was only recently noticed by her doctor, when she had a sore throat. His own view was that it was a lipoma. A number of these cases were seen in which the lateral wall of the pharynx was displaced inwards.

Dr DOUGLAS GUTHRIE said that still another possibility in diagnosis was the rare tumour originating from the tiny ductless gland—the carotid body.* He had seen one case which closely resembled that shown at present; it could be distinguished from the commoner mixed tumour of this region only by microscopic examination. Growth was very slow in his (the speaker's) case; the tumour had hardly altered since coming under notice three years ago, and caused the patient little inconvenience.

ABSTRACTS

THE EAR.

Discussion on Chronic Non-Suppurative Middle-Ear Deafness (excluding Otosclerosis). (*Brit. Med. Journ.*, 12th December 1925.)

Sir William Milligan, said that advanced chronic catarrhal otitis media is incurable. Our aim should be to endeavour (1) to prevent the onset of the disease, (2) to treat it energetically in its early stages so as to prevent, if possible, the advent of incurable fibroid changes. The original cause is a mild sepsis, not sufficient to produce suppuration, but enough to induce submucous changes which lead to atrophic alterations in the mucous glands and to the ultimate formation of fibrous tissue. If any exudate of this non-purulent kind is thought to be present in the middle ear, it should be expelled by paracentesis and inflation. The researches of George and Gladys Dick go to show that a scarlet fever antitoxin administered on the first day the rash appears obviates the onset of ear complications.

The sheet-anchor of treatment is inflation. Bougies are indicated if the Eustachian tube is blocked, but this should be done from above instead of from below, as is usually practised. Paracentesis is performed in the anterior part of the membrane and fine silver bougies passed. These should be retained for an hour or more. Sir William had many years ago tried the effect of the radical mastoid operation but without success. The changes occur mainly on the inner wall of the middle ear, and chiefly in the region of the oval and round windows. If paracusis is present the oval window is chiefly affected; in advanced cases without paracusis, probably the round window. He had tried removal of the stapes in some cases but found it of no value. Where tinnitus is the symptom most complained of it may be necessary to consider ablation of the cochlea. Loss of

* *Journ. Laryngol. and Otol.*, 1924, xxxix., p. 635.

acuity of the cortical centres of hearing is apt to ensue, and it is probable that there may be some value in some of the systems of re-education.

Dr J. Kerr Love, thought that the most hopeful line of investigation was in some improved aid to hearing. An optician succeeds in correcting refraction errors in the eye. Why should not the acoustician be able to do the same with sound-waves, say those of the human voice? The "Audo-amplifier" described by Dr Isaac Jones and Professor Knudsen aims at this, and it is hoped that this instrument or some other will eventually be found to give the desired results. The otologist ought to be able to write a prescription for what Dr Love called for want of a better term — "auditory spectacles." The acoustician would not require to be so accurate as the oculist. All he has to achieve is to reinforce a particular zone of sound, usually the lower zone, and let the rest alone. As regards prevention, Dr Love welcomed all the work done among the school children; in adult patients, already deaf, he was not hostile to such nasal operations as might have any chance of improving or inhibiting the deafness.

Dr Neil Maclay, said that preventive treatment was most important. The public should be taught that the time to treat deafness is at its commencement and that instead of resorting to the removal of wax which generally is not present or syringing which is generally harmful, they should seek expert advice as to the nature and cause of the deafness. Chronic deafness not infrequently owes its origin to inflammatory conditions in early life, and the cause of these could have been easily treated before the permanent post-inflammatory changes set in. Not only tonsils and adenoids but teeth and accessory sinuses should be investigated as also structural defects in the nose. Deficiency of secretion in the thyroid gland might also be a cause of this form of deafness.

It is important also to follow up operative treatment by attention to the general health, disorders of which hinder the full recovery of the mucosa in the middle ear. For treatment of an established deafness, inflation, tympanic massage, and re-educative exercises are the most important items. Simple inflation by the Eustachian catheter is best. Medicaments and instrumentation applied to the Eustachian tube may be harmful. Methods of re-education have had a fair measure of success. The expensive electrical instruments are beyond the reach of the majority of patients, but much can be done by employing an ordinary conversation tube amplified if necessary by a receiver of large dimensions.

