small electric lamp on a slender stem is placed at the distal extremity of the tube. The arrangement appears to be very similar to that of Chevalier Jackson. *Chichele Nourse.*

**Moure, E. J.** (Bordeaux).—*A Foreign Body in the Œsophagus; the Relative Value of Œsophagoscopy and of External Œsophagotomy.* "Revue Hebd. de Laryngol., d'Otol., et de Rhinol.," September 4, 1909.

In spite of the immense value of the œsophagoscope in locating and extracting foreign bodies, cases occasionally occur in which the instrument is useless. For example, a coin lodged just at the entrance of the œsophagus of a young child is apt to be missed altogether, but it can generally be easily and safely removed by means of Kirmisson's hook.

In the case of a child, aged three and a half, who had swallowed a toy anchor, which became impacted in the œsophagus, the œsophageal tube, used under chloroform, slipped time after time into the trachea owing to a condition of violent spasm. The foreign body was located by a radiograph, and eventually external œsophagotomy was successfully practised for its removal. *Chichele Nourse.*

**Pietri, P.** (Bordeaux) and **Pajaud** (Cognac).—*A Ten-Centime Piece impacted at the Entrance of the Œsophagus of a Child aged seven; Removal with Kirmisson's Hook.* "Revue Hebd. de Laryngol., d'Otol., et de Rhinol.," September 4, 1909.

The coin was clearly visible by radioscopy. It was easily extracted with Kirmisson's hook by Professor Moure after the application of cocaine and adrenalin, when other methods had failed.

*Chichele Nourse.*

## EAR.

**Müller, Dr. Arthur** (Heidelberg).—*The "Sérum Antiscléreux" of Malherbe.* "Monats. f. Ohrenh.," Year 43, No. 8.

In order to determine the influence of the anti-sclerotic serum introduced by Dr. Aristide Malherbe, of Paris, on various forms of chronic progressive deafness, the author carried out some investigations, the results of which he gives in full, prefaced with a long account of the conditions which obtain in these cases, and a *resumé* of the theories as to their causation.

His conclusions are embodied in a short paragraph, at the end of an article of sixteen pages, to the effect that: The anti-sclerotic serum of Malherbe cannot in any way be regarded as a curative agent for deafness, whatever may be its cause or character. If any result does take place it is but slight and transitory. Undesirable sequelæ are often observed, and in "adhesive" conditions the utmost caution must be adopted.

The serum contains a small percentage of pilocarpin, to which the author attributes any temporary alleviation of the symptoms which may occur, and is injected subcutaneously. It seems regrettable that so much patient labour should have been directed in such chimerical research.

*Alex. R. Tweedie.*

**De Stella, Prof.** (Ghent).—*Serous Meningitis and Deafness.* "Archives Internationales de Laryngologie, d'Otologie, et de Rhinologie," July–August, 1907.

In an interesting article Prof. de Stella points out that children are

more easily affected by meningitis than adults, and that the predisposing cause is congenital. The real cause is usually some toxin absorbed from the gastro-intestinal tract, which in many cases, so acts on the auditory apparatus as to leave total or partial deafness. He advises calomel internally, ung. hydrarg. externally, and, above all, early lumbar puncture. In this way pressure symptoms are relieved, and the deafness cured.

The serous fluid is clear, abundant, and aseptic.

*Anthony McCall.*

**Smith, S. Macuen.**—*The Importance of Cerebral Lesions complicating Suppurative Otitis Media.* "New York Med. Journ.," April 17, 1909.

The author confines himself to purulent meningitis and temporo-sphenoidal abscess. His experience has decided him that the former is the most frequent and fatal intra-cranial lesion complicating aural disease. He believes that an overlooked or unsuspected aural lesion is an ætiological factor in more than 90 per cent. of all cases of meningitis in children. He believes it to be positively curable. After detailing symptoms and diagnosis (a leucocyte count should never be omitted, and lumbar puncture is valuable) treatment is discussed. The opinion is given that every case of menigitis should be operated upon unless moribund.

*Macleod Yearsley.*

**Botey, Ricardo** (Barcelona).—*Whether or not the Jugular Vein should be Ligatured in Phlebitis of the Lateral Sinus.* "Archives Internationales de Laryngologie, d'Otologie, et de Rhinologie," July-August, 1907.

"Otologists are divided into two groups" says the author, "those who consider the jugular vein ought to be tied to prevent the propagation of the infection to the sinus, and those who believe this unnecessary or tending to diffuse the infection in other directions." The writer belongs to the latter class, claiming that there are fewer deaths when the jugular vein is not ligatured. Several cases are quoted bearing on this point, and he sums up in the following conclusions:

"(1) In cases of attic thrombosis of the lateral sinus without Gerhardt's sign the sinus should be opened and curetted from the upper junction to the bulb without tying the jugular.

"(2) When the jugular is evidently affected (hard cord) it should be opened, tied close to the clavicle, and resected.

"(3) The presence or absence of pulsation in the sinus is not to be relied on as symptomatic of phlebitis, as this may be of cephalic origin. Cases have been known of sinus thrombosis in which pulsations were observed (Moure), and on the other hand a thrombosed sinus may not pulsate (Batey)."

*Anthony McCall.*

**Alexander, G.** (Vienna).—*Clinical Studies on the Surgery of Otogenic Meningitis.* "Arch. f. Ohrenheilk.," Bd. 75, Heft 3 and 4, p. 222; and Bd. 76, Heft 1 and 2, p. 1, July, 1908.

A long and important article. The whole question is discussed and illustrated with case-records.

