and the tonsil with a deep horizontal fissure separating the upper from the middle thirds, are unusually susceptible to acute infections and are especially predisposed to the development of latent foci capable of causing systemic infections. Another type of faucial tonsil which is a frequent source of systemic infection is the stub remaining after partial removal, or where the tonsil has been subjected to igni puncture or surface cauterization. The treatment of a faucial tonsil suspected of harboring foci of infection is the same as such foci elsewhere in the body, namely, thorough removal of the suspected foci.—Dr. George E. Shambaugh, Chicago.

Symposium on Phlegmons of the Upper Respiratory Tract--Report of a Case.

This case illustrates the possibility of erosion of a large blood-vessel. The patient was a male 26 years of age, of poor resistance because of leading an irregular life and having had a recent acute illness. He had suffered from measles and while convalescing took cold. There was marked swelling on the left side with severe pain, but the patient was not prostrated and at no time did his tem-

perature go above 101 degrees F., or his pulse above 80 or 90. Deep incisions were made, but these yielded no pus, and there was no evidence of pointing. Two days later a hemorrhage occurred which was controlled by pressure. On the following day a terrific hemorrhage occurred and quickly proved fatal. Such an examination as could be made immediately following death showed rupture through the posterior pillar, the flood from the eroded carotid finding exit there. Such a mass of cellular infiltration should be explored with a blunt instrument, even the finger, following unfruitful incision. The wonder is not that phlegmons threatening life occasionally develop, but rather, considering the frequency with which infections of this region occur, that they are so rare that an active professional life may pass and not a single one come under observation. Microscopic findings are of little value in determining the treatment of these cases. Early and effective drainage is the best assurance of a favorable prognosis. Suffocation from flooding of the larynx by the sudden rupture of an abscess has been reported, and tracheotomy has been required because of closure of the pharynx by infiltration and edema, but the complication I wish to emphasize is that of erosion of blood vessels by the necrotic process.—Dr. F. E. Hopkins, Springfield.

Report of a Case of Phlegmon Starting as a Peritonsillar Abscess and Extending Downward as Far as the Second Ring of the Trachea.

This case had its origin primarily in a peritonsillar abscess and secondarily in a diseased tonsil, and is a good example of a severe phlegmon.—Dr. George L. Richards, Fall River.

Inflammation of the Lateral Columns of the Pharynx Leading to Abscess Formation, With Report of Cases.

Any isolated mass of lymphoid tissue can in a general way be expected to act when inflamed exactly after the fashion of the faucial tonsil, and can have, like the latter, simple, acute, follicular, rheumatic, diphtheritic and phlegmonous inflammations. The adenoid or pharyngeal tonsil may have acute as well as chronic inflammation. The same is true of the lingual tonsil. If we continue to remove root and branch from young children all of their adenoids and faucial tonsils, there will be abundant need to devote more and more attention to these masses of lymphoid tissue as well as to the lingual tonsil. In years gone by, when adenoids were removed from children and the faucial tonsils were left untouched,