

a gastric ulcer. Following a bismuth meal a skiagram showed that after much had passed into the stomach, the material was held up in the œsophagus, which became dilated, the dilatation terminating inferiorly immediately above the diaphragm. Here the achalasia arose as a reflex transmitted from the stomach. There is no evidence, however, that gastric conditions, either organic or functional, are necessary ætiological factors in producing neuro-muscular œsophagectasia. On the contrary, the direct observation made by Dr. Brown-Kelly proves that the reflex fault may lie in the œsophagus, since the experimental irritation of the mucosa above the cardia, in place of being followed by relaxation of the sphincter, as it is normally, was followed by its closure.

Lastly, amongst the drawings there is inserted one showing a distinct and wide-spread muscular hypertrophy, especially of the circular layer, but unaccompanied with dilatation; the heart was much dilated, and weighed 18½ oz. A similar condition is shown in a second specimen from Guy's Hospital Museum, described by Dr. Newton Pitt.¹ Here the heart was likewise enlarged. The muscular thickening of the œsophagus was most marked an inch above the cardiac orifice. Such results have been attributed to obstruction caused by the pressure of the enlarged heart. Aortic aneurysm may undoubtedly produce œsophageal obstruction and some local dilatation of the canal above.

In connection with muscular hypertrophy of the œsophagus without dilatation, it is enough to point out that it may represent a completely compensated achalasia, or even cardiospasm—a possibility already conceived by Dr. Brown-Kelly.² This could only be established by finding such hypertrophy unassociated with aortic aneurysm, enlargement of the heart, or other extrinsic organic obstruction.

ABSTRACTS.

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Authors of Original Communications on Oto-laryngology in other Journals are invited to send a copy, or two reprints, to the JOURNAL OF LARYNGOLOGY. If they are willing, at the same time, to submit their own abstract (in English, French, Italian or German) it will be welcomed.

PHARYNX.

Researches on the Pharyngeal Reflex.—A. Croce. "Arch. Ital. di Otol.," xxx, No. 4.

The author examined a large number of people with a view to determining the constancy or otherwise of the pharyngeal reflex. The sensitiveness of the pharynx was supposed to be diminished in the case of hysteria. Croce examined 64 cases of hysteria, 24 of aphonia, and 10 mutes. In none of these was there any anæsthesia of the pharynx and the normal reflex was present in all. Eighty-eight healthy persons were also examined and the reflex found present in all. The reflex is weak in thyroid hypertrophy and in old age. Diseases such as tabes cause abolition of the reflex.

J. K. Milne Dickie.

¹ *Trans. Path. Soc.*, 1888, xxxix, p. 107.

² *Brit. Med. Journ.*, 1912, ii, p. 1047.

Enucleation of Tonsils with Local Anæsthesia.—Elbyrne G. Gill. "The Laryngoscope," December, 1919, vol. xxix, p. 715.

In determining whether the operation shall be done under local or general anæsthesia the age of the patient is obviously a decided factor. No local anæsthesia under fourteen years. Patients of an extremely nervous temperament, with sensitive throats, should have a general anæsthetic. A patient should not be persuaded against his will to have a local anæsthetic. Probably 90 per cent. can have tonsils removed successfully and without pain under local anæsthesia. Gill uses the Hurd evacuator for examination of tonsils. This consists of a glass cannula with an opening large enough to fit the tonsil. It is connected to a small rubber bulb. Suction draws the tonsil into the mouth of the glass, and if any pus or "cheesy material" is present it will readily be seen. If definite symptoms of focal infection be present and no evidence is revealed by use of the evacuator, Gill takes a culture from each tonsil before deciding that the tonsils are not diseased. After applying alcohol to the outer surface of the tonsil a sterile platinum wire is introduced into the crypts and culture media inoculated. If he gets a pure culture he feels that the technique was properly carried out. Operation must always be done in hospital. A careful examination is made, including a record of blood-pressure and a *blood-coagulation test*. Preparation and local anæsthesia as usual. Gill begins the dissection at the junction of the tonsillar capsule with the converging pillars at the superior angle. He then inserts the closed ends of the scissor-blades into the opening and separates the posterior pillar. Then with the blades of the scissors opened, one blade is carried around the anterior surface of the tonsil, thus separating the mucous membrane of the anterior pillar from the capsule. Gill now everts the tonsil. If it is not lifted from the fossa, the dissection can be completed by placing the Hurd tonsil separator behind the capsule of the superior pole and gently lifting the tonsil up, making firm traction on the tonsil forceps at the same time. Lastly, the pedicle of the tonsil is snared off with the Tyding snare. Gill has not found ligatures necessary. Hæmorrhage is controlled by making pressure with a sponge in the fossa for three minutes, which is the time required for blood to coagulate. After all oozing has stopped for at least five minutes, Gill applies a 3½ per cent. iodine solution. The ice-bag is immediately applied to the patient's neck. Three hours later morphia (¼ gr.) is given whether there is pain or not. Gill has had no post-operative hæmorrhage in a series of sixty cases.

