

common polypus case. I shall keep the patient in view. Several members have commented upon the title "fibroma" for the specimen. The only alternative that Mr. Shattock could suggest when we studied the specimen together was "fibro-adenoma," but we concluded that the glandular element was not conspicuous enough to justify this name. On the other hand, I quite admit that the growth has its affinities, and any leaning here is certainly towards the turbinal moriform hypertrophy type, but the affinity is not sufficiently close to indicate any clear reason for altering the selected title, which best covers its main features. Mr. Shattock's verbatim report having been asked for, and promised by myself, is here appended:

"(1) *Stroma* of fibrous tissue nowhere of great density. It has a conspicuous amount of gland-tissue distributed in it, but this does not assume sufficient proportions to allow of such tissue being viewed as neoplastic, and enable us to class the growth as a *fibro-adenoma*. The surface of the growth is much fissured, the processes being invested with the ordinary (palisade) epithelium. Some of the fissures run deeply into its substance, and though doubtless continuous with the surface, the connection in many instances is missed in the section. The long columnar epithelium lining such spaces is ciliated, and so differs from that lining the gland ducts. I should think the growth best described as a *fibroma*. I have looked at sections of inferior turbinals with moriform hypertrophy; there are quite as many glands in that tissue just below the epithelium. I take it that this fibroma is somewhat akin to a moriform hypertrophy in which similar deep fissures occur; but in the latter the signs of inflammation are obvious, whereas in the specimen under consideration the pedunculation and volume of the mass justify it being classed as a neoplasm."<sup>1</sup>

(*To be continued.*)

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## Abstracts.

### PHARYNX.

**Bone Metaplasia in the Tonsil.**—Henry Albert and Minnie Douglas.  
"Annals of Otol-ogy," xxvi, p. 909.

The first report of a case of bone or cartilage in the tonsil was made by Orth in 1893. They have been found in the following forms: (a) Elongation of the hyoid bone or styloid process extending into the tonsil; (b) bony plates or nodules and cartilaginous nodules. Interest in the phenomena centres chiefly round the problem of the origin of the bony and cartilaginous nodules not connected with the skeleton. Investigators have disputed their occurrence from two points of view: (a) That they are the result of metaplasia following inflammation in the tonsil; (b) that they are the result of cartilage-cell remnants from the second branchial arch just below which the tonsil has its origin. The cell remnant theory best explains a large number of cases. The authors publish one case, the facts of which favour metaplasia.

*Macleod Yearsley.*

<sup>1</sup> In a subsequent note sent to the exhibitor since the date of the meeting Mr. Shattock points out that the real gland-tissue not being in excess of that found in the normal nasal mucosa should decide against a diagnosis of fibro-adenoma or of fibro-adenomatous hypertrophy.

**Diphtheria presenting Unusual Multiple Paralyses, with Recovery.—**  
**J. L. Brownlie.** "Lancet," February 16, 1918, p. 257.

Girl, aged nine and a half. The case was complicated by six distinct and different diphtheritic palsies. These were, in order of recurrence: Palatal, right external rectus, right levator palpebræ superioris, both ciliaries, right lingual, and right facial. *Macleod Yearsley.*

**Some Clinical Observations on the Lingual Tonsil Concerning Gôitre, Glossodynia, and Focal Infection.** Greenfield Sluder (St. Louis).  
 "Amer. Journ. Med. Sci.," August, 1918.

The writer believes that "the lingual tonsil plays a far greater and more variegated part in the practice of laryngology than is generally thought. It is probably the most frequent clinical issue in the adult throat." Acute follicular lingual tonsillitis not infrequently accompanies a similar condition of the faucial tonsils, and may replace it when the faucial tonsils have been removed. Subacute or chronic inflammation of the lingual tonsil gives rise to various sensations, such as the feeling of mucus in the throat which cannot be cleared away, sensation of a "lump," painful stiffness, globus hystericus, etc. Cough is a frequent manifestation, and may possibly arise from contact of the enlarged tonsil with the epiglottis. "Enlargement of the mass may push the epiglottis down, causing strangling in sleep should the tongue fall back even to the slightest degree." The singing voice is often interfered with; the tone is uncertain, and the voice gives way or cracks after use for only a few minutes. In the author's opinion the faucial tonsils are much less often the cause of, or even party to, these vocal disturbances than the lingual. As a possible site of focal infection with systemic manifestations, the lingual tonsil is quite as much to be considered as the faucial. The writer has "often seen it re-establish the systemic condition, rheumatism, for which the faucial tonsils had been enucleated," and he has "seen the condition relieved by treatment of the lingual tonsil without enucleation of the faucial tonsils." He has frequently observed temporary enlargement of the thyroid gland in association with an attack of acute follicular lingual tonsillitis, and in chronic enlargement of the thyroid decrease in size has followed treatment of the lingual tonsil even though it appeared normal. Lingual tonsillitis has also seemed to play a part in "painful tongue," especially when associated with inflammation of the papilla at the junction of the palatoglossal fold with the tongue.

