

degree. Though scrofula or some such diathetic tendency may in many cases act as a strong predisposing cause to lymphoid hypertrophy in the pharynx and naso-pharynx, these are exciting causes principally connected with digestive derangement which act more surely than diathesis alone. He has noted the following unusual symptoms, noise and difficulty of swallowing, laryngismus stridulus, useless cough and hawking, asthenopia, epistaxis. He discusses also the methods of examination, placing little reliance upon anterior rhinoscopy and more upon posterior rhinoscopy and digital examination. For operation he prefers the forceps or Gottstein's knife.
R. Norris Wolfenden.

LARYNX.

Glasgow, W. C. (St. Louis).—*Cavernous Angioma of Larynx—Removal, with Drawings and Description of the Microscopic Sections prepared by Dr Ludwig Bremer.* "Internat. Jour. of the Med. Sciences," April, 1889. (See also "JOURNAL OF LARYNGOLOGY AND RHINOLOGY," 1889, No. 1, p. 55.)

THE title indicates the nature of the case. The angioma, which was about the size of a pea, was removed from the vocal cord with Schrötter's forceps. Considerable hæmorrhage followed the operation.

Hunter Mackenzie.

Mackenzie, G. Hunter (Edinburgh).—*Case of Spontaneous Disappearance of Laryngeal growths after Tracheotomy.* "Lancet," April 6, 1889.

REPORT of the case of a boy, aged five years, who, in 1883, underwent tracheotomy for laryngeal stenosis from warty growths. The growths disappeared after the cannula had been worn for a year; this was then removed and complete recovery ensued, and without the development of sequelæ.

Hunter Mackenzie.

Brown, J. G. (Bootle).—*Malignant Disease of the Larynx.* "Brit. Med. Jour.," Nov. 30, 1889.

RECORD of a case which presented the initial appearance of a papillated pedunculated growth, springing from behind the epiglottis, and having an attachment from the angle of the thyroid cartilage. The growth and a piece from the left side of the larynx were removed, and tracheotomy was performed. The patient progressed satisfactorily for a short time; in three months the disease had recurred in the larynx, and the glands of the neck also became affected. He died five months after the operations. During the last three or four weeks of life he was troubled with persistent vomiting, which resisted all treatment. *Hunter Mackenzie.*

Chavasse (Birmingham).—*Laryngectomy.* "Brit. Med. Jour.," Nov. 1889. Mid. Med. Soc., Nov. 6, 1889.

EXHIBITION of the right halves of the thyroid and cricoid cartilages,

removed by laryngectomy. The patient was a boy, aged five, who, as the results of diphtheria and intubation, had complete stenosis of the larynx. Result satisfactory. *Hunter Mackenzie.*

Batori.—*Pneumonia from a Foreign Body in the Lung—Cure by Expectoration of the Body.* “Festher Med. Chir. Presse,” 1890, No. 8.

A GIRL, six years old, inspired a melon seed. In spite of the asphyxia the mother would not allow tracheotomy. Pneumonia followed, lasting for nine weeks. Cure was effected after expectoration of the body.

Michael.

Groenw (Breslau).—*Acute Œdema of the Glottis following the Use of Potassium Iodide.* “Therap. Monats.,” Mar., 1890.

THE author has observed this event in three cases, and refers to the cases reported in the literature.

Michael.

Nykamp (Leyden).—*Experiments on the Effect of Hot Air Inhalation in Weigert's Method for Laryngeal Tuberculosis.* “Deutsch. Med. Woch.,” 1890, No. 18.

FROM his experiments the author has found that with this apparatus it is not at all possible to produce as high temperatures as Weigert says; that during the inspiration of hot air of 200°C. a thermometer in the trachea only registers a temperature of 36°C. The author has also applied the method to patients without any effect.

Michael.

Lauenburg (Würzburg).—*Two Cases of Cured Laryngeal Tuberculosis.* “Münch. Med. Woch.,” 1890, No. 17.

