TRACHEA AND ŒSOPHAGUS.

Pierre-Nadal, L. (Bordeaux).—*Contribution to the Study of the Physiology of the Œsophagus.* "Revue Hebd. de Laryngol., d'Otol. et de Rhinol.," January 30, 1909.

The question discussed is whether the lumen of the middle two thirds of the œsophagus is virtual or actual during repose. The conclusion is that in the normal subject, and in a state of repose, the lumen is entirely virtual. *Chichele Nourse.*

Hirschland, L. (Wiesbaden).—*Two Cases Illustrating the Importance of the Direct Methods of Examination.* "Zeitschrift für Laryngol.," vol. ii, Part IV.

In the first case, that of a child, aged three, the symptoms were such as to suggest the possibility of a foreign body in the bronchus. Examination, however, with the bronchoscope through a low tracheotomy opening proved the condition to be that of rupture of a diseased bronchial gland into the right main bronchus. Recovery took place.

In the second case it was found possible by means of the direct methods to arrive at an accurate diagnosis in an obscure case in which an œsophageal abscess with rupture into the trachea had followed a burn by caustic soda. *Thomas Guthrie.*

EAR.

Schoetz, W. (Heidelberg).—*Epidermic Cysts following Transplantation in the Cavity produced by the Radical Mastoid Operation.* "Arch. of Otol.," December, 1908.

In one case the cyst formed a swelling extending from the tip of the mastoid into the retro-mandibular fossa. The author thinks a portion of the plastic skin-flap may have been shut in under the Thiersch graft.
Dundas Grant.

Pistre, E. (Bordeaux).—*Pure Fibroma of the Auricle (Anti-helix).* "Revue Hebd. de Laryngol., d'Otol. et de Rhinol.," March 13, 1909.

The growth of the tumour followed a prick with a thorn of the *Cassia occidentalis.* Five days later a small growth appeared, which in ten days attained the size of a large cherry, attached by a small pedicle. The tumour was solid and quite spherical, very tough, and creaking under the knife. The section was yellowish-white, composed of numerous concentric fibres. *Chichele Nourse.*

Zebrowski, A.—*A Case of Double-sided Mastoiditis after Traumatic Perforation of the Drum Membranes.* Quoted from "Gazeta lekarska," 1909, No. 4; "St. Petersburger med. Woch.," xxxiv, 1909, S. 190.

The case is of interest owing to the rarity of complications which require operation occurring after traumatic rupture of the membrane. The patient, a soldier, was brought to hospital in an unconscious condition caused by a bomb explosion in Warsaw. The unconsciousness lasted some days. Thirteen days after the operation bilateral otorrhœa developed, and on examination a perforation was found in each membrane in the anterior inferior quadrant. The hearing was greatly impaired.

Evidence of mastoiditis developed and Schwartze's operation was performed on both sides. The author was of the opinion that the detonation of the bomb explosion caused a concussion of the labyrinth and middle ear and a rupture of both drums. *W. G. Porter.*

Isemer, F. (Halle).—*Further Clinical Experiences of Bier's Hyperæmic Treatment in Acute Suppuration of the Middle Ear.* "Arch. f. Ohrenheilk.," Bd. 75, Heft 1 and 2, March, 1908, p. 95.

This is the second series of cases treated by the Bier method that Isemer has published, and as a result of his experience he condemns the treatment as treacherous. It rapidly and completely banishes all pain, and gives rise to a feeling of general comfort and well-being, and yet, as several of his detailed cases show, the suppuration may all the time be extending widely in the interior of the mastoid. Moreover, it may mask a cerebral abscess, for in those cases where deep-seated boring occipital headache persisting after the radical mastoid operation is the only sign of the brain-disease, the Bier treatment, by soothing this pain, gives rise to false feelings of security. Consequently, this special form of treatment should never be tried save on patients in hospital, and even then only with the utmost care and vigilance, lest grave symptoms should suddenly make their appearance. *Dan McKenzie.*

Scott, Jas.—*Acute Mastoid Suppuration and Suppuration in the Neck Treated with Staphylococcus Vaccine.* "Brit. Med. Journ.," December 18, 1909.

Man, aged fifty-six; acute middle-ear suppuration, followed by mastoid involvement, which, on operation, proved to be of the Bezold variety. Operation done November 4, 1908; but suppuration, with fresh abscesses, continued until April 11, 1909, when cultures were taken and found to yield *Staphylococcus pyogenes albus, Diplococcus pneumoniæ*, and a bacillus of undetermined species. On April 17 a dose of 50,000,000 staphylococcus vaccine was used, followed by 100,000,000 on April 24, and similar doses every tenth day until he had received eight injections. After the fourth dose no discharge, and wound healed. *Macleod Yearsley.*

Leidler, Rudolf (Vienna).—*Otitic Gravitation (Subcephalic) Abscess.* "Arch. f. Ohrenheilk.," Bd. 75, Heft 1 and 2, March, 1908, p. 14.

An exhaustive dissertation illustrated with reports of twelve cases, exemplifying the various types of otitic subcephalic abscess.