Mr H. Norman Barnett, could not be as pessimistic as Sir W. Milligan about the incurability of this form of deafness. He had

had noteworthy results from two forms of treatment, (1) vaporisation of the middle ear through the Eustachian catheter with a mixture of warm iodine and camphor vapour, and (2) by ionization. He described in detail his method of applying the latter treatment. The negative electrode on a pad of lint soaked in a solution of potassium iodide is applied to the mastoid process, while the positive electrode on a pad soaked in sodium chloride solution is placed under the hands. The current should be low and should be determined by the patient's sensation of giddiness or of pricking heat. The two forms of treatment are alternated daily. "In all cases benefit has resulted and in many cases restoration to normal or nearly normal hearing." The public should be encouraged to believe that we can treat cases of deafness successfully, and the aural surgeon should labour at such cases with faith in the methods he adopts.

T. Ritchie Rodger.

Discussion on Operative Treatment of Chronic Middle-Ear Suppuration. (*Brit. Med. Journ.*, 12th December 1925.)

Mr George J. Jenkins, said that for many years the radical mastoid operation was considered the only one for chronic otorrhœa although Schwartze applied his operation to chronic cases as well as acute, and with some degree of success. In recent years otologists have been experimenting with methods that are something between the Schwartze and radical operations. The radical operation has often to be considered a failure because of diminished hearing power, and this is particularly true where the perforation was in the attic in which case the hearing before operation is often very good. The objects to be aimed at in a mastoid operation should be, (1) to remove all foci of potential danger, (2) to retain the maximum hearing, (3) to leave a state of affairs that will necessitate the least possible after-attention. The radical operation removes possibly more than is necessary; in the modified radical operation our endeavour is to remove only as much as is necessary to attain our object.

In the speaker's experience the focus of infection is very frequently in the aditus with involvement of the incus, and he describes an "extended Schwartze" operation which he has designed to meet such cases. This operation differs from other modified operations in that the incus is removed by forceps or scoop through the antrum, and that although the bony part of the posterior wall of the meatus is removed, with the exception of a fine bridge, the membranous meatus is not interfered with. A periosteal flap with its base above, is turned down into the antrum. In 38 cases, only 2 showed a healthy incus. The results have been good, especially in the maintenance of hearing, so much so that further study of the function of the ossicles is suggested.

In cases of attic perforation, the operation has been extended to include removal of the outer wall of the aditus and attic with as little interference as possible with the rest of the tympanum. Where there is evidence of gross damage to the outer wall of the labyrinth or to the labyrinth itself the radical operation is preferred.

Mr Sidney R. Scott, said that in acute cases treated by Schwartze's operation the hearing returns to normal in a very short time and in nearly every case. Mr Scott has been in the habit of teaching that if, over a series of cases an operator found the hearing defective, he was probably making the mistake of making too free with the aditus and disturbing the incus lying therein. At first sight, therefore, Mr Jenkins' operation seemed a contradiction of this view, but on more careful consideration, since this new operation was suggested, not to take the place of the Schwartze operation but rather to replace the radical in cases where the Schwartze was not likely to be enough, there was really no contradiction. Mr Jenkins' operation might be said to be one designed to spare the malleus rather than to sacrifice the incus. Mr Scott was in favour of operating in the borderland cases *à deux temps*, trying the Schwartze operation and proceeding later to the radical if necessary; the presence of cholesteatoma in the antrum and aditus is a positive indication for the radical operation. In his clinic the Schwartze, Kuster, epitympano-mastoid, and "conversion" operations were much more frequently done than the radical.

Dr J. Bowring Horgan, said that the best treatment of chronic otitis media is to prevent its occurrence. No case of the acute condition should be allowed to continue more than four or six weeks without being subjected to the Schwartze operation. Mr Horgan had had occasional success from the Schwartze operation in cases where he had been doubtful of its sufficiency, but had no good opinion of any form of modified operation. The chief *raison d'être* of such procedures—the conservation of hearing—was important, but in his experience the radical operation was not so destructive of hearing as some seemed to think. He found that in 75 per cent. of his cases the radical operation gave improved hearing. He thought the prospects of good hearing, as well as of rapid healing were greatly improved by primary skin grafting. T. RITCHIE RODGER.

Pathology and Diagnosis of Syphilitic Affections of the Inner Ear. Professor K. GRÜNBERG, Bonn. (*Zeitschrift für Laryngologie, Rhinologie, etc.*, Bd. xiv., December 1925, pp. 27-46.)

