this the death was attributed previous to the post-mortem. In the third case, death was directly due to tetany.

In a previous letter reference was made to the remarkable fact of the frequent occurrence of tetany after this operation, especially in women. In the last 73 operations in the General Hospital here, there were twelve cases of tetany, eight of which proved fatal. Even those patients who do not die from tetany, appear seldom to recover completely from it. The writer has seen two cases of very well marked tetany in women following the removal of enlarged thyroids, performed three years previously. There has not been, as yet, any satisfactory explanation given of this complication. Whether it is due to injury of the recurrent laryngeal or sympathetic nerves has not been proved. Billroth considers that, at least in his cases, irritation of the recurrent laryngeal can have no influence in bringing it about, as he is always extremely cautious in his dealings with this nerve. Very recent investigations of Dr. Weiss, which will be published shortly, prove, he thinks, that in tetany there are changes in the anterior horns of grey matter of the cervical spine.

In the surgical cases of tetany, there is no remedy that seems even to mitigate the symptoms. Billroth has long ago given up performing this operation for the simple removal of a deformity. He never performs the operation now unless the life of the patient is directly in danger from pressure on the trachea.

As the method of operating is so very important, and as there is no description of it, as far as I am aware, in any of the numerous English surgical text-books, I will give the different steps of the operation as always practiced by Billroth. It is to him and Kocher that we owe the modern operation.

The incision is made along the internal border of the sterno-mastoid muscle, its length depending upon the size of the tumor. If it is very large, it is sometimes necessary to carry the incision in a semi-lunar direction to the lower end of the opposite sterno-mastoid. The fascia and omohyoid are cut through. The dissection is carefully made until the capsule of the gland is fully exposed. Here begins the first difficulty in the operation. The capsule is composed of from three to eight or more layers, and