In addition to the familiar Bezold's abscess, pus issuing from a perforation in the mastoid process may travel—(1) into the parotid region, superficial to the masseter and opening through the skin of the face, or under the ramus of the jaw between the pterygoids to the mucous membrane of the cheek; (2) inward to the tonsil and soft palate, and thence to the retropharyngeal space (which may also be reached by extension of the inflammation along the Eustachian tube); (3) backwards along the digastric muscle or the occipital artery to the intermuscular tissue at the back of the neck. Further, the infection may extend to the soft structures of the neck by way of the internal jugular or mastoid emissary veins, or through the carotid canal. It is also pointed out that a wide extension is to be looked for if the pus finds its way into the so-called cervical cellular planes or clefts, the loose tissue of which favours a rapid spread of the infection. These clefts are as follows: (*a*) the retro-visceral or pre-vertebral, which leads into the posterior mediastinum; (*b*)

the pre-visceral, immediately in front of the larynx and trachea, which passes into the anterior mediastinum; (*c*) the peri-vascular, within the carotid sheath, which extends from the petrous bone above to the arch of the aorta below; (*d*) the intermuscular space of Henke, which leads either superficially over the clavicle, or along the omo-hyoid into the perivascular space, or down into the axilla.

With reference to treatment, the usual advice is given to open the mastoid process first of all and to follow up the pus in its burrowing, avoiding, as far as possible, the infliction of large or multiple incisions. The author very properly recalls to our memory the danger that is run when much pressure is applied to abscess-swellings in the neck before they have been opened. *Dan McKenzie.*

Citelli, S. (Catania).—*A Case of Abscess at the Apex of the Mastoid Process, with a Deep Cervical Abscess, the result of Peri-sinusitis.* "Annales des Mal. de l'Oreille, du Larynx, du Nez, et du Pharynx," February, 1909.

From anatomical researches eight years ago the author realised that a peri-sinusal abscess might, by extension outwards through pre-existing channels, give rise to a collection of pus at the tip of the mastoid process extending to the deep parts of the neck, resembling Bezold's abscess. He found that in 25 per cent. of crania the mastoid emissary vein emerged at a point beneath the sterno-cleido-mastoid, and generally in the neighbourhood of the temporo-occipital suture—in 2 per cent. dehiscences were present in this suture—and that rarely an emissary from the sigmoid sinus made its exit near the stylo-mastoid foramen; this he designated the "para-stylo-mastoid emissary." Pus having arrived externally by any of these routes will be situated beneath the sterno-mastoid, most frequently about the tip and posterior border of the mastoid, and if not dealt with early will extend down the neck alongside the carotid sheath, behaving precisely as a Bezold's abscess. The following is an illustrative case:

A man, aged fifty-seven, with a history of having contracted a cold two months previously, experienced painful twinges in the left ear, radiating over the corresponding half of the head. The pains increased, and soon afterwards a swelling appeared at the tip of the mastoid process. Several days previous to his entering hospital he had severe tinnitus, heaviness of the head, a guttural voice, dysphagia, mental dulness, with high fever. He had never had either aural discharge or vomiting. The neck was rigid from purulent infiltration. The drum-head of the affected side was intact, but infiltrated and bulging; the meatus was narrowed owing to sagging of the posterior superior wall. There was tumefaction about the tip of the mastoid and over almost the whole of the upper half of the neck. Pressure over the antrum and swollen parts gave rise to intense pain. Examination of the throat revealed a fluctuating swelling of the left side of the pharynx, which was opened at once; thick pus escaped. Paracentesis performed gave exit to pus. Kernig's sign negative; hearing for speech absent. The diagnosis made was acute suppuration of the middle ear, with Bezold's mastoiditis, lepto-meningitis, and otitic pharyngeal abscess.

Operation: A skin incision was made from just above the antrum downwards to the lower limit of the cervical swelling; the skin and periosteum were detached from the mastoid region. Neither cortical fistula nor pus were found, but on detaching the periosteum and over-

lying tissues backwards a little beyond the posterior border of the mastoid process pulsatile pus was observed issuing from a fistulous track, situated under the insertion of the sterno-mastoid at the lower extremity of the temporo-occipital suture. Pressure applied to the cervical swelling induced a flow of pus behind the tip of the mastoid process. On opening the mastoid the whole of the bone down to the apex was eburnated and healthy. The antrum was full of pus, which had given rise by extension through its posterior wall to a peri-sinusal abscess, involving the whole of the sigmoid sinus. The osseous fistula whence the pulsating pus escaped corresponded exactly to the lower extremity of the peri-sinusal abscess, and was no doubt the mastoid foramen. The base of the antrum and extra-sinusal abscess were freely opened. The sinus was not interfered with, there being pulsation and no pyæmic symptoms. The deep cervical abscess was opened to its lower extremity; an enormous quantity of pus escaped. The entire mastoid apex was removed; its cortex was perfectly intact. The abscess about the tip of the mastoid and neck had arisen from the peri-sinusal suppuration. The author observes that this form of cervical abscess, clinically identical with Bezold's, presents in its very early stage one slight difference, viz. that the tumefaction about the apex of the mastoid tends to spread behind the posterior border of the process; this is only appreciable at the very outset. *H. Clayton Fox.*

Kramm, S. (Berlin).—*Phlebitis without Thrombosis as a Cause of Obliteration of the Sinus in Children.* "Arch. of Otol.," December, 1908.