THE first case was examined one year after the treatment, and the permanence of the cure is stated. In the second case laryngeal ulcers were cured during a progressive tuberculosis of the lungs. Here cicatrization was found at the *post-mortem* examination. In both cases lactic acid was applied.

Michael.

Beale, E. C.—*Laryngeal Affections in Phthisical Persons.* “Birmingham Medical Review,” April, 1890. (A Lecture given by the author at the Victoria Park Hospital for Diseases of the Chest.)

THE author finds the larynx as affected in some manner in about four-fifths of all cases of pulmonary phthisis. He lays stress upon *partial* anæmia as one of the first symptoms—excluding general anæmia. In phthisis this partial anæmia is often limited in extent, especially to the epiglottis or ventricular bands. Narrow injected vessels course over the surface. Along with this is anæsthesia, hyperæsthesia, or paræsthesia. “Blushing of the larynx” is not uncommon upon irritation (*e.g.*, laryngoscopic examination), and the anæmia may then be masked by hyperæmia. General hyperæmia is less common than anæmia. Injected vessels may be localised upon one vocal cord, and patchy hyperæmia may occur upon the arytenoid and inter-arytenoid mucous membrane or either ventricular band. This is only of short duration, and tends to spontaneous recovery, but may persist and be followed by swelling. They are to be regarded with suspicion as indicating the presence in the submucosa of some

irritant. Congestions and catarrhs of the larynx are often limited, and when so to one side of the larynx or one vocal cord, the author has found them less amenable to treatment than when general. These local manifestations in the larynx lead the author to the belief that the larynx is thus rendered liable to infection. The graver lesions which occur later on are also very prone to be limited to one side of the larynx, and lead to the view that such lesions must be the result of local inoculation of the submucous tissue either from within or without, and the earlier local disturbances of circulation may favour the subsequent development of the inoculated morbid material.

The results of local treatment often give the best guide to the diagnosis of a common catarrhal laryngitis in a tubercular patient and a catarrh of really tubercular nature. The former soon gets better, the latter not. The bacillary test is not trustworthy in the early stages. Besides the common forms of infiltrative swellings, the author has three times in 200 cases met with firm, rounded tumours with broad base situated exactly between the arytenoid cartilages, and in a few instances he has seen single or multiple rounded bosses, the size of a split pea, situated on the free edge of the epiglottis or arytenoid cartilage. They are firm, resistant, pale, gelatinous, and surrounded with a hyperæmic ring. He has often also seen little fleshy protuberances on the surface or edges of the vocal cords.

As to treatment, he remarks that "no one, however biassed he may be, can read Heryng's record of work without a feeling that similar attempts ought to be made in our own practice, even though our early results may not be encouraging." No one would advocate the use of such strong and unpleasant remedies in a case of laryngeal phthisis accompanying rapid or advanced tubercle of the lung, but efforts might be made in cases where the pulmonary conditions are quiescent. Spontaneous recovery from tubercular infiltration may, though rarely, take place in the larynx, as in the lungs. All catarrhs in the early stages of phthisis should be actively treated. Inhalation by oro-nasal or steam inhalers should be efficiently carried out with benzoin, creosote, carbolic acid, pinol, iodoform, and eucalyptus. Insufflations of iodoform, boracic acid, morphia, may be employed, and steam applications (lactic acid, chlorate of potash, terebene, or pinol) are useful. In the chronic stages, brush applications of lactic acid, tincture of iron, chloride of zinc, nitrate of silver or menthol are recommended. Local ulceration, if chronic, may require powerful stimulation by solid nitrate of silver or chromic acid. The last stage of ulceration calls only for palliative treatment and the use of cocaine, or solution of morphia in gum acacia, swallowed slowly in sips before attempts to swallow food. Instances are rarely seen in *post-mortem* in which it could be said that tracheotomy would have afforded relief to such cases, and the balance of opinion is against its performance.

R. Norris Wolfenden.

Favitzky, A. P. (St. Petersburg).—*On the Treatment of Laryngeal Tuberculosis by Creolin and B-Naphthol.* "Meditzinskoië Obozrenië," No. 19, 1889, p. 585.