The treatment of acute lingual tonsillitis is similar to that of acute faucial tonsillitis. For chronic conditions with or without enlargement, the most satisfactory application is a saturated solution of silver nitrate in 50 per cent. glycerine. A saturated solution of salicylic acid in 95 per cent. alcohol is also useful. Enlargement is treated by means of the galvano-cautery or Myles' lingual tonsil guillotine.

*Thomas Guthrie.*

## NOSE.

**Some Aspects of Maxillary Antrum Disease.—**W. Barrie Brownlie.  
 "Brit. Med. Journ.," October 12, 1918, p. 403.

Four cases are described illustrative of the relationship of maxillary sinusitis to neighbouring inflammatory conditions. Dacryocystitis associated with nasal sinusitis is by no means rare, and is in many instances, as in the case cited, an ascending infection. Provided the

nasal duct is fairly patent, dacryocystitis may in many cases be cured by treatment of a co-existing sinus suppuration.

The relationship of nasal sinus disease to otitis media is well known, and the author quotes a case of chronic otitis media of five years' duration which had resisted all treatment, including removal of adenoids on two occasions, but which dried up completely in five weeks after drainage of the maxillary antra, both antra containing pus.

Another patient had had a radical mastoid operation performed two years previously, but discharge persisted. Proof-puncture revealed pus in both antra, and after operation on the sinuses the ear became dry.

*Douglas Guthrie.*

**Hay-Fever Resorts in the United States and Canada.—W. Scheppegrell.**  
 "Journ. Amer. Med. Assoc.," August 17, 1918.

It has been demonstrated that, as hay-fever is due to the inhalation of pollen from wind-pollinated plants, the disease may be abolished in certain areas by eliminating such plants. Certain hay-fever resorts have been established on the American continent, where great pains are taken to keep down or destroy all wind-pollinated plants. The commonest weed in America causing hay-fever is the common ragweed (*Ambrosia elatior*), while another common one is the sage-brush (*Artemisia*). Some people are sensitive to the pollen of one variety of weed while others are free. The ragweed does not grow in Europe, so sufferers from the pollen of this plant may find relief there. Contrary to the popular belief, altitude is no protection against hay-fever unless this exceeds 6000 feet. Up to 4000 feet the ragweed flourishes as abundantly as on the plains, but at 6000 feet it grows only with great difficulty. An island that is kept free from weeds and has no land nearer than five miles is generally free from hay-fever. As a rule one or two miles of water is sufficient protection. Seaside resorts are good only so long as the wind blows off the sea, as a land wind, as a rule, brings pollen with it.

The writer appends a list of places where, on account of altitude, presence of forests, etc., where weeds are not found, hay-fever subjects find relief.

*J. K. Milne Dickie.*

**Systemic Manifestations of Chronic Nasal Sinus Infection in Childhood.—Albert H. Byfield (Iowa).** "Journ. Amer. Med. Assoc.," August 17, 1918.

In clinical investigations in connection with the source of infection in chronic deforming arthritis in children, it was observed that removal of tonsils and adenoids and treatment of the teeth as possible foci did not control the progress of the disease. In the search for a septic focus it was found that there was often purulent nasal discharge. In the first two cases in which the antra were examined a streptococcal infection was found. This was vigorously treated, resulting in gradual improvement and ultimate complete recovery.

Routine observations by means of X ray, nasal examination and puncture of the antra were carried out in a large number of children. It was found that 14 per cent. of all children examined in the Otological Department of the State University of Iowa had a demonstrably pathological condition of these regions. At the same time numerous patients in the Pediatric Department were found to have an association of sinus suppuration with other conditions. The writer had a number of cases of infectious arthritis, which recovered in a remarkably quick and

complete manner after radical treatment of infected nasal accessory sinuses. Other disorders associated with infected sinuses are chronic cough, nephritis, pyelitis, asthma, and diphtheria carriers.

