

piece removed: "Carcinoma of adeno-papillary type." The growth involved the lateral mass of the ethmoid. It was removed eight months ago by an external operation which permitted of full exposure of the interior of the nose, but recurrence took place after five months. This was removed, and the nose has, up to the present, remained free from the disease.

(b) J. A.—, aged fifty-nine. Admitted to Western Infirmary, Glasgow, on February 2, 1913, complaining of swelling over nasal bones, extending to region of frontal sinuses. The swelling is symmetrical, slightly irregular; hard, except at one or two places. History: Twelve years ago he had polypi removed from his nose by his own doctor. These recurred from time to time, portions being removed on twelve different occasions. Fifteen months ago he began to wear glasses, straight bar with nose-clips. Within a short time he found that the glasses did not fit, owing to a swelling beginning to form. There was no pain. The swelling gradually increased. Piece removed for examination. The pathologist reported carcinoma.

Sir STCLAIR THOMSON suggested that pathologists sometimes make mistakes. The swelling was symmetrical and not tender. Clinically, the patient has neither had spontaneous nor profuse epistaxis, such as one would expect. Malignant disease of the nose is not common in the opinion of those with large experience. Clinically, it was most unusual for a neoplasm to cause so many symptoms externally and so few internally. He suggested that Dr. Downie should again submit a further specimen to another pathologist.

Dr. WALKER DOWNIE replied that at first sight he thought the new growth might be a sarcoma. But when a fairly large piece was removed and examined the tissue was found to be carcinomatous in nature. The patient was seen in consultation with Sir George Beatson, who, impressed by the report and the position and size of the new growth, advised against operation. He would, however, adopt Sir StClair Thomson's suggestion and have another piece removed and examined.

## Abstracts.

### EAR.

**Dench, E. B.—The Differential Diagnosis between Brain Abscess and Sinus Thrombosis and the Treatment of these Conditions.** "The Therapeutic Gazette," August 15, 1912.

The author states that in cases of middle-ear suppuration one patient in eighty-eight suffers from some intra-cranial complication.

In brain abscess three stages are recognised:

(1) The *stage of infection*, which is acute, and lasts from two to ten days, and is characterised by high fever and rapid pulse.

(2) The *latent stage*, during which the temperature is normal or sub-normal, and the pulse-rate either normal or reduced in frequency. This stage may last weeks or years.

(3) The *terminal stage*, often with general symptoms from rupture of the abscess into a ventricle.

As regards the symptomatology, headache generally is persistent, and is severe enough to keep the patient awake. It is an early and significant symptom.

Vomiting is a symptom of great importance in the initial and

terminal stages. Muscular paralyses naturally depend on the position of the abscess; the sixth nerve is most frequently involved. Optic neuritis is of great importance in suspected cases. Aphasia and nystagmus are of value as localising symptoms.

The most characteristic symptom of a septic thrombus in the lateral sinus or jugular is a sudden elevation of the temperature, followed usually by a rapid fall, but sometimes this remission does not occur, repeated infections maintaining the temperature between 103° and 105° F.

Patients often complain of no discomfort except slight headache when the temperature is at its height. In the author's experience rigors are present in only half the cases. He has not found the cord-like swelling which is described by many observers as being present along the anterior border of the sterno-mastoid muscle, and considers glandular enlargement a symptom of greater importance. In later stages septic pneumonia is the most frequent complication, but septic foci may arise in any of the viscera; not infrequently optic neuritis may be found. The value of differential blood-count in these cases is exceedingly problematical, but a blood-culture, if "positive," practically clinches the diagnosis; a negative blood-culture, however, does not exclude sinus thrombosis.

When intra-cranial abscess has been diagnosed immediate operation is indicated, and the focus of suppuration should be attacked along the path of infection. A wide dural exposure including the original infected area should be made: an incision into the brain through the infected dura will usually enter the abscess cavity. A director passed into the brain will frequently evacuate a few drops of pus along the groove. For this purpose the author finds both the knife and the aspirating needle useless. Two narrow retractors are now passed into the abscess and separated, care being taken to evacuate the abscess slowly, so as to avoid reducing intra-cranial pressure too rapidly.

