EXPLANATION OF PLATE XL.

Fig. 1.—Eosinophil Carcinoma, Originating from Left Ventricular Vocal and Ventricular Bands. Male patient of fifty-five years. Eleventh month of the disease. Death from asphyxiation during twenty-third month of disease and one month after laryngectomy. (Case of Dr. E. E. Wilson, of New York.)

Fig. 2.—Eosinophil Carcinoma, Forming a Large Tumor Covering the Superior Laryngeal Nerve. (After Papel.)

Fig. 3.—The Same Larynx after Excision and Destruction of the Tumor by the Galtzano cystot, with the ventricular bands and left arytenoid in much erasure. (After Papel.)

Fig. 4.—Eosinophil Carcinoma. (After Papel.)

Fig. 5.—Eosinophil Carcinoma, Involving Larynx and Esophagus. (After Papel.)

Fig. 6.—A third instance of Eosinophil Carcinoma. (After Papel.)

Fig. 7.—Eosinophil Carcinoma, Right Side of Larynx. (Patient examined by Dr. Morgan.)

Fig. 8.—Round-celled Sarcoma of Right Vocal Band. Patient aged forty-five. (Case of Dr. Morgan.)

Fig. 9.—Sphincter-celled Sarcoma of Left Ventricular Band and Arytenoid. (After Papel.)

Fig. 10.—Round-celled Sarcoma, Sixth Month, Destroying Epiglottis and the Adjacent Tissues.

Fig. 11.—Eosinophil Carcinoma, Involving Posterior Laryngeal Wall, Left Arytenoid, Aryepiglottic Fold, and Hypopharyngeal Intercourse.

Fig. 12.—Mucous Membrane, Originating from the Anterior Commissure of the Vocal Bands, Causing Pain, Dysphonia, and Urethra.
EXPLANATION OF PLATE XL.

Fig. 1.—Epiploidal Carcinoma, Originating from Left Vocalic, Vocal and Ventricular Bands. Small portion of right true vocal. Evidence of the growth. Death from extirpation during anesthesia. Death of patient. At autopsy and post-mortem in two months. (Case of Dr. Eubanks, of South Carolina, and autopsied in our second year by Eubanks.)

Fig. 2.—Epiploidal Carcinoma. Forming a Lumpy Tumor Overlying the Superior Laryngeal Oesophagus. (After Polet.)

Fig. 3.—The Same Lesion after Extirpation and Destruction of the Basal by the Gaucho Mortem. The ventricular bands and left arytenoid are much eroded. (After Polet.)

Fig. 4.—Epiploidal Carcinoma. (After Polet.)

Fig. 5.—Epiploidal Carcinoma, Involving Larynx and Oesophagus. (After Polet.)

Fig. 6.—A Small Inclusion of Epiploidal Carcinoma. (After Polet.)

Fig. 7.—Epiploidal Carcinoma, Right Side of Larynx. (Pathology accompanied by Dr. Morgan.)

Fig. 8.—Round-cut Carcinoma of Right Vocalic Band. Patient aged forty years. (Case of Dr. Morgan.)

Fig. 9.—Syphilis-caused Sarcoma of Left Ventricular Band and Arytenoid. (After Polet.)

Fig. 10.—Round-cut Sarcoma, Sparing Muscle, Destroying Epiglottis and the Adjacent Tissues.

Fig. 11.—Epiploidal Carcinoma, Involving Posterior Laryngeal Wall. Left Arytenoid, Aryepiglottic Fold, and Oesophageal Gullet.

Fig. 12.—Myocarcinoma, Originating from the Articular Constrictors of the Vocal Bands, Coming from Hypofibrosis and Oesophagus.
phagocytic larvae. Abscess of the liver, and suppura-
tion in the peritoneal surfaces of the peritoneum, repre-
sent the pathological changes in the acute phase of the disease. The morbid processes are diffused and almost always extend beyond the limits of the peritoneum.

Acute peritonitis may be caused by laceration, bruising, laceration, tearing, or crushing injuries to the liver. The disease is characterized by an acute onset, fever, abdominal pain, tenderness, and rigidity. The peritoneal fluid is often bloody, and the disease is usually fatal.

In the chronic phase of the disease, the peritoneal lining is thickened and fibrous, and the peritoneum is often adherent to the underlying organs. The disease is usually characterized by a chronic onset, an intermittent course, and a slow progression. The peritoneal fluid is often turbid, and the disease is usually benign.

In summary, peritonitis is a serious disease that can be caused by a variety of factors. The diagnosis is usually made by a combination of clinical symptoms and laboratory findings. Treatment is usually surgical, with drainage of the peritoneal cavity and excision of the affected tissues.
Larynx. Reference Handbook of the Medical Sciences.

LARYNAX: Diseases of: Protrusion of the Eryngiums. Foramen, excision, or laceration of the arytenoid cartilage may occur in the development of a larynx. The arytenoid cartilage may be excised or lacerated. The patient may present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a larynx that is too small or too large. The larynx may be fixed in the protrusion of the arytenoid cartilage. The patient may also present a