Since the days of Ehrlich and the introduction of the salvarsan therapy much has been written on this subject. Grünberg discusses the views and theories of many authors (Hutchinson, Urbantschitsch,

Alexander, Manasse, Wittmaack, Fraser and others), but no references to their respective publications are given.

The numerous cases which have already been studied microscopically show great variations, but this applies, of course, to the pathology of all syphilitic lesions. We find descriptions of localised meningitis in the posterior fossa with infiltration of the eighth nerve; all the various forms of labyrinthitis may also be simulated. Most authors who have studied this question seem to look upon the localised meningitis as the most important lesion. This is supported clinically by the fact that patients with acquired syphilis, who develop nerve deafness, nearly all show definite changes in the cerebro-spinal fluid, *i.e.* positive Wassermann, increased cell-count.

The findings are very different in syphilitic acoustic lesions of congenital origin. Here the cerebro-spinal fluid is practically always normal, and the seat of the lesion in this group is most likely in the labyrinth itself, without a neuromeningitis.

An interesting small clinical group is formed by affections of the eighth nerve in the primary stage of acquired syphilis before the Wassermann reaction has become positive. This is so characteristic that Kobrak speaks of a stage in syphilis (between the primary and the secondary), in which is found a negative Wassermann with a positive "Octavuszeichen."

Diminished bone-conduction is a well-known finding in the early stages of the disease, without an obvious defect in the hearing; accompanying this there may be evidence of a disturbed vestibular apparatus taking the form of a much diminished or absent reaction to rotation with a normal caloric response.

Certain signs may be looked upon as characteristic of congenital syphilis of the inner ear. Both sides are affected as a rule and the patients are often deaf-mutes:—

(1) A positive galvanic test, even when the labyrinth does not show any response to the caloric and rotation tests. This supports the view that the primary lesion in congenital cases is in the labyrinth. In acquired lesions of the meningeal type, which begin in the acoustic nerve, the galvanic test is negative.

(2) A positive fistula sign (Hennebert) which is occasionally found in congenital syphilis with an apparently normal middle ear. Urbantschitsch even described a case of bilateral positive fistula sign in a patient who was totally deaf and who showed no response to the caloric or rotation tests. No explanation has been given for this sign.

(3) Very rarely a red reflex may be observed in the drum, similar to that seen in otosclerosis. J. KEEN.

Nose and Accessory Sinuses

Disturbances of the Motor Cortex in Otogenic Meningitis. PŘECECHTĚL. (*Zentralblatt für Hals-, Nasen-, und Ohrenheilkunde*, 1925, Vol. vii., p. 797.)

The author points out the vital importance of early operative interference in all cases of otogenic meningitis; especially emphasising that a well-timed labyrinthotomy can check the spread even of an established meningitis. He describes three cases seen in the last six years, which may be summarised as follows: All three were cases of otitic meningitis which occurred in the course of an acute otitis media; in all, the earliest symptoms were localised cortical signs; in one, irritative signs and convulsions followed by paralysis, in the other two, paralysis without any preceding stage of irritation.

In the author's experience meningitis is the more frequent complication of acute otitis, abscess, of chronic otitis. Thus cortical signs have a different significance in the two classes of case; cortical signs appearing suddenly in the course of an acute otitis media suggest the onset of a vertical meningitis and the prognosis is accordingly unfavourable. F. W. WATKYN-THOMAS.

NOSE AND ACCESSORY SINUSES.

On the Absence of Frontal Sinuses in Roentgen Examinations and some Clinical Observations Concerning this Condition. C. O. NYLÉN, Stockholm. (*Acta Oto-laryngologica*, Vol. vii., Fasc. 3, 1925.)

The writer shares with many colleagues the misadventure of having diagnosed frontal sinusitis in cases proved by operation or X-rays to possess no frontal sinuses.

Anatomical works on the accessory cavities show the frontal sinuses (excluding earliest childhood) to be absent in rather more than 5 per cent. of cases. Two thousand cases were examined by X-rays at the Seraphima Hospital, and in quite 5 per cent. the frontal sinus was missing on one or both sides.

The age period between 20 and 30 provides most of these cases, but the sinuses have been found absent at all ages between 5 and 70 years.

Haike states as the result of Roentgen examinations that a cavity in the frontal bone is found at $3\frac{1}{2}$ years at the earliest; between 5 and 6 years it is present in 50 per cent. of cases and at 13 years in 100 per cent., but in the material under consideration Nylén has found cavities absent in some ten cases between 5 to 15 years.

