portance. It occurred 146 times only, in 459 cases of grinding the teeth.

Under which heading the symptom should be considered? It is of no doubt that it should be considered as a *reflex symptom*. The receptive field for the reflex action lies in the naso-pharyngeal mucosa, while the centripetal conductor must be the glosso-pharyngeal nerve or the rami pharyngei of the ganglion sphenopalatinum; the intermediate nerve-units probably lie in the middle brain and the efferent conductor must be the motoric portion of the trigeminus. The presence of adenoid growths is not the only condition for the appearance of the reflex. There must be, also, a certain irritability of the nerve-system, as in other reflectory sequelae of adenoids. Thus, the fact of the diminishing of the symptom being proportionate to the growing up of the children, is to be understood as a consequence of the greater resistance of the nerve-system in the grown-up organism.

PERITONSILLAR ABSCESS AND ITS RADICAL TREATMENT.

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In the April, 1921, number of *THE LARYNGOSCOPE*, Dr. Heller has a short article on the above. I have practiced this operation for about fifteen years and have never had a fatal result nor any unfavorable sequelae.

At the Melbourne General Hospital, the Childrens' Hospital and in private I have done several hundreds of cases.

Occasionally, great difficulty has been experienced in removing the tonsil completely, especially in those cases where repeated slight attacks of peritonsillitis have occurred over a period of several years. The tonsil, in such instances, is extremely firm and the adhesions are so dense that on two occasions I had to use biting forceps to remove the tonsil after evacuating the abscess. As a rule the operation does not present much difficulty, the tonsil, though firmly adherent to both anterior and posterior pillars, is fairly firm and flattened out. When it is friable, the complete removal is more

difficult and requires both patience and care. I seize the tonsil with an ordinary "blunt" reverse guillotine and strip off the anterior pillar with a pair of long, slender scissors curved on the flat and blunt pointed. After the anterior pillar is lifted off the tonsil, the scissors are passed over the tonsil and opened wide, so as to aid in enucleating the tonsil from its bed. Very often the tonsil is firmly adherent to the posterior pillar along its whole length and has to be cut away with the scissors; the lower lobe is then dealt with in a similar fashion by cutting it loose at the upper part and then passing the scissors under it and finally freeing it. Whereas, while enucleating an ordinary tonsil this part is, as a rule, better performed by pulling the lower lobe from its bed—in peritonsillar cases the tonsil is so brittle that such procedure would be ineffective. If there is any indication to justify the removal of the other tonsil, I always do so. A light general anesthesia is always used, and I never yet experienced any serious results from inspiration of pus. I mop up the pus with swabs during the first stage of the operation. In my opinion, it is infinitely preferable to the old method of opening through the palate with subsequent enucleation at a later date, which is often extremely difficult.

The patient is saved a great deal of pain and time of incapacity. I always at the first indication of any edema of palatal tissue.

I have seen one death from purulent pleurisy and pericarditis two days after the patient had refused an operation at the Melbourne hospital. It was the only time I have ever threatened a patient with immediate fatal consequences. He was getting on to the operating table, and then refused to undergo the operation. As a last resort I said, "Well, you are very foolish, you'll be dead in two days." I don't suppose that had any effect on the course of his illness, but it stopped my career as a prophet.