with whom he came in contact, and he had the gift of embellishing his conversations with pithy and quaint remarks, which at once endeared him to those with whom he was conversing. His pride in his City and University of Glasgow was very marked, and he gave very many years of useful service to their well-being.

Dr. Barr was taken ill in the autumn last year, and from the first his physician held out very little hope of his recovery. By his death I and many others have lost a truly great and lovable friend and the profession an aural surgeon of the first rank whose work was based on the soundest clinical knowledge and experience. *Urban Pritchard.*

ORTHOPÆDIC TREATMENT OF LARYNGEAL STENOSIS.

BY CHEVALIER JACKSON, M.D.,

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IN cases of laryngeal stenosis of any kind, the testing of the ability to breathe through the mouth and the establishment of confidence in the oral breathing route have been best accomplished, in our experience, by the corking of the cannula, preceded, if necessary, by a reduction in the size of the cannula. The "cork," which is of rubber, has a slot cut in it, so that it diminishes the air passing through the cannula, but does not altogether obstruct cannular breathing. Gradually the air-leak past the cork is diminished until a solid cork can be worn while the patient is awake. The final test is during sleep. When the patient reaches the stage when sleep is quiet and restful without indrawing at the guttural fossa, at the epigastrium and around the clavicles, the cannula may be removed permanently. Of course it is necessary that the cannula be small, relative to the size of the trachea, in order to allow plenty of air to pass by it through the trachea; because it is, when corked, equivalent to a solid body of corresponding diameter. This method, developed and used for years by Dr. Ellen J. Patterson and the author, has been used successfully by a number of surgeons since its first publication.¹ In looking over the subject as there presented, it is noted that sufficient stress was not laid upon what we have called the "orthopædic" action of the method. By this we mean that in cases with more or less fixation of the crico-arytenoid joint, due to arthritis, perichondritis, or cicatricial adhesions, the enforced effort of compelling the patient to inspire through the larynx, forces the

¹ "Peroral Endoscopy and Laryngeal Surgery," by Chevalier Jackson, M.D.

maximum possible arytenoid movement upon the larynx. This tends not only to limber the stiffened joint but to develop the muscles atrophied from prolonged comparative idleness. The pull of the arytenoid upon a more or less cicatricially margined glottis tends, in time, to enlarge that glottis. In purely paralytic conditions the effect is often marked, especially if undertaken soon after the onset of the trouble. The greatest success is seen in children, in whom, naturally, one would expect the contributory aid of growth during the orthopædic treatment. For success it is absolutely necessary to have nurses trained in tracheal work, because it requires experience and good judgment to determine the amount of obstruction to respiration the child can stand without injury. The best results are obtained in cases that have not been subjected to too much ill-advised active surgery, by thyrotomy, laryngostomy, etc. Success depends largely upon the amount of the intrinsic muscular tissue remaining.

SPHENOID SINUS: PRESENT DAY VALUE OF SURGICAL PROCEDURE.

BY ROSS HALL SKILLERN.

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1. Operations.

THE recognised procedures of to-day of operating upon the sphenoid sinus can be divided into the intra- and extra-nasal. As the latter (extra-nasal) is never used except when other sinuses are co-affected, we will consider more particularly those operations which are performed through the nose. By this method the anterior sphenoidal wall is invariably attacked, although the ways and means are often divergent, as for example Schaffer (1) used a sharp curette, Spiess (2) penetrates the sinus with an electric trephine, Grünwald (3) a conchotome, Andrews (4) a curved knife, Grayson (5) a hand-burr, etc., etc., with or without the removal of the middle turbinate, but it was not until Hajek (6) published his paper in 1904 that the operation assumed a definite form in progressive steps. Briefly, his method is as follows: The posterior half of the middle turbinate was removed by means of the scissors and snare, the posterior ethmoid cells (superior turbinate) broken down with a hook and removed piece-meal, thus baring the anterior sphenoidal wall. This ostium of the anterior wall he removed in its