In opening a cerebellar abscess it is advisable to gain access in front of the lateral sinus unless this is placed too far forward. In some cases a counter-opening behind the sinus is needed to secure thorough drainage. In such cases a separate exposure of the cerebellum should be made, posterior to the mastoid emissary vein.

In cases in which the abscess cannot be located a free, crossed incision of the dura—a decompression operation—is advised and the subdural space should be packed with iodoform gauze. The abscess may then be discovered by incision twelve to twenty-four hours later. By this two-stage method the subdural space is walled off, and the risk of general meningeal infection is diminished.

Operation is equally urgent when sinus thrombosis has been diagnosed. The sinus should be exposed very freely. The signs usually given for detecting the presence or absence of clot in the sinus before opening it, though theoretically perfect, in practice admit of many exceptions. If the diagnosis is reasonably certain the sinus wall should be incised. Any obstructing thrombus should be removed, and the operator should not desist until free hæmorrhage from the torcular end of the sinus is obtained. In dealing with the lower end of the sinus the author is in favour of the same rule, *i. e.* to evacuate any clot by means of the curette, pressure being applied to the internal jugular in the neck, in order to prevent the entrance of air. If, however, the symptoms of general sepsis are severe the jugular is ligatured before exploring the lower end of the sinus. A positive blood-culture invariably indicates

jugular excision. The value of simple ligature of the internal jugular is problematical; cases doing well after it would probably have recovered without interference with the vein. In dealing with sinus thrombosis it is always better to err on the side of radicalism.

*Knowles Renshaw.*

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### NOSE.

**Christie, N. A. (Welland, Ont.)—Nasal Diphtheria.** "The Canadian Practitioner," January, 1912.

The patient, male, aged seventeen, was seen first on July 30, when diphtheria was diagnosed. The face was pallid, the tonsils and uvula covered with thick greyish membrane; from the nares issued a sanguino-purulent discharge, and cellulitis was so great about the angle of the right jaw that the upper and lower sets of teeth were not in line. The odour was characteristic of the disease.

During the first four days 18,000 units of antitoxin were administered. On the sixth day the membrane commenced to loosen in the throat. On the seventh day profuse hæmorrhage occurred from the right nasal passage, and, on forcible blowing of the nose, an almost complete cast of the mucous membrane on that side was ejected. This membrane was very tough, and nearly one eighth of an inch thick. To control the bleeding, a tampon soaked in solution of perchloride of iron was inserted. This was removed on the following day, when a similar cast from the left nasal passage was blown out.

From this time there was marked daily improvement until the twelfth day, when the heart's action became weak and irregular. This was followed by pharyngeal and general paralysis with all the usual symptoms of this complication. Treatment was by the ordinary methods in such cases, including iron, strychnine and electricity, but the patient did not fully recover until four months from the date of the attack.

*Price-Brown.*

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### THYROID GLAND.

**Farrant, R. —Thyroid Action and Reaction.** A Paper read before the Pathological Section of the Royal Society of Medicine on October 15, 1912.

The author said that the thyroid secretion was absorbed by way of the thyroid veins. These veins corresponded in size to the thoracic duct and right lymphatic trunk; they guarded the junction of the lymph with the venous circulation.

Certain toxins were absorbed by the lymphatics and passed up through the terminal lymph-trunks to come into immediate contact with the thyroid secretion. In these toxæmias a hyperplasia of the thyroid occurred without enlargement. This hyperplasia was illustrated by a series of slides taken from cases of infantile diarrhoea, diphtheria, measles, whooping-cough, broncho-pneumonia. So certain was this hyperplasia that in a given series the duration of the disease could be accurately arranged according to the degree of hyperplasia that had taken place. The reaction did not depend on the increased metabolism of febrile conditions, as it only occurred in certain diseases; for instance, infections with staphylococcus.