Attention is called to the difficulty in recognising small frontal sinuses from so-called ethmoidal recesses. From the above it follows we must reckon that every twentieth living individual, infants excluded, is devoid of one or both frontal sinuses.

Abstracts

In 9 of 102 cases with absent frontal sinuses on one or both sides a diagnosis of frontal sinusitis was made by different rhinologists before an X-ray had been taken. H. V. FORSTER.

On the Semeiological Value of Ewing's Sign. J. TARNAUD. (*Annales des Maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, March 1925.)

Ewing's sign is the production of pain by pressure on the area of bone between the supero-internal angle of the orbit and the attachment of the superior oblique pulley lateral to this. In patients who suffer from fronto-orbital headaches, accompanied by ocular weakness but unaccompanied by any obvious lesion of the eye, Ewing's sign may be regarded as proof positive of a nasal cause of the headache.

A positive Ewing's sign may be the expression of:—

1. An inflammatory condition of the frontal sinus, of the fronto-nasal canal, of the region of the middle meatus and of the middle turbinal.
2. Intranasal disorder caused by mechanical error: This refers to the condition of obstruction of the frontal duct described by Sluder as causing "vacuum headache." This is usually found in association with contact between the septum and the lateral nasal wall.
3. Neuralgic attacks accompanied with vasomotor changes, which arise usually in the middle meatal region.

The writer indicates that often the rhinological examination of these patients reveals nothing, but he states that the signs which suggest a nasal origin of the headache may be put down as—*a.* Ewing's sign. *b.* Undue vascularity of the middle turbinal and middle meatus. *c.* Hyperæsthesia of the middle turbinal as tested with a probe. *d.* Disappearance of the headache and the other symptoms by the application of cocain and adrenalin to the region of the middle meatus.

Three cases are quoted to adduce the correctness of the above views.

In addition to cocainisation of the middle meatus, permanent cure was effected by removal of the anterior end of the middle turbinal.

GAVIN YOUNG.

Paranasal Sinus Disease in Infants and Young Children. L. W. DEAN, M.D. (*Journ. Amer. Med. Assoc.*, 1st August 1925, Vol. lxxxv., p. 317-321.)

Dr L. W. Dean mentions the complications of paranasal sinus infection and the treatment of this condition in patients as young as five weeks. The importance of X-rays is emphasised, so that one is informed whether a given sinus is present, and if so, whether on an anatomical basis it has clinical importance.

Etiological factors he considers under climate, diet, and the commonest source of infection from tonsils and adenoids. In all cases of congenital atresia of the posterior nares under the author's care there has been sinus infection.

Under symptomatology he mentions nasal discharge and stuffiness, sneezing in acute cases, fever and leucocytosis, while headaches are only present after the age of five.

As regards treatment the most important point is climate and diet, and in acute stages hot nasal irrigations followed by dropping a penetrating antiseptic into the nose, and the removal of diseased tonsils and adenoids in children. Eighty per cent. of the children's nasal sinus infections were cured after removal of tonsils and adenoids. Sometimes it is advisable to aspirate the maxillary sinus, rarely is it necessary to make a permanent opening under the turbinate.

PERRY GOLDSMITH.

Some Observations on Certain Forms of Chronic Sinusitis. ROSS HALL SKILLERN. (*Annals of Otology, Rhinology, and Laryngology*, June 1925.)

What is meant by chronic sinusitis? Is it an infection of long duration with little change in symptoms and no reference to ultimate termination, or is it a permanent pathological condition, with little hope of spontaneous recovery, regardless of the time it has been established?

There is no fixed limit between an acute and chronic infection.

Cause of chronicity depends on several factors:—

1. Interference with aeration and drainage, natural or acquired.
   (*a*) Deviations of septum causing pressure on bulla.
   (*b*) Long narrow fronto-nasal duct.
   (*c*) Large middle turbinates hugging close to the lateral nasal wall.
   (*d*) Deep recesses and partial septa in the sinuses.
   (*e*) Roots of teeth extending into the sinus (maxillary).
2. Acquired:—
   (*a*) Repeated attacks of coryza.
   (*b*) Changes in the lining mucous membrane and destruction of cilia, etc.
   (*c*) Type of infecting organism.

Whatever the original organism, staphylococcus or streptococcus eventually predominates.

The Frontal Sinus.—Chronic infection usually starts from repeated colds in the head.

