edgewise at the upper and back part of the nose, so
that the cocaine may come into contact with the
attachments of the polypi. The patient is
cautioned not to swallow any that may run into
his mouth. After eight minutes the pledget of
cotton wool is withdrawn, and the snare inserted
with its loop (about one and a half inches long by
half an inch wide), parallel to the septum. The
upper half of the loop should be passed up between
the septum and the polypus, and the snare then so
rotated that the lower part of the wire passes
round the nearest polypus. The wire is advanced
upwards and slightly outwards, so as to get well up
to the attachments, the loop tightened, and its con-
tents removed with a smart jerk. If the loop be
forcibly tightened the pedicle will be cut through,
but it is far better to complete the removal by
traction, as in this way the attachment of the polyp-
us is more thoroughly removed, and less bleeding
results. For this reason, snares, such as Krause’s,
with an undivided barrel, into which the wire can
be completely withdrawn, are not to be recom-

dended, for they cut the polypus, and do not allow
it to be dragged from its attachments. The snaring
is repeated till all polypi in view are removed,
bleeding being mopped up with little wads of dry
wool. It is not well to do more than one side at a
sitting. If the posterior nares are blocked, gas is
necessary. The patient’s mouth is held open with
a Doyen’s gag, the left forefinger passed up into
the post-nasal space, and the attachments of the polypi
defined. Long polypus forceps are passed through
the nose, their points felt behind by the finger, and
thus guided, made to grasp the pedicle of the
growth high up near the roof of the post-nasal
space. It is then a simple matter to twist the
growth off and to bring it away by the nostril.
In all cases, hemorrhage quickly ceases when the face
is sponged with cold water, but one should keep the
patient under observation for twenty minutes or so.
The only after treatment necessary is to stop with
cotton wool, for twenty-four hours, the nostril on
the side treated.

In the worst cases of nasal polypi, they grow so
rapidly, that they cannot be kept clear by snaring.
In such extensive ethmoid disease is usually pre-
sent, and other sinususes are frequently involved. A
major operation under general anaesthesia is then
indicated, curetting away diseased parts and opening
and draining the affected sinususes.

**DISEASES OF CHILDREN.**

**RETROPHARYNGEAL ABSCESS IN CHILDREN.**

Although the treatment of retropharyngeal
abscess is chiefly surgical, the condition is one which
merits the attention of the physician on account of
its liability to be forgotten in the differential diagnosis
of a case of acute diphtheria in an infant. The three
conditions for which it may be mistaken are laryn-
geal stridulus, acute catarrhal laryngitis, and
laryngeal diphtheria. The reason why it is so im-
portant not to mistake the diagnosis is that, whereas
the diphtheria might be such as to require intubation of
the larynx or tracheotomy if the condition were
diphtheritic, the procedure needed for a postpharyng-
eal abscess is incision and drainage.

It is essential that in every case of supposed
laryngeal diphtheria a finger should be inserted into
the child’s mouth, and the pharyngeal wall gently
but quickly palpated; for palpation is the only sure
way of detecting a retropharyngeal abscess. It is
hardly ever visible from the mouth; first of all be-
cause of the struggles of the child, and of the spas-
motic movements of the parts at the back of the
buccal cavity; secondly, because the soft palate or
enlarged tonsils often come in the way. The finger,
on the other hand, can detect the soft fluctuating
mass without much difficulty.

It is essential that the palpation should be gentle,
lest the abscess should be suddenly ruptured; in
which case its contents would almost certainly spout
into the larynx, and might cause death from suffoca-
tion—the very thing that it is the object of the lateral
opening into the abscess cavity from the side of the
neck to avoid.

The cause of the acute retropharyngeal abscess is
very seldom spinal caries; it is almost always lym-
phatic infection from the tonsils, fauces, or posterior
nares. The lymphatics of the retropharyngeal region
form networks on either side, and terminate in small
glands located close to the middle line on each side
between the pharynx and the aponeurosis covering
the prevertebral muscles. These glands exist only
in the infant, disappearing soon after the third year
just as the thymus gland does; and this agrees with
the clinical fact that acute retropharyngeal abscess,
simulating laryngeal diphtheria, occurs only in quite
small children under four years of age, and most of
all in infants. The condition is related to such things
as enlarged tonsils and adenoids; mouth-breathing
and dirty surroundings strongly predispose to all
three. Indeed, the necessity for keeping the possi-

bility of retropharyngeal abscess in mind is much
greater in the poorer class of patient.

The last point holds good for another reason also.
This is the following:—Although acute laryngeal
dyspnoea is the most alarming of the symptoms to
which retropharyngeal abscess gives rise, it is by
no means the earliest one. Better-class patients
would seek advice before the acute dyspnoea was
obvious, on account of the snoring character of the
breathing, especially during sleep, the loss of appe-
tite, the restlessness, and the tenderness in one side
of the neck, which come on gradually and preceed
the acute dyspnoea by some days. It is in cases
where the infant has already been sickly or ailing for
some time, or where it is recovering from some other
ailment, that these earlier symptoms fail to attract
sufficient attention.

In many cases of retropharyngeal abscess a dif-
fuse swelling is visible on one or both sides of the
neck, but a sure diagnosis can only be made by ex-
amination of the pharynx with the finger.