muco-membranous enteritis, chronic coryza, intense nasal pruritus, scarlet fever, hay-fever, intense nasal hydrorrhœa, paroxysmal sneezing, habitual coryza, laryngeal thyrotomy, and even constipation associated with œdematous rhinitis. *J. D. Lithgow.*

## LARYNX.

**Moscoso.—Contribution to the Study of Congenital Stridor of Infants.** "Thesis, Paris," 1909.

This condition, although not in itself a disease, is symptomatic of various diseases. It is characterised by marked inspiratory stridor with very little interference with expiration. There may be marked drawing in of the chest, and even considerable dyspnœa, sometimes amounting to cyanosis. The acute stage passes off shortly and the condition of slight stridor remains. The condition may be sufficiently serious to bring about a fatal termination, or at least may act unfavourably upon the general health of the infant. But more frequently the infection becomes less frequent and disappears about the end of the second year after having lasted almost from birth. The stridor, although nearly always inspiratory, may be of slight expiratory advent, but it is continuous and varies in intensity in many cases. It is most marked on awaking from sleep and becomes less during sleep, on suckling, and when occupying the lateral position, when it may even disappear. Anything which calls for an increased respiratory effort, mental excitement, etc., may exaggerate the intensity of the stridor; even sudden changes of temperature may bring on such an access. The bruit persists when one pinches the nostrils or when the mouth is closed. In spite of the stridor the voice remains normal and the cry is clear. There is nothing unusual about the cough; ordinarily the stridor does not seem to produce any respiratory embarrassment. In certain cases the stridor may only last a few weeks, but in most cases, where the stridor becomes worse during the first two or three months, it remains constantly so till about the eighth month and then slowly diminishes, disappearing about the second year.

*Diagnosis* is usually easy. It rests on a history of the attacks having come on shortly after birth, the inspiratory bruit being more predominant than the expiratory where the latter is also present. If, at the same time that the stridor continues, the cough and voice are unaltered, and the general state is low, while auscultation reveals nothing abnormal, one can be almost sure that this condition is present. In short, onset at birth, chronic progress, and respiratory without vocal trouble are the principal characters of congenital stridor in infants.

*Ætiology.*—In a certain number of cases the affection appears to be due to some latent or manifest parental infection, such as tubercle or syphilis. The nervous heredity has also been remarked upon as more common in boys than in girls. Hypertrophied adenoids, occurring often in newly born infants, would explain congenital stridor due to such causes. The causes may be grouped into four classes: (1) Malformations of the larynx; (2) adenoid vegetations; (3) nervous troubles; (4) compression of the trachea by hypertrophied thymus. If we turn to the results of the investigation of malformations of the larynx one sees that in these cases the vestibular orifice is contracted, the whole or part being mostly reduced to a mere chink. There is not only one variety of vestibular malformation capable of giving rise to congenital stridor, but there are at least two