When the patient is only uncomfortable during exacerbation of an acute attack the mucosa is probably but slightly damaged and will

recover upon removal of a deviated septum or of enlarged middle turbinates blocking drainage.

Even if this stage is well passed, intranasal opening of the sinus should suffice in nearly all cases, the exception being those in which a fistula has arisen, which demand an external and radical operation.

Maxillary Sinus.—The mildest chronic form, never described, shows polypoid degeneration of mucous membrane and a clear, straw-coloured fluid scarcely discernible from irrigating fluid.

This clear fluid sooner or later becomes infected with organisms of suppuration.

Repeated irrigations with an antiseptic fluid are generally disappointing. The author only employs normal saline.

The danger of needle puncture is overrated if three technical points are observed:—

1. Puncture through inferior meatus.
2. A small quantity of air injected first under slightest possible pressure.
3. If resistance is felt, pressure should be removed and the stylet passed through the needle.

Chronic maxillary sinusitis from root canal infection of a carious molar; this source is comparatively rare compared with those of nasal origin, but authorities vary. These cases may become very fetid owing to saprophytic organisms.

A rarer form of chronic infection is due to caseous degeneration of a mucocele of the sinus.

Sphenoidal Sinus.—Less is known about chronic infection of this sinus, especially the mild non-suppurative variety, due to obvious difficulties of approach, etc. The symptoms are those of postnasal catarrh, headache, generally occipital but at times supra-orbital; they disappear on opening the sinus. J. B. CAVENAGH.

Nasal, Aural, and other Focal Sepsis as a Cause of Neurasthenia and Insanity. P. WATSON-WILLIAMS, M.D.Lond. (*Brit. Med. Journ.*, 4th July 1925.)

One case is described in detail in which both antra and both frontal sinuses were operated upon for an infection dating probably ten years earlier. The patient had marked delusions which lasted for months after the operations, but the restoration of his general health was followed by gradual loss of his mental symptoms.

In a second case cited, no actual pus was found in the sinuses but organisms were present with polymorphonuclear leucocytes, and drainage led to loss of depression and mental lethargy. Stress is laid on the importance of the "latent" or hidden character of the focal sepsis in these cases, not only from the point of view of their

being so easily missed, but because it is in these cases rather than in cases of open suppurations with free discharge that mental symptoms are apt to supervene. T. RITCHIE RODGER.

The Vital Risks attending Suppurative Nasal Sinus Diseases and their Methods of Treatment. GEORG RIEDL. (*Münch. Med. Wochenschrift*, No. 30, Jahr 72.)

From the direct and indirect observation of nearly four thousand cases of nasal sinus suppuration the following deductions are made:—

Lavage of the sinuses must be considered to be a potentially dangerous undertaking and should only be carried out under very definite indications.

Lavage should not be carried out on a febrile patient.

On the appearance of fibrinous exudate further lavage is contra-indicated.

In unusually difficult cases of lavage, extra precautions must be observed. In cases of maxillary antrum suppuration, it is better to adopt the less dangerous operative treatment than treatment by lavage. Should such an antral suppuration be complicated by suppurative ethmoiditis or frontal sinus suppuration one should, in the first instance, confine one's attention to the surgical treatment of the diseased antrum, since experience has shown that this treatment may suffice to cure or ameliorate the remaining suppurative conditions. In uncomplicated cases an indication for attacking a sphenoidal or an ethmoidal suppuration can only be held to exist if the suppuration is accompanied by persistent headaches, or if the treatment by lavage is difficult to carry out or causes a rise of temperature.

J. B. HORGAN.

PERORAL ENDOSCOPY.

The Injection of Lipiodol as an Aid in the X-ray Diagnosis of Broncho-Pulmonary Lesions including Tuberculosis. DAVID H. BALLON. (*Canad. Med. Assoc. Journ.*, October 1925.)

The author has carried out a series of X-ray studies of the lung and of bronchial-tree mapping with the aid of lipiodol injection.

The technique is somewhat similar to that used by Lynah with his bismuth emulsion, but the lipiodol gives a very much sharper picture and seems to have no bad effects. Lipiodol was introduced through a bronchoscope after cocainising and cleaning out the bronchial tubes by suction.

The original method of Sicard and Forrestier was to inject the lipiodol through the cricothyroid membrane and then posture the patient. A number of very excellent pictures were obtained illustrating conditions of bronchiectasis and lung abscess, and are reproduced.

