

In the case of Clara Tucksmith the temporary arch (Figure 8), corresponded very well with the curve based upon a width of .36 inch shown by the radiograph of the unerupted permanent upper centrals. But the permanent arch (Figure 9) is deficient in that the centrals are placed at a re-entrant angle and one entire side needs lateral expansion. The radiograph of the unerupted upper centrals showed this indentation of the upper centrals. This was only slightly foreshadowed by that of the temporary centrals. This might have been corrected by moving the temporary teeth.

I am under obligation to Drs. Gillet, Young, Fairchild and Bogue for advice and assistance in this work.

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Complications After Adenectomies. DR. MAX LEWY, Charlottenburg. *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 5, Heft 2, 1912, p. 247.

In removing this chronically inflamed vascular organ, frequently containing encapsulated suppurating foci, we set a wound surface similar to that in infected abortus. We should, therefore, expect post-operative complications in nearly every case. The perfect drainage of the wound-secretions and the drying action of the respiratory air enhance healing.

The writer reports the following interesting complications following adenectomy: (1) Scar-formation, simulating syphilis; (2) torticollis, being practically an acute myositis of the pre-vertebral muscles; (3) fatal septic exanthem; (4) acute middle-ear suppuration with fatal meningitis, 7 days after the operation; (5) arthricular rheumatism; (6) septic letal diphtheria.

As prophylactic measures, the writer recommends postponing the operation when the patient suffers from an acute disease or when there is a case of sickness in the patient's family. GLOGAU.