grafting and on the various modern methods of rhinoplasty. Specially interesting is the chapter which deals with the repair of the syphilitic nose. In such cases the provision of a new lining is the first consideration and is secured as follows. Through a transverse incision in the mucosa from one canine fossa to the other, all adhesions are divided and all scar tissue removed, the nose being turned out like a glove finger to facilitate this procedure. A mould of dental wax is then made to fit the raw inner surface, and this mould, which is supported by a dental splint, is covered by a Thiersch graft, raw surface outwards. In ten days the epithelial graft is adherent, though this support must be retained for several months and removed for cleansing every few days. Finally, a permanent support is provided by costal cartilage implantation.

It is obvious that both author and publisher have spared no pains in the production of this volume, and it may be confidently recommended to every surgeon who may be called upon to treat nasal deformities.

DOUGLAS GUTHRIE.

LETTERS TO THE EDITORS.

ZINC IONIZATION.

TO THE EDITORS,

Journal of Laryngology and Otology.

SIRS,—It was a pleasure to read in the February number of the *Journal*, two papers on treatment based on the use of the electric current to introduce zinc into septic surfaces, or into the actual tissues.

Dr Lister's paper gave an account of work done by herself and others at the Royal Infirmary, Edinburgh, to test the value of zinc ionization in chronic otorrhœa, and reference was made to some statistics of results which I had published. As the technique adopted by these workers differs from that practised by several of us in London and elsewhere, and also as the cases treated in Edinburgh were specially selected and not consecutive cases of chronic otorrhœa, it is not possible to compare the statistical results. It may be permitted to state in tabular form, the bases on which they and we analyse the results of treatment.

IMPORTANCE IS ATTACHED

By them:	*By us:*
1. To the cause starting the otorrhœa.	To what is keeping up the otorrhœa.
2. To the position of the perforation.	To the area of sepsis and its accessibility.
3. To the absence of additional factors such as polypus or granulations.	To the absence of additional factors such as polypus or granulations.

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Letters to the Editors

As two out of three of the principles guiding the selection of cases as suitable for a test are different, it is not surprising that the results should differ. However, the paper is an absolutely straight one and there is no juggling with facts or figures.

With regard to Dr Norrie's paper on the treatment of enlarged inferior turbinals, I can confirm almost entirely what he has said. Some years ago Professor Leduc pointed out to me the superiority of the treatment of such cases by zinc electrolysis over the galvano-cautery. Tissues coagulated by the galvano-cautery are a good pabulum for micro-organisms, while those coagulated with zinc form a very bad one. I found it difficult to introduce his needle cut from zinc sheeting, and used a zinc-plated steel needle. Dr Norrie introduced to me the zinc wire, and I find it most satisfactory. Gauge 22 is suitable for ear work; gauges 16 or 14 are suitable for needles for the inferior turbinal, or for treating synechiæ between the nasal septum and outer wall; and gauge 10 for electrolysis, used for the purpose of destroying an area of the inner wall of the maxillary antrum in the inferior meatus in cases of maxillary empyema without polypus formation or other complication.

The use of zinc ionization, or zinc electrolysis, I have found of great benefit in various common conditions, and in many patients it has resulted in speedy alleviation without operation and loss of work.

A. R. FRIEL.

LONDON, *February* 1926.

HÆMORRHAGE AFTER REMOVAL OF ADENOIDS.

TO THE EDITORS,

Journal of Laryngology and Otology.

SIRS,—In the *Journal of Laryngology and Otology*, February 1926, two cases of hæmorrhage following adenoid curettage are reported. In both the life of the patient was endangered by the bleeding, which in one is described as profuse, in the other as severe. Elaborate procedures were in each case needed for its control. It is moreover recorded that "both patients lost so much blood in a very short time that their recovery was a matter of doubt." Emphasis is laid upon the unconvincing facts that the first had on one occasion bled profusely from a cut lip, and near relations of the second had bled for two days after tooth extraction.

I have noted many similar records in the literature of recent years, but in a long personal experience have never seen post-operative hæmorrhage. I attribute this not to good luck but to the fact that for the past twelve years I have never curetted the naso-pharynx. In every case I have removed the pharyngeal tonsil complete in one