Observations are also made on volunteers in order to study the normal appearances, and to observe the length of time that the lipiodol remained in the bronchial tubes under conditions as far as possible normal.

No unpleasant results were met with and the patients did not seem to be upset by the procedure. E. HAMILTON WHITE.

X-ray Demonstration of Pulmonary Changes in Tuberculosis by Lipiodol Injection. EDWARD ARCHIBALD, M.D. (*Canad. Med. Assoc. Journ.*, October 1925.)

This contribution is really supplementary to the preceding article, the bronchoscopic work and injection being done by Dr Ballon. The same technique as above was used to study cavitation in tuberculous lungs.

Archibald has injected an extensive series of cases in which the lung had been collapsed by rib resection for pulmonary tuberculosis. He found that, after a year or so of great improvement, the patient tends to relapse.

The present studies were undertaken with a view to obtaining a more exact idea of the physical conditions present in these collapsed lungs and ultimately to throw some light on the question of possible further operative relief.

A number of striking pictures of bronchial dilatation and cavity formation illustrate the text. E. HAMILTON WHITE.

Retropharyngeal Abscess from lodgment of a Foreign Body in Œsophagus. GABRIEL TUCKER, M.D., Philadelphia. (*Journ. Amer. Med. Assoc.*, 14th February 1925, Vol. lxxxiv., No. 7.)

The author calls attention to a new diagnostic sign of foreign body in the cervical œsophagus. Movement of the trachea or larynx toward the point of localised tenderness, as indicated by the patient, by pressure from the opposite side of the neck, causes a marked increase in tenderness and pain when a foreign body is present. If the foreign body has passed on or been removed, there will be little or no change in tenderness by pressure from the opposite side. This sign is thought to be particularly useful in cases of fish-bone, splinters of wood, and similar foreign bodies which are non-radiopaque or are so slender as to permit a capsule to pass.

PERRY GOLDSMITH.

The Mechanical Excitation of the Vagus during Œsophagoscopy. Dr Sture Berggren. (*Acta Oto-laryngologica*, Vol. viii., Fasc. 1-2, p. 65.)

Medical literature furnishes no reference to this subject. In normal cases no symptoms of vagus stimulation arise, but this is otherwise under certain pathological conditions.

A case is quoted: A woman, aged 53, had increasing dysphagia and hoarseness for one year. For a month she lived on fluids and was practically aphonic. Bougies had been passed without difficulty, but this was followed by symptoms of collapse, which were not reported, however, when the patient was transferred from the general surgical to the special department. The left vocal cord was in the cadaveric position. There was nothing abnormal in the heart or lungs.

Œsophagoscopy lasting two minutes under local anasthesia (6 c.c. of a solution of aetocain 10 per cent.) showed a firm elastic swelling in the left wall at a depth of 25 cm. from the incisor teeth.

No attempt was made to pass this obstacle. The instrument was scarcely withdrawn before it was seen that the patient was unconscious, cyanosed, and pulseless. Death followed in a few minutes. Post-mortem showed an aneurysm of the left subclavian artery, about the size of a large nut in the immediate neighbourhood of the left recurrent laryngeal nerve.

No abnormalities of importance were present in any other organs.

The aneurysm in itself was not large enough to cause the stenosis, except so far as its presence caused continual vagus irritation and secondary spasms of the œsophagus.

The immediate cause of death must have been due to "heart block" produced by vagus stimulation, as the anæsthetic used, especially in limited amount and weak concentration, could not have been responsible. J. B. CAVENAGH.

MISCELLANEOUS.

The Prophylaxis of the Common Cold and Febrile Catarrhs.
A. L. SINREY. (*Lancet*, 1925, p. 1051.)

The writer deals with "febricula, P.U.O., chill, and influenza," all of which begin in the upper respiratory passages. He directs special attention to their spread in schools, where (in boarding schools particularly) they interfere with work and disorganise the whole life of the school. Of the predisposing causes of these affections very little is known. The author has no faith in antiseptic sprays, etc., as preventives, and considers that "nasal drill" has a psychical rather than a physical effect. Prophylaxis resolves itself into (1) keeping out of the way of infection, (2) raising the body immunity. With regard to the first, parents must be "educated" as to the folly of sending children back to school with colds, or taking them during the last week of the holidays to amusement resorts where infection is likely. Infection must be minimised also by thorough cleansing of schools before the pupils' return, and by avoiding the overcrowding of studies and dormitories. Provision of adequate footgear is important.

As regards immunity, this differs within wide limits in individuals.