The author refers to instances of obliteration of the sigmoid sinus found accidentally at operation [the abstractor has found it *post mortem*]. He holds that it may take place through phlebitis and pressure by an extra-dural abscess. In the cases observed by him the subjects were children, aged respectively seven, nine, and eleven years, and an extra-dural abscess was either present or had presumably existed before the destruction of the bony sulcus. *Dundas Grant.*

Rimini (Trieste).—*Simple Otogenic Pyæmia without Sinus Phlebitis.* "Arch. de Laryngologie, etc.," tome xxviii, No. 4, July–August, 1909, p. 140.

A female, aged fifty-seven, the subject of chronic arthritis. Acute suppuration set in suddenly in left ear, with temperatures running between 103° and 104·4° F. Mastoid, tender on pressure. No operative treatment. Albuminuria on fourth day; swelling and tenderness in right leg on fifth day; collapse and death on the sixth day.

Post-mortem.—Brain, meninges, and lateral sinus all healthy. Purulent infiltration of muscles in right thigh. Bacteriological examination of ear-discharge and contents of the abscess in the thigh showed numerous diplo-streptococci. *Dan McKenzie.*

Vierhuff, Dr.—*Otitic Abscess or Encephalitis?* "St. Petersburg med. Wochens.," xxxiv, 1909, S. 13.

The patient, a male, aged twenty-eight, was sent to hospital with a diagnosis of brain abscess. There was a history of left-sided otorrhœa of six years' duration, with frequent attacks of giddiness for the past six months. The night previous to his admission he lost consciousness. On examination: Left ear, fœtid pus, destruction of membrane; nervous system, reflexes absent; pupils react, no optic neuritis; pulse 64; temperature subnormal; cerebro-spinal fluid normal. The following day a

right-sided hemiplegia developed. Pulse 120, temperature 100·5° F. The next day the radical mastoid operation was performed and the brain explored without finding pus. Three days later the patient died. At the section hæmorrhagic encephalitis was found.

The question is discussed, Was the encephalitis a result of the otorrhœa or not? *W. G. Porter.*

Mosher, H. C.—*A Specimen of an Encapsulated Brain Abscess.* "Boston Med. and Surg. Journ.," July 15, 1909.

The specimen was taken from a man, aged forty, who had been operated upon for acute mastoid three months before. A brain abscess was evacuated by operation immediately. The patient became worse next day, after some amelioration, and was again explored, and an encapsulated abscess was discovered. The patient died forty-eight hours after admission. The pathological findings are described and illustrated by two excellent photographs. *Macleod Yearsley.*

Jones, Ernest.—*The Differential Diagnosis of Cerebellar Tumours.* "Boston Med. and Surg. Journ.," August 26, 1909.

The comparative frequency of cerebellar tumours is shown by the fact that the author has seen sixteen cases in the past twelve months, and his remarks are based upon the study of twenty cases. An excellent and exhaustive account is given of the symptoms with the order of their diagnostic value, as (first) ataxia; then the characteristic vertigo, the hypotonia, paresis, nystagmus, and skin deviation. Differential diagnosis from supra-tentorial, parietal, frontal and other tumours is then discussed. Attention is especially paid to cerebello-pontine angle tumours with which paralysis of the seventh and eighth nerves practically always occurs. The paper is one that should be read by otologists with interest.

Macleod Yearsley.

Alskne.—*A Case of Otitis Media and Mastoiditis ending in Bilateral Blindness.* The Society of General Practitioners in Libau; Meeting held on May 1, 1908: "St. Petersburger med. Woch.," xxxiii, 1908, p. 739.

The author described a case in which he diagnosed thrombosis of the cavernous sinus. The patient, a soldier, aged twenty-four, came under observation on January 6, suffering from purulent discharge from the right ear and mastoiditis. The right eye was nearly quite blind, and the sight in the left was greatly impaired; optic neuritis was present on both sides. The author thought this was due to a thrombosis of the cavernous sinus following on one of the lateral sinus.

The lateral sinus was explored; it was very tense, and contained black fluid blood. The wound progressed favourably and the sight in the left eye improved at first, but later the headache returned and the sight was quite lost. The patient refused further operation.

W. G. Porter.

MISCELLANEOUS.

Feldt, Dr. A.—*Concerning Estoral and its Use in Laryngo-Rhinology.* "St. Petersburg. med. Wochenschr.," 1909, xxxiv, S. 377.

Estoral, the menthol ester of boric acid, $B(C_{10}H_{19}O)_3$, is a fine crystalline white powder, which smells strongly of menthol. It is soluble