THE author details results obtained in Professor D. I. Koshlakoff's clinic from the treatment of laryngeal phthisis by painting with creolin and naphthol. Creolin was tried in nine cases (seven men and two women, aged from thirty to fifty-two). It was employed in the form of solutions made of from a few grains to half-a-drachm of the drug and three ounces of distilled water and glycerine (in equal parts). The paintings (first with weak solutions, and later on with increasingly stronger ones) were repeated three or four times weekly for a fortnight to six weeks. The results were very far from being satisfactory. In a majority of the cases, no amelioration, either subjective or objective, whatever could be noticed. In a few, a slight improvement occurred, which, however, soon passed away, and sometimes was even followed by a marked aggravation of the laryngeal process.

Naphthol was resorted to in ten cases (seven men, three women, aged from twenty-nine to fifty-two). It was used in the form of a solution prepared of from half to two drachms of the drug, and one ounce of oil of sweet almonds, the painting being made several times a week. In several cases, the drug produced a distinct local anæsthetic action—that is, relieved pain on swallowing and diminished cough. In some, the patient's voice became stronger and clearer, or even was fully restored to a normal condition. The action on the morbid process itself, however, was found to be limited to some decrease of infiltrations and a slight improvement in the appearance of the ulcers. In none was anything like healing observed.

Valerius Idelson.

Cheatham.—*Intubation.* “The American Practitioner and News,” Dec. 21, 1889. THIS is an account of a few out of thirty-two cases intubated by the author of the paper with ten successes, all the patients being *in extremis* before the operation was performed.

B. J. Baron.

Eastes, T.—*Catherization of the Larynx.* “Brit. Med. Jour.,” Dec. 14, 1889. S.E. Branch, E. Kent Dist. B.M.A., Nov. 28, 1889.

NARRATION of the case of a newly-born infant, who had been rescued from a state of asphyxia by catheterization of the larynx, and subsequently by the performance of artificial respiration.

Hunter Mackenzie.

Powell, R. Douglas (London). — *The Diagnosis and Treatment of Aortic Aneurism.* “Brit. Med. Jour.,” Dec. 21, 1889. Med. Soc. of London, Dec. 16, 1889.

IN replying to the discussion on this subject, Dr. Powell expressed concurrence with the view advanced by Dr. de Haviland Hall, that stridor in these cases is usually caused by pressure on the trachea or bronchus, and is, therefore, not likely to be relieved by tracheotomy.

Hunter Mackenzie.

Giesen.—*A Contribution to the Pathology of the Laryngeal and other Crises in Tabes.* “Med. News,” Mar. 5, 1890. New York Hæmological Soc.

THE author read notes of a case of tabes with laryngeal attacks during the last year of illness. One of the crises proved fatal. Microscopical examination showed the lesions of a chronic neuritis of the roots of the

vagus and accessory portion of the spinal accessory nerves on both sides. Neuritis of the root fascicles or trunks of one or both of these was regarded as more frequently the cause of the laryngeal crises than central lesions.

The author divided laryngeal crises into two classes: First, those in which the glottis constrictors and dilators were normal and the crises occurred from reflex spasm of the adductors; second, a larger class of cases in which the constrictors and dilators were in a greater or less degree of paralysis.

The first form of the crises might be produced by a neuritis of the roots of the accessory portion of the eleventh nerve, irritating the sensory fibres of the larynx, and being responded to by motor impulses through the vagus, which would produce closure of the glottis by contraction of the adductors. The second form of the crises might be produced by a destructive stage of the neuritis in the vagus, inducing a motor inability of both the adductors and abductors. But as it has been shown experimentally in animals that the adductors are stronger than the abductors, a reduction of power in both sets of muscles would render the equilibrium of the two sets of muscles so unstable that reflex irritation of the motor laryngeal fibres, or direct irritation of these fibres in the vagus by the neuritis, would be responded to by a contraction of the stronger adductors, analogously to the results of artificial stimulation of the motor laryngeal fibres in animals. When the neuritis affects both the vagus and accessory nerves together, the conditions are favourable for the production of violent crises. A localization of the lesions causing the other crises in tabes was based on Gaskell's description of the distribution of the sympathetic system.

