Nose

Tinnitus associated with Facial Spasm—G. J. JENKINS, F.R.C.S.—Female, aged 53. Spasm of left facial nerve, one year five months. Tinnitus began with onset of the spasm. A single twitch of the muscles was associated with a synchronous noise in the left ear. Patient described the noise as a "bang." When twitches followed one another rapidly the noise was like the "popping of a motor car." When twitches were very rapid the noise became continuous and sometimes bell-like. There was pain in the left ear at the onset of the disease when the twitching was very bad. Post-suppurative effects in the right ear. Tympanic membrane on left side showed opacities.

Sir JAMES DUNDAS-GRANT said he thought the murmur was perhaps a muscular one caused by the contraction of the stapedius, associated with contraction of the facial muscles. If the normal subject closed the ears and then shut the eyes tightly, a deep-toned hum was perceptible. Mr Jenkins' patient said that the sound she was hearing was the same as that which followed the energetic shutting of the eyes in the way mentioned.

Mr SYDNEY SCOTT said he had seen some similar cases at Queen Square, but was unable to throw light on the pathology. He believed the subjective noise might be caused by the repeated contractions of the stapedius, because in some cases the patient felt momentarily giddy during the attacks of twitching of the face. This patient said she was not giddy, but she was deaf in the opposite ear.

Mr G. J. JENKINS (in reply) said he had shown the case because it seemed to be one in which a specific cause for the tinnitus could be made out. There was a spasm of the left seventh cranial nerve. The tinnitus might possibly be due to the sound produced by the contraction of the facial muscles being conducted to the ear, or by a movement of the pinna, but he thought it was due to the movement of the stapes produced by the contraction of the stapedius muscle. As to whether the tinnitus was due to the simple movement of the stapes or a vibration set up in the tympanic membrane and ossicles it was difficult to say, but he thought it was more likely to be due to movement of the stapes itself.

ABSTRACTS

NOSE.

External Nasal Deformities: Description of the Operative Technic of a New Method for the Correction of Certain Types. Dr J. D. LEWIS. (*Laryngoscope*, Vol. xxxii., No. 3, p. 214.)

It is proposed under local anæsthesia to make an incision half an inch long in the mid-line of the lower half of the columella nasi. The edges are undermined laterally and towards the tip of the nose, so that the latter is raised to enable scissors to cut towards the

nasal bones and thus form a pocket for the transplant. The tip should be undercut about an eighth of an inch beneath the skin. It forms a hood and provides a support inferiorly for the lower end of the graft.

ANDREW CAMPBELL.

Rhinolithiasis. H. KEY-ABERG. (*Acta Oto-Laryngologica*, Vol. iii., fasc. 4.)

This is a comprehensive discussion of the etiology, chemical composition, and symptomatology of rhinoliths, together with statistics of cases published in Sweden. Attention is drawn to the predilection of rhinoliths for the female sex, *i.e.*, 70 per cent. of the cases. A detailed account is given of the various foreign bodies which have been found to form the nuclei around which the salts have been deposited. As regards the chemical composition, phosphate of calcium is always and the carbonate usually present: magnesium is found only occasionally, and chlorine was met with once. In one case the author found more than 15 per cent. of iron, the largest quantity discovered in a rhinolith apart from a case described by Jörgen Möller in which more than a third of the total substance consisted of oxide of iron.

Although the prognosis in these cases is usually so favourable, the author gives details of a case which resulted in death from septicæmia, set up by accessory sinus infection due to the presence of a rhinolith. In this case and in one other observed by the author a rhinolith was accompanied by empyema of the maxillary antrum, an association met with in only six previous cases.

THOMAS GUTHRIE.

The Use of Submucous Injections of White Vaseline in the Treatment of Ozæna. C. CALDERA. (*Arch. Ital. di Otol.*, Vol. xxxiii., 1922.)

