culation were fairly good. It was a surprise to us all when he reported her death at the following meeting.

Dr. GEORGE A. LELAND: I was called last winter to see an old lady, aged seventy-three, who had enlarged glands in the neck. I made the diagnosis of lymphosarcoma. She was put under treatment with Coley's fluid, and he writes me that the tumour has entirely disappeared.

Dr. HARMON SMITH: We should not depreciate the benefits of Coley's fluid. I recall a case of sarcoma of the antrum occupying the entire nasal cavity and projecting outward. There was lymphatic involvement and the case seemed hopeless. It was pronounced sarcoma by the pathologists. I said the only thing we could do was to operate, and that if he died on the table it would be the most satisfactory termination of the case. The patient went to the General Memorial Hospital, was put under treatment with Coley's fluid, and the sarcoma entirely disappeared.

Dr. HENRY L. SWAIN (New Haven): Whether the disappearance of these tumours is due to tumour transformation, as has been suggested, or to the agents employed, the fact is that we stand with reference to them in the position of strict empiricism. This applies to Coley's fluid as much as to anything else. If we could collect all the observations on the subject, we might then have something to go by; until that is done its use will always be empirical. I have two cases in which it seemed to do good, and many others in which it accomplished nothing.

Abstracts.

PHARYNX.

Davis, E. D. D.—Ulceration of the Soft Palate. "Proceedings of Royal Society of Medicine." Section for the Study of Disease in Children, June, 1916, p. 79.

The case shown was that of a girl aged thirteen. She had a large irregular ulcer involving the left half of the uvula, soft palate, and left pillar of the fauces, with considerable loss of the left half of the palate. The ulceration was a typical of lupus, tubercle, or syphilis. There was no other lesion of the nose, pharynx, larynx, or ear.

The Wassermann test yielded a positive reaction. There was a definite history of infection with syphilis of both parents. *Archer Ryland.*

NOSE.

Wheelock.—The Blood-clot Dressing in Operations for Simple Mastoid Abscess. "Laryngoscope," 1916, p. 93.

The paper is based on thirteen consecutive operations for simple acute mastoid abscess in which the wound was closed at the time of operation. The cases only remained seven days in hospital. Wheelock is aware that many of the best surgeons have tried the method and put it aside. The blood-clot dressing was first proposed by Sprague, of Providence, R. I.,

and first used by Blake, of Boston. Wheelock uses iodine to prepare the skin, but does not interfere at all with the hair. He insists that the operation should be a thorough one—every vestige of softened bone being removed. "We must go to the dura within and to the skin without." At the end a free incision is made in the drumhead and a gauze drain inserted. The writer claims the following advantages for the method: rapid healing, no painful dressings, no deformity, and no failures. He recalls Mygind's statement in London in 1913, that the healing of the cavity formed in the Schwartz operation generally takes from six to twelve weeks. Wheelock claims that Mygind's operation for secondary suture does not differ in any essential from the blood-clot method. From the experiments of Metchnikoff, Nuttall, Fodor, Vaughan, and Novy, Wheelock concludes that the bactericidal power of drawn blood is greater than that of the blood circulating in the vessels. The germicidal power is, however, lost after forty-eight hours. *J. S. Fraser.*

H. O. Reik—The Ideal Mastoid Operation. "Laryngoscope," 1919, p. 99.

Reik defines an ideal mastoidectomy as "one that submits the patient to the least additional risk, and offers the maximum assurance of cure in the shortest space of time with a minimum of deformity or scar." In the preparation of the patient Reik advises shaving the usual area, the use of soap and brush, alcohol or ether, and a moist bichloride dressing. He uses gloves and a cap and face mask. Each used instrument is washed in carbolic and then in sterile water before being replaced. The entire head and shoulders of the patient are covered by a sheet, which is carried over a metal frame on the distal side of the table so as to shut off the anæsthetist. Reik uses a Doyen burr to perforate the mastoid cortex, because there is no danger of concussion and less risk to the dura. He holds that it is scarcely possible to do too much in the way of removal of bone, though he does not remove the mastoid tip. The inner wall of the mastoid shell should be curetted as long as there is any bleeding from the bone. The majority of sinus thromboses arise because the primary operation is not sufficiently thorough, so that if there is any doubt about the bone covering the sinus the bone should be removed. The bony cavity should be washed out with sterile saline solution, and allowed to fill with blood-clot. The wound is closed with subcutaneous silver wire sutures or Michel's clamps, and covered with silver foil and dry gauze. The clamps are removed on the *second* day. If primary union occurs the patient is usually dismissed in from five to seven days, though he should be kept under observation for some time longer. If the wound breaks down Reik holds that we are no worse off than if the cavity had been packed. Reik obtains 75 per cent. of primary healings in acute cases and 50 per cent. in those associated with old chronic purulent otitis. He states that not a single instance has been recorded of any serious complication resulting from the blood-clot dressing, and maintains that the wound is always the direction of lesser resistance. *J. S. Fraser.*