R. Norris Wolfenden.

Grossmann (Wien).—*Tracheal Stenoses.* "Wien. Klin.," Heft 3 and 4, 1890.

THE author has produced a very complete and well-written treatise on the subject. He begins with the etiology, and treats first of—

(a) *External compression* by struma, illustrated by very instructive tables of rare cases of benign and malignant tumours of the thyroid gland. Compression also may be produced by tumours of the lymphoid glands, hygromata, acute and chronic inflammation of the cellular tissue, and by aneurisms. He relates a case of aneurism from his own practice, and gives the illustration of the specimen.

(b) *Intra-tracheal stenoses.* — They are caused by intra-tracheal diseases, and, secondarily, by operations, such as tracheotomy, and the use of cannulas. In the first group are inflammations and consecutive œdema. Most dangerous are the erysipelatosus and phlegmonous inflammations. Œdema also may be produced by perichondritic, metastatic, and ulcerative processes, and by granulomata. Granulomata may be produced by ulcerations, and by cannulas. Sometimes after the removal of the cannula these neoplasms may arise and cause fatal result. Characteristic of the granulomata is the circumstance that the dyspnœa caused by them is greater during sleep. After tracheotomy the trachea also can become stenosed by formation of spurs (Passavant), by swelling of the mucous membrane from inspiratory traction (Michael),

by formation of valvulae in the mucous membranes (Koch), by weakening of the cartilages (Michael), and by formation of cicatrices (Weber, etc.).

Neoplasms of the trachea are rather rarely observed. A curious case is recorded by Lange. An intussusception of the trachea was produced through traumatism. The patient could only respire when the head was retroflexed. The condition was so painful that the patient ended it by suicide. The diagnosis of the disease was made by the *post-mortem* examination. The usual cause of chronic stenosis is syphilitic cicatrization. Also in typhus and tuberculosis cicatrices are sometimes observed.

Concerning diagnosis, the most important symptom is the characteristic noise. To a certain degree the stenosis is compensated for by slow and deep respiration, so that in some cases the patients do not know that they are dyspnoëic. The author then treats extensively of the influence of stenoses on the heart, and relates the opinions of other authors on the subject. In nearly all cases is the pulse diminished and stronger. Mechanically, and from the effect of the bad oxidation of the blood, the pressure in the venous system is increased. At this time the heart is so damaged that, even if the stenosis is removed by tracheotomy, an improvement of the patient is not often possible. The special diagnosis is to be made by the laryngoscope. The stenosed place can often be viewed directly. Sometimes by the paralysis of the left vocal band, or of both, an aneurism or a tumour compressing the recurrent nerve can be diagnosed. The prognosis varies according to the originating cause and its curability. Deep-seated stenoses cannot often be cured. High situated stenoses can be cured by tracheotomy. To cure the causative condition we use, in cases of cicatrices, dilatation; in cases of neoplasms, extirpation; in compressing stenoses, operations upon struma or neoplasms; in aneurisms, the more or less effectual methods which have been recommended. *Michael.*

THYROID, NECK, &c.

Young, A. H. (Manchester).—*Adenoma in a Thyroid Gland in a Leopard.*
 "Brit. Med. Jour.," Nov. 23, 1889. Pathological Soc. of Manchester, Nov. 13, 1889.

EXHIBITION of sections of the thyroid gland from a young adult leopard, which contained numerous small nodules of tumour growth. With the exception of these nodules, the gland was normal.—*Hunter Mackenzie.*

Chavasse (Birmingham).—*Tumour of the Thyroid Gland.* "Brit. Med. Jour.,"
 Nov. 23, 1889.

EXHIBITION of specimen, weighing nine ounces. It was removed from a woman, aged forty, in whom it had existed since very early life, a marked increase following each pregnancy. *Hunter Mackenzie.*