Gill reports two cases: (1) Infected tonsils with chronic laryngitis, cured by the above operation; (2) septic tonsils with latent pulmonary tuberculosis and profuse night-sweats, which gave an equally satisfactory result.

J. S. Fraser.

LARYNX.

Intrinsic Cancer of the Larynx.—Sir StClair Thomson. "Lancet," 1920, vol. ii, p. 183.

Sir StClair Thomson publishes his observations, based upon forty-four cases treated by laryngo-fissure, on impaired mobility of the affected cord in diagnosis and prognosis. He concludes that (1) impaired mobility is not a necessary or frequent symptom, and is met with only in a minority of cases. (2) It is more likely to be seen in an early case when the growth is embedded in the end or growing into it than in a

distinctly sessile or even pedunculated tumour. (4) When present it is a very valuable symptom in distinguishing a malignant from an innocent tumour. It is misleading in the diagnosis of malignant growth from tubercle or syphilis. (5) It is unfavourable in prognosis.

Macleod Yearsley.

E.A.R.

Paralysis of the Facial, Cochlear and Vestibular Nerves from Shell-Burst.—C. A. Torrigiani. "Arch. Ital. di Otol.," xxx, No. 4.

The author reports a case of paralysis of the above nerves from the blast of a shell. The patient fell as if he had received a blow on the head. He did not lose his senses but was very giddy. He noticed almost at once that he could not shut his mouth, vomited, and had loud hissing noises in the head. A little blood came from the right ear. The giddiness was so severe that the patient could not raise himself in bed.

On examination there was complete paralysis of the right side of the face and mixed nystagmus to the left. Some blood-clot was seen in the right meatus, and the tympanic membrane was completely destroyed. The right ear was found to be totally deaf, and the caloric test was negative. Romberg's sign gave falling to the affected side, the direction of falling being influenced by the position of the head. There was a spontaneous pointing error. An X-ray picture showed no fracture.

The author evidently considers a foreign body excluded though he does not specifically say so, and gives as the probable explanation of the case a tearing of the nerves at the point of their emergence from the medulla, where the fibres have less support than elsewhere.

J. K. Milne Dickie.

Larvæ of *Sarcophaga Carnaria* in the Ear.—P. Caliceti. "Arch. Ital. di Otol.," xxx, No. 4.

The author reports two cases of maggots in the ear. The first case was that of a peasant who had been sleeping in the open. He woke up one morning with very severe pain in the right ear. The pain continued and was followed by the appearance of bloodstained discharge, which later became purulent. There was a feeling of something moving in the ear. After syringing out the pus the larvæ were seen. The second case was a woman with a similar history. The larvæ were removed with considerable difficulty with strong forceps. From the one case five and from the other two maggots were removed. Antiseptics have little or no effect on them. They can live for six to eight hours in 5 per cent. carbolic or 8 per cent. formalin. They are nearly 19 mm. long and about 4 mm. in thickness, and are furnished with two strong hooks at the anterior extremity.

J. K. Milne Dickie.

Two Years and a Half of Oto-Laryngological Medico-Legal Service in the XII Territorial Corps.—S. Pusateri. "Arch. Ital. di Otol.," xxx, No. 4.

Out of 12,328 patients 9347 complained of their ears, 1373 of their nose, and 1608 of their throat. There were 610 ear malingersers, and of the total number of patients (12,328) only 11,363 had any discoverable lesion. From these figures the high proportion of malingersers is very striking. Self-inflicted lesions of the ear accounted for 47 per cent. of the ear cases.

J. K. Milne Dickie.

ŒSOPHAGUS.

On a Case of Foreign Body in the Œsophagus with an Impending Breach into the Trachea.—G. Holmgren (Stockholm). "Acta Oto-laryngologica," i, fasc. 1.

The patient was a man, aged thirty, in whose œsophagus a piece of meat-bone had become impacted at a distance of 20 cm. from the upper teeth. The symptoms were pain in the back, dysphagia, cough and bloody expectoration. Examination of the trachea showed its posterior wall at a point somewhat below the larynx to be red, swollen, and bulged into the lumen. On œsophagoscopy a bone was found with its more pointed end perforating the anterior wall of the œsophagus and its thicker end fixed in the posterior wall. The thicker end was grasped with forceps and the bone removed, the patient making an uninterrupted recovery.