As regards treatment, the writer is in favour of trying conservative treatment in the first instance, and if that fails to resort to radical surgical measures.

*J. K. Milne Dickie.*

## LARYNX.

**A Case of Fracture of the Hyoid Bone.**—**Elizabeth L. Ashby.** "Lancet," June 8, 1918, p. 803.

Man, aged seventy-two, fracture due to a crush under the wheels of a motor-van. Able to walk to hospital. Sudden death next day, probably due to delayed shock consequent upon severe injury of the cervical region.

*Macleod Yearsley.*

**Lymphangioma of Larynx.**—**W. Richardson.** "Rev. de Laryngol., d'Otol., et de Rhinol.," June 15, 1918.

A large supraglottic tumour entirely occluded the larynx in a man, aged thirty-two, causing dyspnoea and dysphagia.

Preliminary puncture caused no bleeding, and therefore the neoplasm was removed by the endolaryngeal route under local anaesthesia. Histologically it was a true lymphangioma. (It is a pity that this interesting case, shown at the American Congress of Laryngology, is not reported more fully.—*Abs.*)

*H. Lawson Whale.*

**Amyloid Laryngeal Tumours.**—**A. Pognat.** "Journ. de Laryngologie, etc.," May 15, 1918.

The rarity of these neoplasms is exemplified by the fact that the author's case is only the twenty-eighth hitherto reported. They occur in middle or old age, usually in males, and most often in the conjunctiva, the next most frequent site being the larynx. Neither syphilis nor abuse of the voice plays any ætiological rôle, and when they affect the larynx there is no site of election.

Their histology is not uniform. Their symptomatology, given fully in the original paper, is that of any innocent laryngeal neoplasm. Their duration may extend to forty years; metastasis is unknown. In differential diagnosis, which must be made especially from fibroma, the cardinal points are the vitreous semi-translucent appearance and the histological staining reaction with methyl violet.

The prognosis after removal (preferably, of course, endolaryngeal) is good, except in a very rare diffuse form, which may eventuate in glottic stenosis.

*H. Lawson Whale.*

**Primary Acute Laryngeal Perichondritis.**—**G. Canuyt.** "Rev. de Laryngol., d'Otol., et de Rhinol.," February 15, 1918.

Moure, Macdonald and Lennox Browne have testified to the existence of this as a clinical entity. Of the circumscribed form the salient features are persistent pain, exaggeration of vocal fremitus felt by a finger on the laryngeal box, with absence of dyspnoea.

Resolution may occur without necrosis. There is also a diffuse form,

in the course of which there will be found, in addition to the signs just mentioned, an œdematous laryngo-tracheal stenosis producing dyspnoea and pain on speaking, with phono-phobia. In this second diffuse variety the formation of discrete pus is exceptional. A phlegmonous inflammation may extend down the trachea as far as the mediastinal part of its course.

The differential diagnosis must be made from perichondritis secondary to neighbouring septic foci, from lymphadenitis, acute thyroiditis, tuberculous and syphilitic disease, new growths, and perichondritis occurring in the course of the exanthemata.

In treatment the external use of belladonna and moist dressings may be supplemented by laryngeal insufflations. If pus forms, the incisions made should be bold.

*H. Lawson White.*

## THYROID GLAND.

**The Toxic Element in Goitre.**—Sydney Pern. "Medical Journal of Australia," April 6, 1918.

Pern says the thyroid hypertrophies if certain toxins are present, and such hypertrophy can reasonably be looked upon as a defensive process or an attempt to eliminate or destroy such toxins. Why one person affected with a certain toxin should develop a thyroid enlargement and another with the same infection escapes is explained by the complex functions of the thyroid body. Besides dealing with toxins, it plays a very important part in the calcium and iodine metabolism. Goîtres, often of very large size, which give rise to no signs of hyperthyroidism or constitutional disturbance have their iodine metabolism at fault; such are found in the limestone districts in Switzerland. The other type, in which the calcium metabolism is at fault, is found in Victoria, principally in Gippsland, where goitre is usually associated with increased thyroid activity. Here lime is deficient in the soil. The drinking of rain-water, and the dislike to milk by the children who do much milking, lead to the deficiency of calcium in the system.

