that in May tracheotomy had to be performed. Prof. Massei suggested gastrotomy, but the author tried incising the cicatrix with a pharyngotome, followed by dilatation with Bajeux's and O'Dwyer's tubes. The result was very satisfactory, and the patient can swallow well through the space gained, although this does not permit a view of the subjacent larynx or the œsophageal aditus. There are copious references to the cases of other writers as well as a useful bibliography.

James Donelan.

Duverger, J., and Bain, A.—A Rare Case of Lingual and Pharyngeal Sporotrichosis threatening Asphyxia. "Rev. Hebdom. de Laryngol., d'Otol., et de Rhinol.," April 15, 1911.

In this case of lingual and pharyngeal sporotrichosis the *Sporothrix Beurmanni* was found on bacteriological examination, and treatment with a peroxide mouth-wash and iodide of potassium internally brought about a rapid cure. The paper concludes with a *résumé* of the characteristic features of "sporothrix stomatitis." The onset is insidious and probably very slow. All parts of the bucco-pharyngeal mucosa and even that of the larynx may be affected. The disease is characterised by the formation of ulcers, which are coated with a fœtid material varying in thickness and resembling *papier mâché*. The bases of the ulcers, which may be either discrete or confluent, fungate and bleed readily. There is more or less infiltration of the mucosa, and this may give rise to considerable swelling of the tongue and pharynx. On the palate and pharynx are scattered whitish spots, which probably represent the ulcers in an early stage. The lesions are painless, and may be curetted without anæsthesia. There is not often any glandular enlargement nor rise in temperature. Recovery is usually rapid. *John M. Darling.*

NOSE.

Sieur and Rouvillois.—Anatomical Research on Puncture of the Frontal Sinus. "Rev. Hebdom. de Laryngol., d'Otol., et de Rhinol.," March 4, 1911.

Intra-nasal puncture of the frontal sinus has been recently advocated and systematically employed by M. Vacher. Encouraged by his work MM. Sieur and Rouvillois have revised the subject from the anatomical point of view. They approve of Vacher's instrument—a steel instrument with the double curve of the frontal sinus probe, point and convexity blunt, and with a saw edge on the terminal part of the concavity—and they recommend the following technique: The parts are anæsthetised with pledgets of wool soaked in 5 per cent. cocaine. The middle turbinal and meatus are carefully cleansed. The patient's head is held in the horizontal position by an assistant. The thumb of the operator's left hand gently raises the tip of the nose, the remaining four fingers being steadied on the forehead. The rasp is introduced, and the extremity carried along the angle made by the nasal bones and the septum until an obstacle is met with. The handle of the instrument is now lowered and the point directed outwards towards the upper and inner angle of the orbit. A continued moderate pressure will now carry the point into the sinus.

This procedure was carried out with success on the cadaver by the authors in twenty-four cases. They hold that it is possible to perform intra-nasal puncture of the frontal sinus, and they consider that clinically it would at least be a useful adjuvant to removal of the middle turbinal and opening of the anterior ethmoidal cells in order to avoid acute retention while awaiting a convenient occasion to employ external methods.

John M. Darling.

Frankenberger, O. (Prague).—Ocular Disturbances in Diseases of the Nasal Accessory Sinuses. "Zeitschr. f. Laryngol., Rhinol., etc.," Bd. iii, Heft 3.

The author first refers to affections of the lacrymal apparatus caused by intra-nasal disease, and then goes on to discuss cases of orbital abscess due to rupture of an empyema of the sphenoidal, ethmoidal or frontal sinus. Case 1: Male, aged thirty-seven, had diminution of vision and diplopia for five months, left eyeball displaced outwards. Left ethmoidal bulla enlarged, left nasal cavity contained pus. Bulla opened with Hajek's hook, anterior ethmoidal cells opened up. The orbital displacement soon recovered. Case 2: Male, aged sixteen, suffered from swelling of eyelids on right side of four days' duration. Right middle turbinal swollen. Sondermann's suction apparatus removed a good deal of pus. The orbital abscess was at first incised and later the ethmoidal labyrinth was opened up and curetted. Case 3: Female, aged twenty-three, suffered from attack of coryza. Some days later sudden swelling of right eye; globe displaced forwards. Right middle turbinal polypoid with pus in middle meatus. Patient refused external operation and orbital abscess burst spontaneously. The middle turbinal was later resected and the ethmoidal region curetted. Both the ocular and nasal conditions returned to normal.

Passing to affections of the uveal tract the author notes that Ziem believes in a direct connection between sinusitis and iritis. Kuhnt, on the other hand, believes that sinusitis is only a predisposing cause; he has, however, seen opacity of the vitreous clear up after treatment of an antral empyema. Finally, in connection with affections of the retina and optic nerve the author gives a short account of Onodi's work, and states that if the wall of the optic canal be thin or dehiscent, suppuration in the posterior sinus may lead to perineuritis or to retrobulbar neuritis with limitation of the field of vision, amblyopia, central scotoma and amaurosis. As Hajek has shown, there may be pressure on the inner wall of the optic canal or on the veins from the sphenoidal sinus which have a collateral connection to those of the optic nerve. The author then gives a brief account of the cases recorded by ten writers. It is interesting to note that in several cases suppuration and even necrosis existed in the ethmoidal and sphenoidal cavities with little or no sign of it in the nose. Frankenberger records the case of a patient, aged twenty-eight, who had had nasal polypi frequently removed, and had suffered from severe headache since the last operation. Four days after there was sudden loss of vision in the left eye and the fundus was seen to be hyperæmic. The frontal sinuses and antra were normal, but there was pus and polypoid tissue in the left ethmoidal region. A radiograph showed a shadow in the left sphenoidal region. The middle turbinal was removed and the ethmoidal and sphenoidal sinuses freely opened up and

curetted. They contained pus and polypi. Colour vision gradually returned, but a central scotoma for red and green remained on the left side. The case is not reported as "cured" because polypi and pus are still present in the nose. *J. S. Fraser.*

Fabri, Dr. Elio (Florence).—On the Action of Iodo-thiocinnamine on Exuberant Cicatrices of the Nasal Cavity. "Bolletino delle Mal. d'Orecchio, etc.," Florence, 1911, p. 80.