The *post-mortem* investigation of meningitis has more than exhausted its possibilities, since we have been led by it to despair of ever being able to drain the meningeal spaces successfully. Clinical experience showed us that it was possible for mild cases to get well, but under the influence

of the *post-mortem* teaching these cases were disguised under the name of "meningismus" or "meningeal irritation." Moreover, wholly unprofitable efforts are made to distinguish clinically "circumscribed" from "diffuse" meningitis.

Lumbar puncture is no certain guide to the type of meningitis, but the mode of development of the symptoms is of considerable value. The more fulminating the onset of the early symptoms is so much the worse is the outlook, whereas a long-drawn-out initial stage is much more favourable.

The author discredits the supposed *rôle* played by meningeal adhesions in limiting the spread of the process. Purulent meningitis localised to the base of the brain, for example, is often found without any evidence of adhesions. As a matter of fact the type of extension is postulated by the mode of invasion. Meningitis which is in direct continuity with a suppurative inflammation in the ear has from the start the features of an abscess, and tends to remain localised. But when the meningitis is set up by infection conveyed from a distance there is a tendency to an early diffusion of the inflammation. For this reason the most reliable information as to the type of meningitis is obtained from the findings at the operation. When, that is to say, the disease-process can be traced from the ear into the cranium along a definite localised tract, then the meningeal infection is probably circumscribed; and when, on the other hand, meningeal symptoms are present in a case in which at the operation on the ear no such obvious tract can be discovered, then the chances are that the meningitis is general and serious.

The value of the examination of the cerebro-spinal fluid receives detailed attention. The pressure of the fluid as it emerges from the spinal cannula may be clinically determined as follows: The pressure is normal when the fluid flowing from the cannula forms an arc of a circle; the pressure is raised when it assumes the appearance of an arc of an ellipse; and when the pressure is lowered the stream forms an angle with the cannula, or comes away in drops. Raised pressure is an unmistakable sign of meningitis, generally of the serous or diffuse purulent variety; but the pressure may be normal or reduced in meningitis if there is a considerable invasion of leucocytes and the fluid is thickened. In these circumstances, indeed, lumbar puncture may fail to draw off any fluid whatever. Turbidity favours the diagnosis of meningitis, but it is not infallible, for collections of pus in close proximity to the subarachnoid space may render the fluid turbid without inducing meningitis. Further, the intensity of the turbidity is not proportionate to the extent of the disease, and it has no special bearing on prognosis. Leucocytosis with bacteria in the fluid is a reliable indication of meningitis, but in purulent meningitis the fluid is sometimes sterile and free from leucocytes. The finding of leucocytes in a fluid free from bacteria generally indicates some septic focus near the meninges, such as sinus phlebitis, extra-dural abscess, or an intact brain-abscess.

The operative treatment is carefully described. Special stress is laid upon a wide exposure of the dura and a free incision of the membranes. In severe cases four incisions, 1 to 2 cm. in length, are recommended—two in the middle fossa, one between the lateral sinus and the labyrinth, and one behind the sinus. Multiple incisions are not required when the site of infection is evident. In those cases a single incision should be made through the infected area. In extra-dural abscess, however, it is better to open the membranes to one side of the lesion.

The article should be read in its entirety. *Dan McKenzie*

**Küstner, W.**—*A Case of Chronic Middle-Ear Suppuration complicated with Tumour of the Pons (Glio-sarcoma).* "Arch. f. Ohrenheilk.," Bd. lxxv, Heft 3 and 4, p. 181.

Female, aged twenty-three. Suppuration in left ear six years. Pains left side of head and ear. Suppuration also in right ear, but no pain. No serious loss of hearing.

Three months before coming to hospital violent vertigo came on while dancing, and continued for several hours. Six weeks later another attack associated with dragging of right leg. A month later vertigo so violent that patient had to go to bed. Subjective movement of external objects.

On admission paresis *right* arm and leg; facial paralysis *left*, and paresis *left* masseter and temporal. Reduced sensibility skin of *left* side of face, tongue, and soft palate; anæsthesia fingers and toes of *right* side. Tip of left mastoid tender, and tenderness of left side of skull on percussion. Operation: Radical mastoid left, and skull trephined over left temporo-sphenoidal lobe. No brain abscess found.

After operation the condition of the ear improved while the patient's strength declined, and she died two months later.

*Post-mortem.*—Glio-sarcoma left side of pons of the usual infiltrating type. *Dan McKenzie.*

**Gould, G. M.**—*The Myth and Mystery of "Ménière's Disease.* "Medical Record," October 31, 1908.

A long article to prove that "Ménière's disease" is nothing more or less than migraine, and that eye strain is at the bottom of most cases.

*Macleod Yearsley.*

**Stoker, F.**—*Atrophic Rhinitis complicated by Mastoid Abscess and Extradural Abscess.* "Brit. Med. Journ.," February 6, 1909.

An interesting case with fatal issue. No autopsy was obtained, which was unfortunate, although the diagnosis appears to have been fairly clear. *Macleod Yearsley.*

**Borden, C. R. C.**—*Aural Complications in the Exanthemata.* "Boston Med. and Surg. Journ.," July 15, 1909.

The complications in measles, scarlet fever, and diphtheria only are discussed, and illustrative cases given. The author emphasises the greater frequency of middle-ear inflammation in children than in adults in scarlet fever, pointing out that in measles the relative liability is equal. He urges the necessity of early operative interference.

*Macleod Yearsley.*

**Muck, O.** (Essen).—*The Treatment of Acute Middle-Ear Suppuration with Nipple-Shaped Perforation by Aspirating the Pus into the External Meatus.* "Arch. of Otol.," December, 1908.

The author believes this treatment capable of aborting the process, and quotes five cases in which recovery ensued after five, eight, ten, two and five days' treatment respectively. *Dundas Grant.*