Caldera has used submucous injections of paraffin in ozæna for about ten years, and has found it on the whole very satisfactory. Some cases give unexpectedly good results, and at the worst some improvement is to be expected. The use of melted paraffin is dangerous on account of the risk of embolism. Hard paraffin, again, has the drawback of being very liable to cause rupture of the thin mucosa. In the last few years Caldera has been using ordinary white vaseline instead of hard paraffin. The vaseline is kept in glass tubes which fit the bore of the syringe accurately, and is sterilised in an autoclave. An ordinary paraffin syringe with a screw piston is used. By the use of vaseline the danger of rupturing the mucosa is greatly lessened, and the same beneficial results are to be expected as with hard paraffin. Before using this method a preliminary course of treatment of five to six months' duration is

necessary in order to get satisfactory results. This consists of thorough lavage followed by the application of irritating solutions, such as 1-5 per cent. silver nitrate, with the idea of toughening the mucosa. If this is not done failure is apt to result. J. K. MILNE DICKIE.

Nasal Obstruction in Infants during the First Year of Life. J. ARNOLD JONES. (*Lancet*, Vol. ii., p. 327, 1922.)

A very useful paper, classifying causes into:—1, Congenital occlusion of (*a*) anterior nares, (*b*) posterior nares; 2, temporary presence of mucus with engorgement of nasal mucosa; 3, congenital syphilis; 4, mongolism; 5, adenoids. In adenoids, operation without anæsthetic is advised, and the author gives his results.

MACLEOD YEARSLEY.

A New Local Hæmostatic. PUGNAT, Geneva. (*L'Oto-Rhino-Laryngologie Internationale*, April 1922.)

The problem of hæmostasis in rhinology has not yet been properly dealt with. It is true that during operation a bloodless field can usually be procured, but so far, packing is the only effective means of preventing post-operative bleeding. Taking advantage of the coagulating powers possessed by aqueous extracts of the body organs, Pugnat has made use of lung extract in the form of a very finely divided powder.

To prove the power of the extract, it was used first in turbinotomy cases where the anæsthetic employed was alypine, a vase-dilator. Application of the powder at once stopped the hæmorrhage. The extract was then used in cases where cocaine and adrenalin had been used, and in no case of those treated in this way had there been post-operative hæmorrhage.

Pugnat states that the extract is useless in persons where for any reason the coagulative time of the blood is not within normal limits.

GAVIN YOUNG.

Antro-choanal Polypus of Exceptional Size. G. W. DAWSON. (*Lancet*, Vol. i., p. 1095, 1922.)

Case of an antro-choanal polypus, weighing 9½ drachms, in a man, aged 47. The patient could breathe well through either nostril, his only symptoms being muffled speech and occasional fits of suffocation. The growth was removed by opening the antrum through the canine fossa and detaching the polypus at its origin.

MACLEOD YEARSLEY.

Abstracts

PERORAL ENDOSCOPY.

Pharyngeal Diverticulum and its Surgical Treatment, with a Record of Two Cases. D. P. D. WILKIE and J. N. J. HARTLEY, Edinburgh. (*British Journal of Surgery*, Nov. 1922.)

Killian has shown that the condition is due to a protrusion of mucosa between the transverse and oblique fibres of the crico-pharyngeus muscle in the mid-line posteriorly.

The wall of the sac consists of stratified epithelial lining, and some loose muscle fibre round the neck, and the main and outermost coat is formed from the pharyngeal fascia.

Two etiological factors are involved—one a weakness of the wall, and the other increased intrapharyngeal pressure, probably due to irregularities in action of the sphincter at the entrance of the œsophagus, and in most cases the primary cause would appear to be the incoordinate action between the propulsive and sphincteric elements of the pharyngeal muscle. Treatment must be directed to removal of the cause as well as to extirpation of the sac.

Numerous methods of removal of the diverticulum are described, and on the whole a two-stage operation is advocated for the majority of cases, in order to avoid the risk of cellulitis extending to the mediastinum. In this type of operation the sac is freed from its surroundings and carefully packed round and the skin sutured down to its neck; later, the sac itself is excised. In the case of a small sac it can be excised at one operation.

