

symptoms from that seen in the white race. Atrophic rhinitis was seen in one case only, which would seem to disprove that theory making large nasal passages a predisposing cause for this condition. No case of chronic maxillary abscess was seen. It is a well-known fact that few negroes have bad teeth. Syphilitic lesions were frequent, as also purulent rhinitis in the young, which readily yielded to antisyphilitic treatment of the old regime—i. e., mercury and iodid of potassium.

Pharynx, epipharynx and larynx. There were one hundred and six cases involving these parts, by far the largest percentage. Diphtheria is exceedingly rare in spite of the poor hygienic surroundings of many of these people. Laryngeal tuberculosis occurred only twenty-three times. Laryngeal and pharyngeal syphilis, two hundred and seventy. Adenoids and enlarged faucial tonsils occurred two hundred and ninety-six times, which refutes the statement made several years ago that adenoids are very infrequent among the negroes.

DISCUSSION.

DR. CHARLES W. RICHARDSON, Washington: In the main my observation is in accord with Dr. Roy's, but this is not the case with regard to the apparent immunity of the negro to diphtheria. For a number of years I had charge of the diphtheria ward in the Government Hospital in Washington, which was, in fact, the municipal diphtheria ward. There were practically no negroes in it. I do not remember a case of laryngeal diphtheria in any of the wards. I never intubated a negro child in my whole experience.

My experience is not in accord with Dr. Roy's with regard to the presence of adenoids and enlarged faucial tonsils in negro children. I think some of the worst cases of adenoids I have ever seen and operated on have been in negro children. Some years ago I was inclined to believe that negroes do not have this condition, but latterly, probably in consequence of school inspection, they come into the clinics in great numbers.

Syphilis among negroes is quite general in Washington as well as in Atlanta.

True Myxoma of the Rhinopharynx—Report of Two Cases. DR. VIRGINIUS DABNEY, WASHINGTON.

Extreme rarity of true myxoma anywhere in the body, but especially in the rhinopharynx, leads to report of two cases. Some pathologists reject entirely the term, believing no such pure tumor exists. However, sections show absolute absence of any fibrous elements.

Case 1.—Tumor seen on drawing forward soft palate. Under ether, large adenoid curette fitted over growth which was removed from attachment to the basilar process. No recurrence after ten months.

Case 2.—Two growths found at operation. Only one could be seen at examination; smaller attached to basilar process, larger to posterior ethmoid. Both were divulsed with large adenoid forceps. Patient had had similar growth removed eleven years before. Photographs of growths and of microscopic sections were given.

DISCUSSION.

DR. HARMON SMITH, New York City: This must be the exception which proves the rule. It has been definitely stated by many histologists and

pathologists that true myxomata do not occur in this region. In the majority of instances myxoma has sprung from the ethmoid or somewhere else; mixed fibroma and myxoma, on the other hand, arise in the nasopharynx. So far as I know, there has been no other case reported of true myxoma springing from this region.

DR. JAMES E. LOGAN, Kansas City: I would like to ask the nationality of these patients, especially the one with the very large growth. It often happens that these growths appear in individuals of certain nationalities. Those of Scandinavian birth are more apt to have them than any other class of patients. I have had two pathologists at variance on two cases, one operated by myself and the other by Dr. Fenger. One pathologist said there was every evidence of myxoma, the other, that it was fibroid or myxofibroma. The tumor in one case, a boy of Swedish nationality, was attached to the basilar process.

DR. DABNEY, closing the discussion: One patient was German, the other American. What Dr. Smith says about the origin of these growths is the excuse for this report. They are supposed never to occur. I had the specimens examined by very skilled pathologists in Washington, at Howard University—a school for colored students, having very excellent pathologists—and also at the government school. They are true myxoma. I have looked up the literature, and there are no other cases reported of true myxoma of the rhinopharynx.

The Surgical Anatomy of the So-Called Capsule of the Faucial Tonsil.

DR. G. HUDSON MAKUEN, PHILADELPHIA.

(Published in full in the present issue of THE LARYNGOSCOPE.)

DISCUSSION.

DR. WILLIAM E. CASSELBERRY, Chicago: I am very glad to have heard this definition of terms. I have been doing the same operation that Dr. Makuen has been doing, but whereas he called it the intracapsular method, I have been calling it the extracapsular method. I still object to his term intracapsular for either his way or mine. Intercapsular would be a better term than intracapsular, it seems to me. Whether the capsule develops from the aponeurosis or from the tonsil itself matters not. I would not, in either event, forget the word capsule, for surely, as we see it, it is a capsule of the tonsil. The tonsil is enveloped in a smooth membrane which can be separated from the major portion of the aponeurosis. The smooth dissection of the capsule from the major portion of the aponeurosis is, I believe, the best operation. It results in no distortion of the pharynx. In the majority of instances it is unnecessary to cut much of the plica or mucous covering of the pillar itself. Cutting the covering of the pillar is one of the things which results in infection and distortion. I, too, have been struck by the difference in the thickness of the capsule. Sometimes, when I have exposed a piece of muscle, I have thought I have gone too far, and when I have tried to get only a thin portion, I have gotten a thicker portion.

DR. J. GORDON WILSON, Chicago: If the surgical anatomy of the tonsil is different from the anatomy, I miss Dr. Makuen's point. I cannot understand how he can call the part of the covering of the tonsil which comes from the aponeurosis of the muscle a part of the capsule of the