

Clinically, the observation is curious in view of the latence of cerebral symptoms, which were not suggestive of any invasion of the encephalon. It shows, too, once more, the prudence requisite in undertaking extirpation of nasal growths, for there was no serious contra-indication in this instance, and yet, in all probability, sudden death would have ensued during an operation.

It is interesting, too, as a fresh example of the tolerance of the brain, and particularly of the frontal lobes, to lesions which should apparently have determined death, or at least grave nervous symptoms long before they had reached the extent they had undergone.

In concluding, the remark is made that, as both frontal lobes were equally affected, there could be no assumption that the unknown functions of one side had been here supplemented by an intact homologous region of the other side.

A NEW METHOD OF NASAL IRRIGATION.

PINS, of Vienna (*Mercure Medical*, April 20, 1890; *Rev. de Lar.*, etc., August 15, 1890) uses a small Wolfe bottle, to the longer tube of which a mouthpiece is attached by rubber tubing, while a nozzle is similarly attached to the short tube. The patient blows the liquid into one of his nasal passages, and, as the forced expiration occludes the rhinopharynx, the liquid escapes by the other nostril.

POSTERIOR HYPERTROPHIES OF THE TURBINATES.

DR. HARRISON ALLEN, of Philadelphia, in an excellent clinical article (*University Med. Mag.*, August, 1890), enforced by a number of briefly narrated cases in illustration, shows that direct surgical interference is by no means always necessary. When the anterior end of an inferior turbinate body is small and well located above the floor of the passage, he finds it much better to apply astringents or caustics to the free inferior border, which is apt to impinge upon the floor of the passage, or to operate with the view of increasing the diameters of the nasal passages by resecting the triangular cartilage and drilling away superfluous projections from the septum; plans which in his hands have been quite successful in reducing the bulk of the posterior masses.

He urges care to avoid mistaking for posterior hypertrophies a normal condition due to a congenital defect of the vomer, which he has termed *recedent*. Thus, when the vomer unites with the floor of the nose at the region of the maxillo-palatine suture, the posterior ends of the turbinates will approach each other, and even come into contact from absence of the septum which would have kept them apart, so that they appear to be protruding into the free space of the rhinopharynx.

Several instances are narrated in which treatment of concomitant pathological conditions succeeded in curing, or greatly relieving, catarrh and asthma without any topical treatment of the posterior hypertrophies; complete relief ensuing in some of the cases even without any diminution of bulk in the posterior hypertrophies. In other cases the posterior swellings diminished or disappeared.

Dr. Allen concludes that it is a good rule to suspend treatment of posterior hypertrophies until all other morbid conditions have been carefully corrected, when, indeed, it may be found, as in three of the instances cited, that they will not require treatment at all.