It is interesting to note that the condition occurs most frequently in men past middle life. E. MUSGRAVE WOODMAN.

Retro-Œsophageal Abscess. JEAN GUISEZ. (*La Presse Médicale*, 29th April 1922.)

Three cases in children are described. It is a condition met only in young children, and due to a scratch or prick by a fish bone or similar object. The site of the abscess is behind the posterior wall of the gullet and mainly opposite the sixth and seventh cervical vertebræ. Its development is slow, and in the later stages dysphagia and dyspnœa are features; the dyspnœa may be urgent enough to require a low tracheotomy, and is due to a flattening of the trachea from pressure. Diagnosis depends on inspection by direct œsophagoscopy, and the treatment adopted, which in each case was perfectly successful, was firstly, a low tracheotomy, and secondly, the opening of the abscess by means of cutting forceps and a suitable œsophagoscope. The differential diagnosis must be made from that of a foreign body in the trachea. F. J. CLEMINSON.

Peroral Endoscopy

Cicatricial Stenosis of the Œsophagus. L. LEDOUX (Brussels). (*L'Oto-Rhino-Laryngologie Internationale*, June 1922.)

1. Emphasis is laid on the peri-œsophageal inflammatory changes which are frequently present in cases of this condition. The pleura is not uncommonly involved, and three cases are related in which a right pleural effusion followed dilatation of the stricture. In each case effusion cleared up spontaneously within a few days.

2. Certain cases of stricture are found to resist dilatation and to contract rapidly down again when it has been effected. This is probably due to traction and kinking of the œsophagus by pleural adhesions or the fibrosis of glands in the hilus of the lung. Severe strictures are most usually situated at the broncho-aortic isthmus where the pleura is intimately related to the œsophagus.

3. The formation of complete stenosis is difficult to explain. In three cases no bismuth could be seen to pass, and no passage could be made out with the œsophagoscope. The continual passage of food and secretions and the communicated movements from heart and lungs should prevent an absolute stenosis. Final closure is a secondary effect, due partly to the contraction of the cicatrix and partly to the ulceration of its edges.

4. The broncho-aortic region is the most common site for a stricture. Factors which determine the seat of delay of the corrosive fluid, and therefore the site of the stricture, are: The attitude of the individual when the fluid is drunk, the concentration of the fluid, and the resulting presence or absence of spasm of the sphincter.

5. The lateral position is the most suitable for œsophagoscopy as it facilitates the emptying of secretions. Application of adrenalin is useful to assist in finding the opening of the stricture.

6. Radiography gives the most exact information as to the extent of the stricture. With a normal œsophagus, the passage of fluid bismuth is too rapid to be observed on a plate or screen. In any case in which a stricture is present, however short, the bismuth shadow below the stricture will be filiform, the fluid passing through in a fine stream. This appearance is sometimes interpreted as showing a stricture of considerable length, but probably single and uniform strictures are never of a greater length than 5 or 6 cm.

7. In cases of multiple strictures, the dilatations tend to have the form of a pear with the stem pointing upwards. This would seem to favour the employment of retrograde dilatation, but the fact that there are usually bands and irregularities in the œsophageal wall above the stricture frequently outweighs this theoretical advantage.

A. J. WRIGHT.

Abstracts

The Liver Tunnel and Cardiospasm. H. P. MOSHER, Boston. (*Laryngoscope*, Vol. xxxii., No. 5, p. 348.)

In a previous paper the author demonstrated that the liver was responsible for the shape of the lower end of the œsophagus. The lower end is cone or trumpet-shaped; it has liver to the right, in front, and in many cases to the left; behind, it has the descending aorta. Thus a "liver tunnel" is formed for the subdiaphragmatic œsophagus. When a normal patient swallows Barium milk the œsophagus comes to a point at the upper edge of the liver, then after a delay of a second or two the tunnel opens up and the milk streams into the stomach, as the diaphragm is lowered. Experiments on the cadaver show that lowering of the diaphragm opens up the tunnel. There must be some correlation or rhythm between the peristaltic movements of the œsophagus and the relaxations and contractions of the diaphragm.

