possibly not at the first attempt but the second attempt never fails. I have no difficulty in working in the anterior commissure through the small tube. The objection has been made that it is too small to work through. We know that Dr. Jackson operates successfully through a 4 mm. bronchoscopic tube. If one will learn to use a 10 mm. tube in direct laryngoscopy, one will never go back to the larger tubes.

In examinations in the sitting position, the head is almost or quite straight; in a few patients it has to be somewhat extended. An important point with the small tube is that it almost drops into the larynx and the posterior commissure immediately comes into view. If the anterior commissure is not seen—particularly in adults—the nurse is told to push the head gently forward when, in most cases, it comes into view. You will notice in one of the photographs that the patient is sitting with the head flexed and the entire larynx is exposed, which proves that extension is not necessary to expose the larynx.

I remove foreign bodies from the trachea in children through a short, direct laryngoscope. By manipulating the instrument I make a straight line of the mouth and trachea and of the mouth and esophagus with the head straight on the table. I have seen down in a child's esophagus with the head perfectly straight.

I start the anesthesia in adults with a Kelly forceps with the swabbing of a twenty to thirty per cent solution of alypin on the pharynx and epiglottis. After waiting a minute or two I introduce the small speculum. The epiglottis is then pulled forward and with an applicator I anesthetize the upper end of the esophagus or the larynx.

The light that I use is the tungsten lamp made by the Electro-Surgical Instrument Co. I discarded the Jackson double battery because I found that I could do as well with the small two-cell battery. With the large battery the lamps occasionally burned out, which never happens with the hand battery.

AUTHORS' ABSTRACTS.

Eye, Ear, Nose and Throat.

The Tonsil as a Chronic Infective Focus. By Henry B. Decherd, Dallas, Tex. Texas State Journal of Medicine, May, 1915, pp. 44-45.

Only very recently has the faucial tonsil been recognized as a chronic infective focus for organs and tissues of the body either nearby or far removed. Thanks to the good work of investigation by Shambaugh, Rosenow, Davis, Billings and others. "Rheumatism" from an infected tonsil has been shown to be a most common occurrence. It is now an accepted fact that usually in the child's second year, but often even earlier, the tonsil becomes a chronic infective focus, and so remains for the rest of its life, unless completely

extirpated. These early attacks of tonsillitis are rarely causative of sore-throat, and hence may not be mentioned by the child. However, he may be having constant "growing pains," chorea, "rheumatism" of muscles and joints, cardiac, renal or other involvement. So in adult life, the very tonsil that may be the most dangerous may not be the cause of any soreness at all. As a rule it is a strain of streptococcus that causes the most severe results in these cases, although the staphylococcus or other organism may be associated or in pure culture. In my own personal experience, I have had cases of chorea, endocarditis and myocarditis, nephritis, epileptiform convulsions, arthritis, neurones, et cetera, clear up completely after an adequate tonsillectomy. Between three and five every child would be better off to have its tonsils enucleated in capsule. This is of course a radical stand and will meet with strong disapproval from operators who find tonsillectomy unsatisfactory both to themselves and their patients.

Some of the More Common Inflammatory Conditions of the Eye and Their Treatment. By Hunter H. McGuire, Winchester, Va. Virginia Medical Semi-Monthly, Feb. 26th, 1915, pp. 553-564.

This paper, read before a society of general practitioners, is intended to emphasize some of the diagnostic differences which exist between the more common inflammatory conditions of the eye and to point out sources of error which occur in these cases. Stress is laid upon the importance of objective examination by oblique illumination rather than by ordinary daylight.

Ulceration of the cornea and its treatment is referred to in detail. The early use of atropine, so frequently overlooked by the general practitioners is commented upon, though attention is called to the danger of glaucoma when it is injudiciously employed in elderly persons. The use of cocaine in all forms of ulceration is strongly condemned. Holocaine is an efficient substitute, combines both an anaesthetic and antiseptic action, and has no deleterious effect upon the cornea. Direct applications to ulcerated areas and the employment of iodine and carbolic acid for this purpose are shown to be of great value in intractable ulcers. Subconjunctival injections of saline solution are also useful in combatting these infections.

The diagnostic difference between iritis and acute inflammatory glaucoma, are dwelt upon at length. Atropine, the most efficient therapeutic agent in iritis, is absolutely contraindicated in glaucoma. The medical treatment of acute glaucoma is not looked upon with favor by the author. Early operation is advocated. The article concludes with the citation of a case of intraocular tumor, in which the symptoms were identical with those of acute inflammatory glaucoma and the difference between the two states are pointed out.