in the writer's presence on September 19, 1895. On October 11, 1895, Dr. Morris reported the patient's convalescence to have been uneventful. —*N. Y. Med. Jour.*

A SAFE AND SURE METHOD OF REDUCING ENLARGED TONSILS.

BY H. W. KENDALL, M.D.

The etiology of acute and chronic tonsilitis seems settled in the minds of all pathologists, but my experience points to a cause entirely overlooked by all the authors that I have consulted. Superacidity of the prima viæ is in my opinion the essential cause of both the acute and the chronic disease, the catarrhal accidents being merely excitors.

I think that in every case of acute or chronic inflammation of these glands the salivary secretions will be found acid instead of alkaline, and that free doses of potassium or soda locally applied and ingested will give most rapid relief. The anatomy of the tonsil is well understood, but the great variation in the size and number of excretory ducts has not been particularly pointed out. These ducts are greatly enlarged in either acute or chronic hypertrophy of the glandular structure unless contracted by astringent or caustic applications. Since the general disuse of astringent gargles, suppurative cases are rarely seen. Cauterization, once the general practice, is now almost abandoned for the reason that it is obstructive and converts the acute into the chronic condition.

We have an efficient cauterant and at the same time an antiseptic and alterant in pure hydrochloric acid, which is always friendly to human flesh. This is the agent that I have found so efficient in reducing enlarged glands in all parts of the body, but the method of using it is the particular point that I wish to present in this short paper. My method is the use of capillary glass tubes (Bohemian or Whital and Tatum's glass), one-eighth of an inch caliber, heated in a Bunsen flame and drawn to a point, the shaft of the drawn part two inches long with caliber one sixty-fourth of an inch, broken off and fire polished. Now if the shaft of the tube is five inches long the drawn part will hold, after dipping in a fluid, one minim; if the larger shaft is increased in length it will hold more. When the point of this tube touches any substance it will deposit a fraction of the drop; by long contact it will deposit all that it contained.

I dip these tubes into pure fuming hydrochloric acid and push them into the excretory ducts of the tonsils, three in each gland at each sitting, twice a week. This operation is painless and produces no inflammation or swelling. Five or six applications are sufficient for moderately enlarged glands. Nitric acid used in the same way will produce swelling and sloughing. Chromic acid so used is rapidly effective, but I abandoned it for ever after producing tetanus in a malignant case.

The advantages of this mode of application are the ability to deposit a definite and minute amount of acid and avoidance of strangulation and choking effects of the fumes. After ten years' experience with this treatment I can quite positively say that in my opinion tonsils ought never to be removed with knife or scissors.

If a local anæsthetic is desired a saturated solution of bromide of potassium and bicarbonate of soda is better than cocaine because the latter produces subsequent delirium or dizziness with asthmatic breathing in many cases.—*Jour. Am. Med. Assoc.*