form best seen as an early post-diphtheritic phenomenon, to the incomplete variety of early bulbar palsy.

The conditions under which palatal palsy may be met are:

1. Diseases interfering with the nucleus ambiguus in the medulla oblongata, these are (a) chronic bulbar paralysis, in which is found a progressive bilateral degeneration of the nerve cells. (b) Tabes dorsalis, a state in which the degeneration of the nucleus may be on one or both sides. (c) Symptomyelia, characterized by new growth formation extending upward into the medulla oblongata and involving the nuclei of origin of the nerve root.

2. Implication of the nerve root between their emergence from the side of the bulb and their exit from the cranium through the jugular foramen. The causes of this are numerous, but are chiefly meningeal, *e. g.*, syphilitic, and malignant affections of the membranes of the basis cranii.

3. From the pressure of malignant, tubercular or other growths deeply in the neck upon the bunch of the vagus before the pharyngeal branches are given off.

In conclusion, it may be stated, that the evidence is in favor of the *tensor palati muscle* receiving its nerve supply through the motor division of the fifth cranial nerve. Stimulation of this nerve, after the mucous membrane has been removed from the soft palate, has shown obvious contraction of the fibres of this muscle. (Henri, Rethi.)

Extirpation of Soft Palate and Tonsil for Carcinoma—EDWARD H.

LEE—*Medicine*, February, 1898.

The patient, a man aged fifty-three, had good family and personal history. No cause could be found for carcinoma except smoking. The trouble had existed nine months at the time of operation. Swallowing became painful the second month and had increased up to a point of not allowing the swallowing of solid food. The tumor involved the whole soft palate and left tonsil and was one inch in diameter. The microscope established the diagnosis of carcinoma. The submaxillary gland was enlarged.

The first step in the operation was the ligation of the external carotid to control hemorrhage; the second, inferior tracheotomy and packing the larynx with gauze; the third, temporary resection of the symphysis of the inferior maxillary bone and drawing the tongue into the space thus formed to make room for work; the fourth, the removal of tumor by dissection and suturing incised edge to mucous membrane of the hard palate with the interrupted suture. Six months after the operation there was no sign of a return of the tumor.

EWING. (BISHOP.)