vision was $\frac{5}{7}$ and the colour scotoma gone. On the tenth day the vision was $\frac{5}{5}$, the inner margin of the papilla was indistinct and was still so by the end of January as some neuritis was still present.

Case 10.—Neuritis acuta. A young man who, in December, began to suffer with left-sided headaches and within five days completely lost the sight of the left eye, presented himself with the following report from the oculist: Almost absolute central scotoma left side, cannot see the hand before his eyes but only the finger-tips; axillary neuritis; the papilla is red and its margin indistinct.

The left middle turbinal was much swollen and the middle meatus filled with pulsating pus. Acute purulent ethmoiditis was diagnosed, the frontal sinus being probably similarly affected, as transillumination showed this side much darker although no tenderness could be elicited over it. After the application of cocaine and adrenalin to the middle turbinal and its neighbourhood, the patient already stated that he could recognise light in the left eye. The middle turbinal was at once removed and the ethmoidal cells opened up. After the operation vision $\frac{5}{50}$, headache gone and did not recur. The third day, vision $\frac{5}{20}$; the fifth day, $\frac{5}{7}$; no scotoma could be detected and the neuritis had completely disappeared. By February the vision was $\frac{5}{5}$, and since January all discharge had stopped.

The very rapid and complete cure of this case was a most gratifying surprise, says Baumgarten, both to the oculist and himself, and quite eclipsed anything either of them had seen.

In conclusion he adds that he has since seen a "number" of similar cases which he has been able to either cure or considerably improve, and he urges very strongly that a very careful watch should be kept for such conditions and their recognition met with prompt intra-nasal treatment.

[The article is perhaps principally worthy of note in relation to the discussion which followed Prof. Onodi's paper this summer at Birmingham, where the very frank expression of opinion on this subject and the personal experience of most members were certainly somewhat at variance with the most satisfactory results as described by Baumgarten. This report should be read in conjunction with its predecessor or the two original articles should be studied together. An endeavour has been made to represent the paper without bias, but it is obvious that many points arise on which further information would be desirable before one can unreservedly associate oneself with the author's sanguine conclusions, whilst the last case should not be included in the same category as that of the previous three here reported. The account would further command much more reliance were it leavened with the relation of but one *un*successful case, for such indeed, occasionally at any rate, do occur.]

Alex. R. Tweedie.

MOUTH AND PHARYNX.

O'Meara, J. M.—Note on a Case of Adenoids Associated with Albuminuria and Casts in the Urine. "Lancet," May 6, 1911, p. 1204.

Boy, aged seven, with marked adenoid symptoms, in whom was found a very large number of casts and a quite small quantity of albumen. Very marked improvement set in immediately after removal of the adenoids,

so that there was more improvement in the three days after the operation than in the three weeks preceding it, when he was kept in bed on a milk diet. The casts were epithelial, granular, hyaline and blood, with renal cells and red blood-corpuscles. *Macleod Yearsley.*

Guyot, F.—General Anæsthesia in Operations on Tonsils and Adenoids.—"Revue Méd. de la Suisse Romande" July 20, 1910.

Dr. Guyot thinks that ordinary tonsillotomy, performed with the guillotine, is not painful, or at any rate not painful enough to justify the use of a general anæsthetic; and the same may be said of curetting adenoids. The adenoids themselves contain very few nerves and the bulk of the pharynx is very insensitive. Therefore as a rule tonsillotomy and curetting of adenoids can be performed quite successfully, and ought to be performed without general anæsthesia. Only when a child is intractable or is very delicate or nervous ought a general anæsthetic to be used. Ethyl chloride is the safest and in every respect the most convenient general anæsthetic to use, and should be administered in the mask designed by Dr. Camus. *Arthur J. Hutchison.*

Burack, S. M. (Charkoff).—Cases Illustrating the Complications met with after Removal of Adenoids and Tonsils. "Zeitschr. f. Laryngol.," Bd. iii, Heft 5.