Abstracts

Attention is directed to raising immunity by vaccines, a question which is at present in a state of chaos. "What is wanted is a combined test effort on the part of medical officers of schools to tackle the problem." Encouraging results are reported from the use of stock vaccines. MACLEOD YEARSLEY.

Respiratory Catarrh in Children. R. C. CLARKE. (*Lancet*, 1925, Vol. ii., p. 864.)

The catarrhal child has received far too little attention, and the author insists upon the early occurrence of catarrh in a large percentage of infants. The signs upon which he bases his diagnosis are (1) snuffles, (2) sucking in of the lower ribs, (3) definite bronchial catarrh. The earlier the infant suffers from nasal catarrh, the longer the complaint takes to clear up; in the majority, it never recovers and becomes chronic. Probably this is the one and only cause of "tonsils and adenoids." It accounts also for the fact of the frequency of discharging ears. Dr Clarke makes the surprising statement that every baby he has examined under 4 weeks old with nasal catarrh has had definite signs of bronchial catarrh. He discusses the pathogenesis of catarrh in the child under two heads: (1) The number and virulence of the catarrhal organisms which attack the mucous membrane; (2) the local resistance of the mucous membrane and the general immunity of the body. It would appear from clinical observations that (1) the very young mucous membrane is deficient in resistance; and (2) that the mucous membrane, which has been the object of early and repeated attacks, either loses or never acquires an adequate resistance. The author agrees with Kenelm Digby of Hong-Kong, that a normal child acquires its local, and in part its general, resistance to catarrhal organisms by frequent submorbid doses of these organisms, but morbid doses do not cause local immunity but rather permanently damage the respiratory epithelium. Obviously prevention of respiratory catarrh is the only correct treatment, and to effect this the infant must (1) avoid "the direct hit" of virulent organisms, and (2) be kept out of stuffy places. The whole article is stimulating and illuminating in its relation to the prevention of nose, throat and ear diseases.

MACLEOD YEARSLEY.

Pemphigus from the Laryngologist's Standpoint. G. B. NEW and P. A. O'LEARY, Rochester, U.S.A. (*Archives of Oto-Laryngology*, Vol. i., No. 6, June 1925, pp. 615-623.)

The authors state that, contrary to usual opinion, patients suffering from pemphigus generally consult a laryngologist because of trouble in mouth and throat. The rapidity with which cutaneous lesions appear

after lesions of the nose and throat may be taken as a criterion of the virulence of the disease and as a guide to prognosis.

T. W. McCART.

The Relation of the Nose and Throat to Endocrine Disturbances. EDWARD A. LOOPER, M.D., Baltimore. (*Annals of Otology, Rhinology, and Laryngology*, September 1925.)

Infection being admittedly one of the most important etiological factors in the production of disturbances in the function of the endocrine glands, the author, taking each of those glands as his headings, proceeds to note cases where the disturbance in their functions has been connected with sepsis in the nose and throat, and has been corrected by treatment of the sepsis.

The cases are collected from numerous sources, as may be gathered from a list of thirty-eight references, to which is added a bibliography of a page and a half.

The author's actual contribution to the subject is the presentation of five cases of glycosuria which appeared to result from infections around the nose and throat, all of which cleared up promptly after the removal of the infected tissue. Three of the cases had infected tonsils removed; the fourth had an infected sublingual gland drained; the fifth case had the sinuses (ethmoids and antra) drained.

NICOL W. RANKIN.

REVIEWS OF BOOKS

Les Grands Syndromes Oto-Rhino-Laringologiques. By A. MOULONGUET. Paris: G. Doin. Pp. 515 with 109 figures. 1926. Price 50 francs.

Although this work may be regarded as a compendium of diseases of the ear, nose, and throat, the subject has been approached from an unusual angle, the various diseases being grouped together according to their symptoms. Under "Nasal Obstruction," for example, are included all varieties of obstruction in the infant, the child, and the adult, and the nasal obstructions of adult life are classified as temporary, permanent, progressive, and post-traumatic. Operative treatment is only briefly mentioned, although there is some account of the anatomy and methods of examination. "Nasal Discharge" and "Epistaxis" are the titles of the next sections; then follows an excellent description of the various causes of "Fetor of the Breath," a symptom which usually receives scant attention.

Diseases of the larynx are described under the following headings: "The Dysphonias," "Laryngeal Dysphonia," and "Tracheo-bronchial