Pern selects thirty-five cases from his case-books where the treatment of pyorrhœa, sinus suppuration and the removal of septic tonsils is said to have brought symptoms of Graves's disease to an end.

*A. J. Brady.*

## EAR.

**Mastoid Disease in the Balkans.**—J. Arnold Jones. "Lancet," May 18, 1918, p. 704.

The author points out that there are two diseases—trench fever, incidental to the campaign, and malaria, incidental to Macedonia—which complicate the diagnosis of suppuration in the temporal bone. The author notes two cases in which trench fever caused him to open a normal mastoid. He also describes a case in which the presence of malignant malaria co-existed with a suppurative lesion of the temporal bone, and gave rise to great difficulties in diagnosis.

*Macleod Yearsley.*

**War Deafness.**—McBride and Logan Turner. "Lancet," July 20, 1918, p. 73.

The authors have come to certain definite conclusions after a painstaking analysis. These conclusions are against the suggestion that normal results to vestibular tests are presumptive evidence of malingering. They are as follows:

(1) That concussion-deafness is generally due to some organic change.

(2) That the prognosis is usually bad.

(3) That the results of the vestibular tests can only be utilised in conjunction with information derived from other sources. Thus, if the patient shows other hysterical symptoms, vestibular tests may perhaps under certain circumstances help diagnosis; but to state that they do more than this is, in their opinion, "misleading and dangerous."

*Macleod Yearsley.*

**Hysterical Mutism caused by Shell Explosion.**—Marcel Natier (Paris).

Natier records the case of a soldier, aged thirty-six, who had always been very nervous, and suffered from headaches accompanied by giddiness and vomiting. On October 3, 1914, a shell exploded close to the right side of the patient and hurled him a distance of 6 metres. The patient was not rendered unconscious, and on the way to the field hospital was exposed to a hail of shells. Shortly afterwards he lost the power of speech and suffered from right hemiplegia. In hospital electro-therapy was applied to the right half of the body and the larynx, and at the end of a week the patient could move his right arm and thigh. Later the patient was removed to the Salpêtrière in Paris, where a minute neurological examination was carried out—too long for abstraction. The patient was very emotional, and when questioned made violent efforts to talk, but these only provoked facial contractions. Natier carried out respiratory gymnastics and obtained a complete cure, but does not give any details of the method. He considers that simulation could be excluded, because the patient made repeated efforts to talk and was sincerely delighted when recovery occurred. Laryngoscopic examination showed that on attempted phonation the glottis was hermetically closed. Natier holds that his inability to speak was due to motor inco-ordination. Violent measures to obtain a cure may only make such a case worse, while patience and gentleness appeal to the reason of the soldier and convince him of the benignity of his condition.

*J. S. Fraser.*

**Posterior Mastoiditis.**—E. J. Moure and J. Rozier. "Rev. de Laryngol., d'Otol., et de Rhinol.," March 15 and March 31, 1918.

Abscesses which have formerly been known under the generic title of Bezold's mastoiditis may occur in certain special regions of the neck. Their formation and situation depend upon—

(1) *The disposition of the posterior groups of mastoid cells.* These are postero-superior, posterior, and postero-inferior.

(2) *Situation of the perforation of the mastoid abscess.* This may occur—

(a) Posteriorly, through the canal for the mastoid emissary vein or through the temporo-occipital suture; or

(b) Postero-inferiorly, through either the mastoid apex or its internal surface into the digastric groove.

(3) *The normal musculature of the neck.*

Three important regions are naturally delimited: the trapezo-sterno-mastoid, in the upper part of the posterior triangle of the neck; the retro-maxillary, between the sterno-mastoid and the jaw; and the region of the great vessels, along the carotid sheath.

Treatment consists in operating on the mastoid, and after so doing (*never before*) tracing out the sinus from the interior of the mastoid to the neck, and, finally, opening the neck abscess.

Except for a small drain in the antrum, the mastoid wound is closed; the neck wound is freely drained.

*H. Lawson Whale.*

## ŒSOPHAGUS.

**Total Expulsion of the Œsophageal Mucous Membrane.**—*Mme. A. Sauvint-Thury.* "Rev. Med. de la Suisse Romande," June, 1918.