Taro Matsui (Japan).—**The Turbinal Origin of "Bleeding Polypus" of the Nose.** "Laryngoscope," 1916, p. 109.

Bleeding polypus of the septum occurs as a rule in women, and may be related to puberty and pregnancy. The condition has been classified as a fibroma, a telangiectasis, or an angioma, but these terms correspond to different stages of growth. The etiology is doubtful. Mechanical

irritation and rhinitis sicca may be concerned. Matsui records two cases in which the polypus grew out of the inferior turbinal. (1) Male, aged forty, nasal obstruction and frequent epistaxis. Right nose blocked by a dark purple strawberry-like growth on anterior and posterior rhinoscopy. The swelling was removed by the hot snare with little bleeding; no recurrence. (2) Similar. Microscopic examination showed greatly dilated vessels and many "decayed glands." Baurowicz has stated that in one case out of eight the growth takes place from the lower turbinal. Matsui says the term "bleeding polypus of the septum" should be replaced by "bleeding polypus of the nose." *J. S. Fraser.*

Hays and Lewisohn.—Hæmorrhage following Posterior Tip Operation (on Inferior Turbinal). Blood Transfusion. "Laryngoscope," February, 1916.

The writers record the case of a male, aged thirty, who complained of irritation in his throat. On examination it was found that the posterior end of the left inferior turbinal was enlarged. (The patient had had tonsils removed under general anæsthesia two years before.) Local anæsthesia was now employed, and the turbinal operation was carried out without difficulty and with almost no hæmorrhage. At 4 p.m. there was profuse hæmorrhage with pallor and feeble pulse. Packing removed and nose syringed with hot saline. Bleeding stopped. On the seventh day again severe hæmorrhage: anterior and posterior nasal plugging, followed later in the day by morphia hypodermically and saline per rectum. Afterwards horse serum was injected into the gluteal region, and on the same evening the temperature rose to 104° F. On the next day pain in left ear, followed by spontaneous rupture of drumhead, and later by mastoid tenderness (pneumococcus infection): 900 c.c. of citrated blood transfused. Two days after that another profuse hæmorrhage from nose necessitated anterior nasal plugging, and a deep injection of human serum, and later a second transfusion. Again next day profuse epistaxis. Yankauer was called in and placed two sutures round the raw area and then packed the nose with gauze soaked in coagulin. There was no more bleeding, and the patient made a good recovery in spite of arthritis in the shoulder and wrist.

The writers gives the following account of the technique for transfusing citrated blood: A tourniquet is applied to the donor's arm and a vein punctured with a large size cannula. While the blood is running into a glass jar it is mixed with a 2 per cent. sodium citrate solution at the rate of 1 : 10. For instance, if we want to transfuse 500 c.c. of blood we would mix it with 50 c.c. of the 2 per cent. citrate solution. We then introduce a cannula into the recipient's vein, and with the aid of a salvarsan flask inject the donor's blood into the recipient's vein.

J. S. Fraser.

THE LATE DR. JULES BROECKAERT.

In the issue of the Journal of Laryngology, Rhinology, and Otology for October, 1916, there appeared from the pen of Sir Felix Semon an obituary notice of our distinguished Belgian colleague, Dr. Jules Broeckaert whose untimely death in tragic circumstances we all deplore.

The tragedy is deepened by the straits in which his wife and four