pital three years ago, complaining of nose-bleed. The tongue condition was discovered at this time, and the patient stated that it also had been bleeding for some weeks, but only at the time of eating. The patient has always been well with the exception of scarlet fever when nine years of age. As a child, she had bled from the gums between the central incisors. Nose-bleeding commenced at fifteen to sixteen years of age. At the present time she is under treatment for epistaxis, which is responding to cautery treatment.

The interesting features of the case are the family tendency to bleeding, and the method of treating the lip and tongue. The patient says her father's face was similarly affected, and her mother states that he had frequent nose-bleeds. He also suffered from tuberculosis, but died from dysentery. Her only brother is troubled with bleeding from the nose. A sister is troubled with nose bleeding and has spots on the tongue similar to those shown by the patient. One sister died of scarlet fever when young.

This family history is rare. Osler's investigations up to 1901 showed but one case reported, that of Rendu. Osler added three cases at that time, and Dr. Van Wagenen of this Section added another two years ago. This case would have been reported earlier, but has been deferred on account of an ineffectual effort to present the brother and sister at the same time. This may be done at another time.

Dr. Law has been treating the case by the application of fulguration to the budding capillaries with very satisfactory results, reducing the size of some and causing the disappearance of others. He gave twelve or fifteen treatments, and then the patient stopped coming as she said the bleeding had stopped and the treatments were somewhat painful.

Cancer of Larynx; Hemi-Thyroidectomy, Total Laryngectomy. DR. MACKENTY.

The case was presented because of peculiar and interesting conditions.

The woman, referred to me by Dr. Howel, gave a history of hoarseness existing for many years. Last fall this grew worse, and her larynx rapidly closed up. In December, Dr. Dowd inserted a tracheotomy tube for the relief of dyspnoea, and she wore this for a month before she was admitted to the Manhattan Eye, Ear and Throat Hospital. She suffered much from attacks of spasmodic choking not due to lack of air, but to irritation in the larynx. On looking into the larynx the vocal cords were seen lying against each other, and the larynx was filled with thickened tissue, not typically malignant. Two examinations of the tissue at different laboratories were both positive. The patient also had a large thyroid gland.

Six weeks ago I operated. The right half of the thyroid gland, part of the isthmus and the entire larynx were removed. The end of the stump of the treachea was curved forward and sutured to the skin. The first ring was removed to get a flap of mucous membrane tension, stitches were taken in the second ring so as to hold the trachea forward. Then the mucous membrane and skin were carefully sutured, the object being to eventually secure a continuous epithelial lining into the trachea, so that the patient would not have to wear a tube and have subsequent contraction.

The patient was fed through a tube inserted through the nose into the esophagus at the time of operation and left in place during the period

of convalescence, (three weeks). This is a very important feature. It is not well to feed these patients by introducing a tube at every feeding for it increases the danger of false passage and infection. The tube should be left in place until the wound is fairly well healed. If removed too soon, it is sometimes difficult to replace it.

The patient developed a good deal of infection in the neck, as is usua. The fact that she had an infected sinus prior to operation, made it more difficult to secure asepsis. On one side was the cut wall of the thyroid, which was also a source of irritation. The infection was quite severe and the posterior wall of the trachea sloughed away for three-fourths of an inch, and a fistula opened into the hypopharynx. There was a gutter between the mouth and the trachea. This was another condition that showed the advantage of using a feeding tube in the esophagus and so avoiding the danger of the food falling into the trachea. To obviate the gravitation of saliva, the wound was kept packed with gauze, frequently changed.

After the infection was checked, the wound closed up and at the end of six weeks there was a good wound and an opening into the tracheal presenting a good muco-cutaneous junction. The tracheal tube will in all probability be unnecessary.

The feeding after the operation is most important. Dr. MacKenty said that he fed these cases on a mixture of milk. oatmeal, strained milk and sugar, butter and oil. This makes a thick mixture which is forced into the stomach, and gives a fairly well balanced food product. It is a mistake to try to feed such cases on milk alone, or even on milk and eggs. Sugar, butter and cereals should be added.

Dr. MacKenty said that this was the only case he had seen or heard of where the thyroid had to be removed in order to do a laryngectomy. The after treatment is as important as the operation. Each case presents new problems. Two things are strongly indicated: Sustaining diet and a trachea kept clear of secretion. The suction pump used frequently during the day and night has been of great help in carrying out the latter indication. If feeding by esophagus became impossible, I would not hesitate to do a gastrostomy at once under novocaine anesthesia.

Occlusion of Larynx Following a Cut Throat. DR. MACKENTY.

Seven months ago this patient was brought to Dr. Mial's service in the Morristown Hospital with a cut throat. The larynx was terribly hacked. With much difficulty a tube was inserted and his life was saved. This tube was inserted through the crico-thyroid membrane.

The patient has come now to see if something cannot be done to relieve the obstruction of the larynx, which is complete, resulting from the severe injury at the time of cutting.

The first step was a low tracheotomy, putting the tube over the sternal notch, and removing the tube above. That was done three or four weeks ago. The upper wound is slowly healing. It will be necessary to wait until it has entirely healed and the larynx is quiescent, and then see how much space, if any, there is in the larynx for breathing.

Dr. MacKenty said that the case was presented to get the opinions of the members of the best methods of procedure from then on. It was his intention to do a laryngo-fissure and make an attempt to remove the thickened tissue from beneath the mucus membrane, covering as much