Before coming under the author's care the case had been treated by the blind passage of bougies. He considers that the serious nature of the condition which he found was due to this cause, and reports the case as a good illustration of the danger of random attempts at removal of foreign bodies impacted in the œsophagus, and of the comparative ease and safety with which this can be accomplished by means of the œsophagoscope.

Thomas Guthrie.

MISCELLANEOUS.

Functional Diagnosis of Polyglandular Disease in Acromegaly and other Disturbances of the Hypophysis.—C. P. Howard (Iowa). "Amer. Journ. Med. Sci.," December, 1919.

In the six cases of disease of the pituitary body which form the material of this paper, the author applied the methods devised by Karl Csépai for investigation of the diseases of the endocrine glands. The methods and the author's conclusions as to the value of each are briefly as follows:

(1) Decreased sugar tolerance: This Howard found to be present in five early cases, and he considers that in the presence of other symptoms of disturbance of pituitary function it justifies a diagnosis of increased activity of the pars intermedia. On the other hand, in the later stages of hypophyseal disease when the pars intermedia has been destroyed by pressure or invasion has occurred, as in one of his cases, increased sugar tolerance may be expected.

(2) Conjunctival "adrenalin" test: Three drops of a 1 in 1000 solution of "adrenalin" normally causes a blanching of the conjunctival sac, which persists from ten to twenty minutes, while in cases of acromegaly the blanching remains from thirty to forty-five minutes. In Howard's cases the persistence of the blanching was normal in three, slightly prolonged in one, and decidedly prolonged in two. He concludes that the test may be of positive value in certain cases of dyspituitarism in demonstrating a hypofunction of the chromaffin system.

(3) Subcutaneous Adrenalin test: Csépai found in some cases of acromegaly an absence of the rise of blood-pressure and pulse-rate which normally follows subcutaneous injection of 5 mg. of adrenalin. He also found variations of the leucocytosis which follows the injection of this substance in normal persons. In Howard's experience this test was of very doubtful value.

(4) Tests of a similar nature, both conjunctival and subcutaneous, carried out with pituitrin Howard found to be quite unreliable.

He also found that the internal administration of pituitary extract, either of the whole gland or the anterior or posterior lobes, appears to exert no definite influence upon the symptomatology of the disease.

Thomas Guthrie.

Jugular Phlebitis, Sinus Thrombosis, Ulcerative Endocarditis.—W. S. Laurie (Melbourne). "Med. Journ. Austr.," March 13, 1920.

The case recorded, which ended fatally, was that of a young woman, aged twenty-seven. There was no history of ear disease, past or present. The source of infection was possibly the tonsils, which were somewhat large and spongy.

A. J. Brady.

OBITUARY.

ADAM POLITZER.

By the passing away of Prof. Adam Politzer in the eighty-fifth year of his life, the otological world is deprived of one of its most distinguished figures. The unhappy war has broken up many associations, and there is probably none more regretted than our long and intimate association with this outstanding otologist. His visits to this country were sources of profit and pleasure to the guests and the host alike. The welcome he received here was always warmly reciprocated to those of us who visited Vienna, and his hospitality was to some so profuse as to be almost embarrassing. Such remembrances make the regrettable events of the last six years all the more regrettable.

The older members of the present race of British otologists owe what is soundest and best in their knowledge to the teaching of Politzer, but he, on his part, attributes the pathological basis of his teaching to Toynbee, whose work and specimens he came to London to study in the earliest days of his career. Those who met him at an informal gathering at Sir Wm. Dalby's house in Savile Row will remember his looking round and recalling his visit to Toynbee amid the same surroundings.

The incidents of his life are such as would be expected of a man of his purposive and artistic nature. They are narrated so clearly and sympathetically by Sir StClair Thomson that our readers will welcome their reproduction here from the pages of the *British Medical Journal*:

"Adam Politzer was what the French call a *grand maître* in modern otology. Possessed of a charming individuality, he was thoroughly equipped in his youth, and started early on a career in which he became so distinguished. He was well advised by his teachers, who appreciated his talents, and he directed his attention to otology from his earliest years, realising the opening there was for this speciality at Vienna. Hence he passed several years travelling over Europe, studying acoustics with Helmholtz, histology with Kölliker, and physiology with Ludwig. In Paris he worked in the laboratory of Claude Bernard, and then he came to London to study with Toynbee. There can be little doubt that it was his English teacher who inspired him with his appreciation of the pathological anatomy of the mastoid. Politzer returned to Vienna in 1861, and it was sufficient for him to show his teachers the results of his scientific journeys for them to create a Chair of Otology, and he was elected as professor. He was not yet thirty years of age. He only had four pupils in his first course, but it is interesting to recall that one of them was Lucae, who afterwards was the well-known professor in Berlin. His name soon became known throughout the otological world, as it was early in his career that he discovered the method of 'Politzerising' the ear. His reputation