The author describes a very interesting case in which as the result of a severe accident extensive synechiæ with almost complete occlusion had formed in both nasal cavities. Having cut with scissors the most prominent bands the surfaces were dressed daily with pledgets of gauze in iodo-thiocinnamine for twenty-four consective days. Cocaine was applied before each dressing. One c.c. iodo-thiocinnamine was given on alternate days by deep gluteal injection on forty occasions. An excellent result is reported. The author leaves it an open question how much of the success obtained was due to the local treatment apart from the injections. *James Donelan.*

Arrowsmith, H.—A Case of True Papilloma of the Nasal Septum. "Laryngoscope," February, 1911, p. 85.

The patient, a girl, aged twelve, had had left-sided nasal obstruction with some bleeding and soreness for a year. A small growth $\frac{3}{16}$ in. in diameter was found on the left side of the septum just behind the columnar cartilage. The growth was removed and on section found to be a papilloma. This is the thirty-fifth case that the author has been able to find recorded. *John Wright.*

Freer, O. T.—Sarcoma of the Nasal Wall of the Maxillary Antrum. "Laryngoscope," February, 1911, p. 98.

The patient, a woman, aged forty, was first seen in December, 1908, with a history of left nasal obstruction with bleeding and fœtor for five months. A pink, lobulated growth was found filling the left side of the nose and naso-pharynx. This growth was removed intra-nasally without any great loss of blood with the author's per-nasal forceps. The turbinal bones and ethmoidal cells on that side were found to have been completely eroded by the growth. Six recurrences were removed intra-nasally from the naso-antral wall, and the patient when last seen had been free from recurrence for eight months. Histologically the growth was a mixed-celled sarcoma with extensive necrotic areas. *John Wright.*

Metzenbaum, M.—Submucous Resection, with a Description of the Author's Special Instruments. "Laryngoscope," February, 1911, p. 86.

The author advocates the administration of $\frac{1}{100}$ gr. of hyoscin hydrobromide half an hour before operation, and has found that by this means satisfactory anæsthesia can be obtained by the use of as weak a cocaine solution as 2 per cent. applied locally. The special instruments consist of a chisel on the pattern of Ballenger's knife but with a fixed blade, and a pair of cutting pliers, the author being able to remove cartilage and bone in one piece by means of these instruments. *John Wright.*

Carter, W. W.—Transplantation of Bone for the Correction of Depressed Deformities of the Nose. "Laryngoscope," February, 1911, p. 94.

The author has treated successfully three cases of depressed nasal deformity with loss of bone by autoplastic transference of bone. A piece of the ninth rib free from periosteum and about 2 in. in length is removed from the patient and a suitable piece of the outer compact layer split off and shaped. Through a transverse incision over the naso-frontal suture the skin and subcutaneous tissues are elevated with a thin curved two-edged knife and the graft inserted. The inserted fragments can be shown by the X rays to persist. *John Wright.*

LARYNX.

Citelli, Prof. (Catania). — Intubation and Tracheotomy in Acute Laryngeal Stenosis in Children. "Zeitschr. f. Laryngol., Rhinol., etc.," Bd. iii, Heft 3.

This is a contribution to the old question, intubation *versus* tracheotomy. The author thinks that those who uphold one method only go too far, and that the operations are not really opposed—they are complementary; in fact, Citelli believes in the combination of both methods in many cases. In urgent cases of diphtheria the author believes in intubation, but says that in many cases this proceeding must be followed later by tracheotomy on account of stenosis of the larynx remaining after the disease has passed off. Tracheotomy is also indicated in cases of repeated spontaneous extubation. The most common cause of stenosis is swelling of the subglottic region with or without ulceration; if the tube be removed in these cases the dyspnœa recurs as a rule in a few hours, but it may not come on for five or eight days. In cases of chronic stenosis laryngotomy may be indicated, but Citelli advocates his own method—tracheotomy combined with the introduction of a small laryngeal tube through the tracheotomy wound. Citelli again calls attention to the fact that after tracheotomy stenosis is usually due to the incision having been made through the cricoid cartilage; this leads to subglottic œdema or to granulation-tissue formation. He narrates a diphtheria case in which tracheotomy was performed by another surgeon; after eight days the tube was removed, but had to be replaced. The tube was again removed, but the child soon began to have dyspnœa. On laryngeal examination Citelli saw a cicatricial ring below the cords at the lower border of the cricoid which had been cut at the operation; he treated the case by introducing an intubation tube, and only removed it fourteen days later; complete recovery.

In cases of stenosis following diphtheria, measles or typhoid, Citelli recommends intubation. The tube should be left in position for twenty-four hours. If symptoms recur the tube should be again introduced, and then tracheotomy slowly and carefully performed, the incision passing through the second and third tracheal rings; by this method the intubation tube can be introduced through the tracheal wound if necessary. In other cases in which the intubation tube is spontaneously coughed out on several occasions, it is advisable to perform tracheotomy at once. Finally, if the surgeon cannot remain near the case, both intubation and tracheotomy are indicated. By these methods laryngostomy with its troublesome after-treatment may often be avoided. *J. S. Fraser.*