

method of entering the antrum with a sharp trocar through the inferior nasal meatus, with occasional infections of the pterygo-maxillary fossa from propulsion of the instrument after sudden penetration of the bony wall, as well as accidents from entrance of the point of the trocar into an orbital cell, determined to discard the sharp-pointed trocar for a smooth tipped rasp modelled on those used by Vacher, and by Watson-Williams for penetrating into the frontal sinuses intranasally. The rasp enables him to make an opening long enough and large enough to facilitate irrigation, and to avoid premature closure of the artificial opening.

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**Bony Occlusion of the Posterior Nares.**—WHITE, in a somewhat elaborate essay with abundant references (*Laryngoscope*, August, 1918), describes and depicts an operation of his own which he has performed with a favorable result in two cases therein reported. Under the free use of adrenalin the bony plate of obstruction is perforated with a long, flat chisel held close to the septum, and a triangular section is removed. The bone is then punched out as thoroughly as possible and the rough edges are smoothed off with a mastoid curet. The posterior end of the septum is then removed with rasp or curet and after being carefully smoothed off is covered with mucous membrane which had been previously detached and elevated for the purpose. After careful removal of all shreds and wiping the nose clean, each nasal passage is packed with a strip of gauze covered with cargile membrane or with rubber tissue. This packing should be removed in twenty-four hours, when the subsequent treatment will be only such as may be needed to keep the nose clean and free from crusts. If the operation has been done thoroughly no further packing will be necessary, nor will there be any need for wearing any device to keep the openings patulous.

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**Sarcoma of Orbit Mistaken for Ethmoidal Mucocele Successfully Removed through the Killian Incision.**—COFFIN reports (*Laryngoscope*, December, 1918) this case: After the usual Killian incision as for an ethmoidal operation, it was found that the anterior border of the naso-orbital wall had been absorbed. Dr. Coffin removed this wall well back toward the apex of the orbit cavity. The entire contents of the orbit appeared smooth and covered with an aponeurosis. As his finger moved over the surface he noted a slight depression as between two avoid bodies, and he introduced a curved periosteal elevator into this sulcus when the growth popped out free and clear. It proved to be an encysted sarcoma.

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**Epiglottectomy by Transthyrohyoid Access.**—BEAUSOLEIL in an elaborate paper (*Revue de Laryn., d'Otol. et de Rhin.*, February 15, 1919) extols an operation for excision of the epiglottis in cases of morbid growths, cicatricial adhesions from disease and injuries, and other conditions. Two cases operated upon by Prof. Moure are recorded, one for epithelioma of the epiglottis and the other for cicatricial stenosis between epiglottis and arytenoids after a wound in warfare so serious as to require immediate prophylactic tracheotomy. Neither of these cases seems very convincing as to the value of the procedure, the first