The paper is the result of an experience of 2000 cases; 3 per cent. of the patients were middle-aged and three individuals were over fifty years. Dangerous hæmorrhage occurred on three occasions; in the first of these Mikulicz's compressor was used, in the second case the hæmorrhage stopped when the patient fainted, while in the third prolonged digital compression was successful in arresting the bleeding. Mathieu's tonsillotome was used in every case. Out of 1500 cases of adenotomy there were five with severe hæmorrhage. In the first post-nasal plugging was carried out; no cause could be found for the bleeding, but Burack suggests that the knife may have been too sharp (!) In a second case the hæmorrhage ceased when a tag was removed. Other complications were: Injury to uvula; slight septic infection; seven cases of purulent otitis media, as a rule in children suffering from purulent rhinitis; catalepsy; laryngeal spasm; paresis of soft palate; peritonsillar abscess; loss of teeth.

J. S. Fraser.

Labourè, Jules (Amiens).—Respiratory Re-education of Adenoids. "Arch. Internat. de Laryngol., d'Otol., et de Rhinol.," March–April, 1911.

Respiratory exercises should first be short. After a certain number of exercises have taken place the more freely moving parts of the thorax may be partly immobilised by an elastic band for the purpose of enabling the more inert parts to participate in the action. The breathing exercise should take place through the nose and in the recumbent posture while the patient is relieved of all tight clothing. (1) Simple respirations unaccompanied by movements. The patient is requested to fill the chest, then to empty it while the thorax is compressed. These movements at first are somewhat fatiguing, and later, when less so, should be performed in the standing, sitting and kneeling positions. (2) Later, respiration is performed while massive movements of the arms and trunk are made, these movements somewhat resembling those made in artificial

respiration. The same movements are then gone through in the upright posture. (3) Active movements follow combined with the deep respiration; the movements of Swedish gymnastics are here suitable. Later, these respiration exercises are combined with walking, running and climbing upstairs, the respiration being regulated to successive movement of the right or left foot. Respiration should be of the inferior costal type, which implies abdominal at the beginning and apical towards the end of inspiration. These movements, of course, should be combined with suitable hygienic conditions. *J. D. Lithgow.*

LARYNX.

Sytschow, K. (Moscow).—Trichloracetic Acid in Laryngeal Tuberculosis. "Zeitschr. f. Laryngol.," Bd. iii, Heft 5.

The writer first paints the laryngeal mucosa with the following solution: Cocaini muratici, 1·0; antipyrin, 0·5; ac. carbolici, 0·05; aq. destillat, 10·0. To this a drop of adrenalin may be added. Sytschow prefers the crystals of trichloracetic acid as they penetrate more deeply and do not spread; he deposits these in the ulcerating surface and has never seen œdema or spasm result. He claims that the applications are painless. In cases with unbroken mucosa the acid eats through the healthy epithelium and basement membrane. The author reports three successful cases of interarytænoid tumour treated as described, and twenty-two cases with ulceration, infiltration, œdema, and granulation formation. The dysphagia was relieved, the surfaces became healthy, the infiltration and œdema quickly diminished, the cough and hoarseness were greatly improved. *J. S. Fraser.*

Sieur and Rouvillois.—Regional Anæsthesia of the Larynx in Tuberculous Laryngitis. "Arch. Internat. de Laryngol., de Otol., et de Rhinol.," May–June.

Boulay, in the *Presse Médicale*, January 15, 1911, has considered this subject, describing the three following methods: (1) Submucous injection of novocaine, (2) passive hyperæmia of Bier, (3) injection of alcohol into the trunk of the superior laryngeal nerve. The author has only experience of the third method, and preferably employs, instead of alcohol, a ½ per cent. solution of cocaine, which is injected according to the method described by Chevrier and Cauzard in the *Bulletin Médical*, February, 1910. The following is the method: Take a point along the superior border of the thyroid cartilage about 2 cm. from the middle line and 1 mm. or 2 mm. above this border. Inject the skin and submucous tissue slowly, pressing the needle towards the thyroid cartilage. The point of the needle is then directed slowly upwards and backwards, and the injection progressively finished. Gently massage the region with the thumb from below upwards, and from before downwards, to assure diffusion of the cocaine. It may be necessary to make these injections every second day. After the third or fourth injection the pain disappears. This method will also be found of use in tracheal or bronchial examination by Killian's method, and in endo-laryngeal surgery (cauterisation and removal of polypi). It may also be found of use in external operations, such as tracheotomy, thyro-fissure, and partial and complete laryngectomy. *J. D. Lithgow.*