—those of the type of Lees-Variot and that of the Paterson type. One should add the glottic malformations described by Semon, Lévy, and Etienne, which give rise to the same syndrome. According to Robertson Smith the presence of adenoid vegetations in the naso-pharynx produces constant irritation which brings about reflexly the production of stridor, and it seems quite evident that adenoids may produce this condition, for not only is their removal followed by amelioration or immediate cure, but in many cases of congenital stridor nothing else than adenoids can be found to account for it. Politzer was one of the first authors who attributed the stridor to nervous origin; he supposed that affections of the innervation of the muscles of the larynx due to some change in the action of the recurrents was to blame. Thomson also favours this theory. It is this that Moscoso has in view in the course of this article. In the first period, when the malformation of the larynx was not accepted as playing an important *rôle* in the pathogenesis of stridor, he promulgated the theory of spasm. In support of his hypothesis he mentioned the relationship which exists between stridor and stammering. The author cites a case where the stridor existed without any laryngeal malformation. In short, it seems preferable to the author to consider the stridor as the effect of malformations of the vestibule, because this is sufficient to explain the symptom without the necessity of assuming the existence of nervous alterations, but there are cases where an autopsy shows no anatomical features which can explain the stridor, and for these cases Moscoso gives the hypothesis of a nervous origin, as it is the only plausible explanation of the phenomena. Many authors have shown that hypertrophy of the thymus is the cause of certain cases of chronic congenital stridor in infants, and this may explain certain cases of stridor. No one doubts nowadays the possibility of the trachea at least being pressed upon by the hypertrophied thymus. To prove that congenital stridor is due to such a hypertrophy of the thymus it is necessary to show (1) that the hypertrophied thymus is actually compressing the trachea, (2) that this compression is the cause of the stridor. The compression of the trachea by a hypertrophied thymus no longer remains in doubt. The author cites a few cases. In almost all the operated cases one sees that the stridor disappears or diminishes when one draws the thyroid forward in its capsule, and reappears when it is allowed to sink back into its place. In short, one can say that there are incontestable cases where the syndrome of congenital stridor is produced by a compression of the trachea by the hypertrophied thymus, and these cases are not rare. Other affections giving rise to congenital stridor are hypertrophy of the thyroid body and angioma of the cervico-thoracic region (Terrien and Bodolec), ring pharyngitis (Boulard), obstetrical laryngitis (Guilbert and Cerf), enlarged thoracic glands, sometimes congenital (Geffrier). From all this it is easy to conclude that the congenital stridor of infants is not a disease, but a syndrome. It is necessary to recognise also that there are many laryngeal manifestations which can give rise to this, but there are many cases of congenital stridor where one can put the larynx out of account by examination *in vivo* and by anatomical examination, although such cases may in no way differ clinically from the others. According to Hochsinger the infants which present the type of congenital stridor have constantly an enlarged thymus, and almost always the radiogram shows considerable enlargement of this organ. Contrarily, cases where there is no stridor present the clinical examination and a radiograph show nothing abnormal. Diagnosis of stridor by laryngeal malformations can only be made by a laryngoscopic examination, which is difficult and dangerous in the case of

infants. Touch is preferable, but it is only at the disposal of persons very accustomed to its practice. It seems preferable to Moscoso to make the *diagnosis* by elimination. All the means described to establish the diagnosis of hypertrophy of the thymus itself are found difficult. Only radiography gives us definite information upon the size of the gland.

The *prognosis* of congenital stridor is bound up in the causal affection. The *treatment* will also vary in a similar way. When hypertrophied thymus is the case it is marked by crises of suffocation, which in almost all cases indicate surgical interference. According to Veau, thymectomy is a simple, easy, and efficacious operation. *J. D. Lithgow.*

## ŒSOPHAGUS.

**Gerrado, Dr. S. (Naples).—Circular Destructive Ionisation in Œsophageal Cicatricial Stenosis.** "Archiv. Ital. di Laring.," Naples, 1911, p. 5.

The author gives details of a number of cases from the clinic of Prof. Massei as well as an extended account of the work done in this field on the Continent. While some writers have obtained good and permanent results from the use of the negative pole as the active agent with a current of 3 to 5 m.a. for twenty minutes on alternate days, the author has employed 5 to 8 m.a. for ten to twelve minutes. *James Donelan.*

## EAR.

**Yearsley, Macleod.—The Education of the Deaf.** "Lancet," February 25, March 4 and 11, 1911.

From his experience the author is convinced that the whole system of deaf education in England needs thorough reorganisation on wider and more extended lines. He pays a tribute to teachers of the deaf, who are not to blame for failure under present conditions. Taking statistics of some 548 deaf children in L.C.C. schools, it is shown that 25·1 per cent. are failures at lip-reading and 30·4 per cent. are oral failures as regards articulation. After a brief sketch of the history of deaf-mute teaching in this country, the author proceeds to ask why the present system is a comparative failure, and points out that it is because education begins too late and the classification of the deaf child is defective. The needs of deaf education are postulated as (1) more scientific and comprehensive classification; (2) earlier education; (3) greater care of the deaf child; (4) encouragement of the deaf child to mix with hearing people; (5) diminution of the number of deaf children by the application of eugenic principles to congenital cases, and a better care of the ear in children.

Classification in different countries is then reviewed, and praise is given to the United States for the vast experimental work being done there in deaf education. This leads to an exposition of the author's ideas of classification, based upon the study of individual children. His scheme embraces every deaf child from the slightly deaf to the blind and mentally defective deaf-mute. Not only is earlier education advocated, but education should be prolonged, and adequate reasons are given for the latter contention.

These matters occupy two articles, the third dealing with the age at