and it recurred. Mr. Trotter excised it by removing a window in the thyroid cartilage. It was an aryteno-epiglottidean cyst, which spread downwards into the larynx. The operation was successful. I think an operation will be necessary in this case.

Mr. NORMAN PATTERSON (in reply): I shall attempt to deal with this tumour by suspension laryngoscopy, and at the next meeting of the Section I shall further report on the case.

Left Frontal Sinus Suppuration; Radical (Killian) Operation.

By IRWIN MOORE, M.Ch.

PATIENT, a boy, aged 16, was first seen in consultation with Dr. Thomas, of Welwyn, on February 20, 1919. On February 11, following a cold, the temperature reached 105° F., and patient complained of severe pain over the left eye and temporal region. Gradually increasing œdema of the left upper eyelid followed, along with a swelling over the centre of the forehead. There was no purulent discharge from the nose, but on February 19 a severe hæmorrhage occurred from the left side. Between February 11 and 20 the temperature had varied between 102° and 105° F. When first seen on the latter date, there was extensive œdema of both the right and left eyelids, together with a large, tense and painful swelling over the centre of the forehead. It was concluded that pus had burst through the anterior wall or floor of the left frontal sinus. On opening the left frontal sinus, which was found full of pus, no connexion with the external abscess could be traced. The right frontal sinus was opened for inspection and found healthy. A radical (Killian) operation was performed on the left frontal sinus, including removal of the ethmoid cells. Patient made an exceptionally rapid recovery due, in the exhibitor's opinion, to B.I.P. dressing.

The case is shown to demonstrate the safety with which, under proper technique, the frontal sinus may be opened externally and drained or obliterated in cases of suppuration.

DISCUSSION.

Dr. P. WATSON-WILLIAMS: I understand the boy had a large frontal sinus. Will Dr. Irwin Moore give particulars as to the way in which the B.I.P. was applied in his case and in Mr. Tilley's cases? Does Mr. Tilley pack the cavity with the B.I.P., or merely apply it and allow it to find its way out? And does he pack it with gauze?

Mr. J. F. O'MALLEY: Will Dr. Irwin Moore tell us in what way he uses the B.I.P. dressing? The usual method is to staunch the bleeding and then touch with spirit, to dry it still more, and wipe the raw surface over with B.I.P., then shut the wound up. That was the method taught and used during the war, and the method I used myself. Has Dr. Irwin Moore found a better means of application?

Dr. IRWIN MOORE (in reply): Mr. Tilley applies the B.I.P. freely to the cavity by means of gauze, and then closes up the cavity. I have been criticized for using the term "proper technique" in my notes of this case. Sir StClair Thomson in discussion has frequently referred to the danger in this operation of the "dead space" under the bridge, which is the chief drawback. In view of Mr. Tilley's experience with B.I.P. in both mastoid and sinus operations, it appears to me that, added to our usual technique in carrying out the complete radical or Killian operation, either by closure of the wound at the time of operation, or by keeping one corner open for drainage, we have a much safer procedure than we had formerly if in addition we use B.I.P. instead of merely leaving the parts to drain. In my case it was not until the third day after operation, when the wound was breaking down, that I packed the cavity on three occasions with gauze saturated with B.I.P. I was much struck with the unusually rapid healing which followed.

Baby with Depressed Bridge of Nose.

By W. DOUGLAS HARMER, M.Ch.

No abnormality was noticed at birth; the infant was breast-fed for three weeks, had marked snuffling, difficulty in breathing through the nose and occasional discharge. The bridge of the nose began to drop when the child was three weeks old and the deformity had steadily increased. X-rays show that the nasal bones are depressed, but there is no evidence of destruction or fracture. The child is well nourished, has had no rash nor enlargement of the spleen. Wassermann reactions: Mother negative, child negative.

Suggestions are invited as to the cause of the condition and its treatment.

DISCUSSION.

Dr. P. WATSON-WILLIAMS: It is difficult to form a conclusion now as to the cause, but I think the child might have had a septal abscess due to traumatism at birth, and developed the signs three weeks after that. The mother perhaps did not notice anything until obstruction was developed and a discharge came away. As to treatment, one can only wait, and see what will happen as the child gets older.