A healthy woman, aged forty-eight, rose as usual at five o'clock feeling perfectly well. At seven she took breakfast, and towards the end of the meal felt a violent pain in the region of the ensiform cartilage, as if she had swallowed too big a piece of bread. At eleven o'clock, still suffering terribly, she began to vomit blood. She choked, her neck swelled, and about twelve o'clock she coughed up a long membrane, which her husband pulled out of her mouth. This membrane was in the form of a long, flattened cylinder, smooth on both its external and internal surfaces, pale, and of an even thickness throughout. It was in two parts, the one 34 and the other 4 cm. long. Prof. Huguenin examined a portion and reported that it consisted of stratified pavement epithelium and a little connective tissue, apparently the mucosa of the œsophagus, with no signs of inflammation in it. For a few days the patient had great pain and difficulty in swallowing, but gradually the pain ceased and in a month's time she could swallow almost quite well. Nothing could be found in the membrane, in the patient or in her previous history to account for this remarkable occurrence. The heart, lungs, digestive system, urine, etc., were normal; no signs of burn, ulceration, etc., were to be found either in the membrane or in the woman's throat. About a year earlier she thought she had swallowed a piece of bone which lodged at the bottom of the œsophagus and caused some bleeding, but no foreign body was found by endoscopic examination.

The reporter suggests as a possible explanation the spontaneous sub-mucous rupture of an œsophageal varix.

*Arthur J. Hutchison.*

## MISCELLANEOUS.

**Infection of the Upper Respiratory Tract with Staphylococcus Pyogenes aureus, presenting the Symptom-complex of Acidosis.** *L. U. Gardner* (Boston). "Amer. Journ. Med. Sci.," March, 1918.

The three fatal cases recorded in this paper occurred in children of the ages of seven, one, and two years respectively. All showed an acute laryngitis with membranous deposit, broncho-pneumonia, and various toxic reactions in the lymphadenoid tissue in the walls of the blood-vessels and in the renal epithelium. The clinical picture suggested that acetonuria was present. Culturally and morphologically the causal

organism obtained in pure culture from the blood, larynx and lungs was a typical *Staphylococcus pyogenes aureus*. There are very few records in the literature of a true diphtheritic membrane in the larynx due to *Staphylococcus aureus* such as occurred in these cases. They illustrate the necessity for examination of the larynx—an organ often neglected by pathologists in the course of routine autopsies. *Thomas Guthrie.*

**The Selection of Candidates for the Air Service.**—**H. Graeme Anderson.**  
“Lancet,” March 16, 1918, p. 395.

In the course of a general discussion on this subject, the author lays stress upon absence of pyorrhœa, sore throats, earache, deafness, otorrhœa, and nasal obstruction. Defective hearing in the pilot or air mechanic may lead to serious injury or death. A sound equilibration and muscle-sense is essential in flying, but most of the impressions which control balance in flying come through the eyes. *Macleod Yearsley.*

**Radium in Tuberculosis of the Skin.**—**W. H. B. Aikins.** “Canadian Pract. and Rev.,” February, 1918.

The writer describes a number of cases of lupus of face and nose treated with radium. In most instances the radium was applied in sufficient doses to cause destruction of the lupoid tissue, after which a clean, healthy scar formed. Finsen light treatment is in many cases more satisfactory, but radium gives better results in some cases, and has the advantage that it can be applied to the mucous membrane of the air-passages in situations where other forms of treatment are unsatisfactory. *J. K. Milne Dickie.*

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## NOTES AND QUERIES.

SIR ROBERT WOODS, M.P.

We extend our heartiest congratulations to Sir Robert Woods, Professor of Otology and Laryngology in Trinity College, Dublin, who has been elected one of the Members of Parliament for Dublin University at the recent General Election. He is, we believe, the first oto-laryngologist to become a member of the Imperial House of Commons.

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## INFORMATION.

“Earache,” wrote Harry in his physiology examination, “comes from bits of information getting inside the ear tubes.”—*Pall Mall Gazette.*

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## BOOKS RECEIVED.

**Headaches and Eye Disorders of Nasal Origin.** By *Greenfield Sluder, M.D.* With 115 illustrations. London: Henry Kimpton. 1918. Pp. 272. Price 35s. net.

**Equilibrium and Vertigo.** By *Isaac H. Jones, M.D.* With an Analysis of Pathologic Cases by *Lewis Fisher, M.D.* With 130 illustrations. Philadelphia & London: J. B. Lippincott Company. Pp. 444. Price 21s. net.