In cardiospasm the diaphragm is usually lowered and its downward excursions are small, though its upward excursions are normal. The lowering closes the œsophagus and the raising opens it up, the reverse of what normally happens.

In reviewing 10 cases of cardiospasm a stricture was found in all, varying from a crescentic fold to a full annular stricture. In 1 case the whole tunnel was narrowed. In all these strictures there may be an element of spasm, which reinforces the obstruction, but the spasm is a minor consideration. The cause of the annular stricture is probably due to some previous infection of the lesser omentum. Cases are cited in support of this view. The paper is well illustrated by the author himself. ANDREW CAMPBELL.

The Bronchial Tree: Its Study by Insufflation of Opaque Substances in the Living. Dr CHEVALIER JACKSON. (*American Journal of Rœntgenology*, Vol. v., p. 454.)

The author in a number of cases deposited a small amount of bismuth in the bronchi for aid in localisation of foreign bodies and also in bronchiectatic and abscess cavities. In none of these cases were there any after-effects.

In a young man, aged 23, with a metallic F.B. "around the corner" in an ascending branch of the left upper-lobe bronchus, bismuth subcarbonate was blown in with an insufflator. A radiogram showed the main bronchus, upper-lobe bronchus, and some of the branches. The foreign body was removed. In twenty-four hours a radiograph showed that all the bismuth had disappeared from the lungs. There was occasional cough and expectoration was free, the sputum being milky white.

By means of insufflation and stereoscopic X-ray pictures the

tracheo-bronchial tree can be shown up *in situ*. This is of great value in upper-lobe bronchus cases. Injection of opaque fluid or insufflation of powders through the larynx gives a degree of visibility to the trachea and larger bronchi, but the best results are obtained by insufflation through the bronchoscope. The method opens up a field for investigation of the action of the cilia, lymphatic drainage of the lung, mapping out of bronchiectatic cavities, etc.

ANDREW CAMPBELL.

A Case of Lung Stone removed by Bronchoscopy. H. BURGER. (*Acta Oto-Laryngologica*, Vol. iv., fasc. 1.)

The patient, a female, 43 years of age, had always enjoyed good health until six months before she came under observation, when she began to suffer from an acute burning pain in the chest, which was followed three months later by fits of coughing, asthma, and shortness of breath.

Bronchoscopy showed the left main bronchus to be almost completely blocked at a point 5 cm. below the bifucation by a pale red swelling arising from the median wall. The swelling was smooth and firm and a bougie could not be passed beyond it. The appearances were those of compression of the bronchus by a tumour of the lung.

On examination, six weeks later, the swelling was found to be soft and dark red in colour, with a tendency to bleed. It presented a little depression with a white base, and from this situation the author removed with forceps a carbonate of lime calculus measuring $9 \times 5 \times 4$ mm. and weighing 185 mgr. The removal of the stone was followed by almost immediate relief and all symptoms gradually disappeared.

This is the first case in which the various stages of the perforation of the wall of a bronchus by a pneumolith have been observed, and in which bronchoscopy has rendered possible the removal of the stone.

THOMAS GUTHRIE.

REVIEWS OF BOOKS

Smell, Taste and Allied Senses in the Vertebrates. G. H. PARKER, Sc.D., Professor of Zoology, Harvard University. Illustrated. Philadelphia and London: J. B. Lippincott Company, 1922. Price 10s. 6d. net.

Within its limits, imposed no doubt by the editor of the series to which it belongs, this small book of 200 pages supplies in a conveniently arranged manner much of the anatomy and most of the physiology of the senses of smell and taste in man and in the other vertebrates. In form it is compact, and in diction severely