SOME NOVELTIES IN THE TREATMENT OF NASAL POLYPI.—Dr. W. Spencer, Watson *(Lancet,)* says: In the removal of polypi, whether by snare, forceps, or cautery, it is very difficult to be quite sure that the whole of the growths has been extracted. It is probably due in part to this uncertainty that polypi are so liable to recur. Often, no doubt, rootlets or fragments of one or more of the growths remain behind. If therefore we can by more thorough extirpation avoid this uncertainty the chance of recurrence is so far diminished; for though it is possible that the diseased mucous membrane has a tendency to reproduce the same morbid overgrowth, yet, *cæteris paribus*, the more complete the operation the less will this tendency show itself. The object then to be attained is to detach the polypi as close to the bone as possible, and it is even better in some cases to remove a portion of the turbinated bones with them. It is generally tolerably easy to get away those polypi which hang near the anterior apertures of the nostrils, but for the complete removal of those more deeply situated the usual methods are often insufficient. To meet this difficulty I have devised the polypus ring-knife (made by Messrs. Krohne and Sesemann). It consists of a rod of softish steel (which allows of being somewhat bent to any desired curve), which, with the handle and the ring-knife, measures eight inches and a half. The handle resembles that of a door-key, and is large enough to admit two fingers; at the other extremity is the knife, of oval form and one inch and a quarter long, being at its widest part five eighths of an inch broad. The outside of this ring is thick and blunt, its inside beveled, and with a cutting edge extended round the semicircle farthest from the handle. The knife when used is passed along the lower part of the nostril with its sides parallel to the septum, until it reaches the posterior aperture of the nares. At the same time the forefinger of the left hand is passed behind the velum palati and hooked up in the posterior aperture of the nostril. If there are any pendulous portions of polypus in the pharynx they can now, by a little manipulation, be slipped through the ring of the knife, which is then directed by the finger toward the outer wall of the nostril. The instrument is then slowly withdrawn, and, as it passes forward, is made to scrape away the polypi from their attachments to the bone. The operation is necessarily painful, and can be best done under an anæsthetic, the mouth being kept open by the use of a Mason's gag. The instrument thus used can be directed with considerable precision, and is, I think, preferable to forceps, when the polypi are deeply seated, and especially when of the sarcomatous or firm myxomatous variety. If the antrum is involved, the blade may be passed into it after the curve of the shank has been somewhat altered. But to reach the extreme depths of this cavity the ring-knife used by Meyer for adenoid vegetations of the pharynx is well adapted. I have succeeded quite recently in clearing out the antrum with these two instruments in a case of recurrent myxo-sarcomatous polypi, without laying open the alæ nasi. In this case, however, I followed up the treatment by the application at intervals during several months after of the acid pernitrate of mercury to spots on the surface of the mucous membrane, at which there seemed a tendency to return of the growths. The application of nitric acid, or acid pernitrate of mercury or similar fluid escharotic, in such a narrow channel as the nostrils seems at first sight a somewhat formidable and dangerous proceeding; but when carefully done with the acid in the platinum canula, and under a good light from the short-focus mirror, the proceeding is not really dangerous nor painful. The platinum cannula is guided carefully to the spot to be cauterized. A pencil of wood previously dipped into the acid is then passed along it, and when it reaches the aperture in the canula is made to press against the diseased tissue. The surrounding parts are thus completely protected, and if the point charged with the acid is again drawn into its sheath before the instrument is withdrawn only a limited area of mucous membrane is touched. A slough, of course, forms, and becomes detached in the course of a week, or less. This plan has succeeded very well in some of my cases. It should, I think, be employed in all cases of polypi, whether gelatinous or sarcomatous, after the removal of the principal mass, but, of course, only after such an interval has elapsed from the time of the first operation as to allow of all swelling having subsided, and so to enable the operator to get a clear view of the parts with the rhinoscopic mirror. From three weeks to a month from the first operation is about the best period. It is, I think, only by repeated aplications at intervals of a few weeks to several months that we can hope for a satisfactory result. I am not prepared to say that this plan is never followed by recurrence of the diseased growths, but I think it offers a good prospect of retarding it in all cases, and it has certainly appeared to me to delay the recurrent form of polypi from reappearing for an indefinite time.

INCISION AND DRAINAGE IN PURULENT PERICARDITIS.—With regard to operative surgical interference in pyo-pericardium, most authorities agree in considering it a delicate and hazardous operation, to be undertaken as a last resort, and only by means of the aspirator or a fine trocar and canula.

This treatment by the use of an exploring trocar was recommended by Ramberger and Friedreich, with the subsequent injection of chlorine water or iodine, or irrigation by detergent antiseptic solutions, and is referred to also by Fothergill, who regarded it as a forlorn hope, but thought it capable