MOUTH, &c.

Renner, W. Scott (Buffalo, N.Y.).—*Chronic Follicular Tonsillitis.* "Med. Record," Aug. 28, 1897.

THE plugs in the crypts are made up of leucocytes, epithelium, chalk, mucus, and various bacteria. The tonsils affected are often more or less hypertrophied, but some are considerably atrophied. The large tonsils, with numerous crypts, do not often give as much trouble as those with less secretion, especially if in the latter the crypts are so located that the secretion is expressed with difficulty by the ordinary movements of the throat. The larger tonsils, when filled with secretion, cause only (unless acutely affected) a sense of fulness. Where, however, there is more obstruction to the discharge of secretion there is pain in the throat, pain extending to the ear or chest, pain externally in the neck on one or both sides, fatigue of the neck muscles, severe neuralgia, or other reflex phenomena. Symptoms usually disappear for the time when secretion is expressed. As the plugs increase in size they often cause swelling of the orifices, or the middle of the duct external to the plugs. This is specially apt to occur after exposure to cold or after hot food. Acute inflammation, too, may result, owing to increased virulence of streptococci in secretion, and may last a day or two, or may end in a regular acute follicular tonsillitis. Patients subject to frequent quinsy are usually subject to chronic follicular tonsillitis. The upper angle of tonsil, often hidden from view by the approaching palatine folds, often has one, and sometimes two, crypts, whose orifices pointing upward do not permit the easy escape of secretion. The patient recognizes this to be the offending part when touched. Dysphagia, otalgia, or a tickling in external auditory canal are complained of. The last-mentioned symptom was relieved in one case by painting the upper part of tonsil with cocaine.

He gives a case of aching and acute burning sensation in the throat, following singing or continued talking. This was treated in many ways, but not relieved till the tonsil was discovered to be a small crypt-like organ distended with secretion, and was thoroughly destroyed by the electro-cautery. Paroxysmal cough is often due to diseased tonsils.

Treatment.—Open and destroy every crypt, or, if necessary, the whole tonsil. The author prefers, when tonsillotomy is necessary, to do it with the cold snare, as being more thorough than with the tonsillotome. Whatever method is used adhesions between palatine folds and tonsils should be broken down. Fibroid tonsils require an *écraseur* or the galvano-cautery snare. Flat tonsils which cannot thus be grasped he treats by opening the crypts with long sharp bistoury, and removing intervening portions with cold snare or cutting forceps, or by destroying them with electro-cautery. Destruction with the electro-cautery is required for cases of large crypts with scarcely any tonsillar tissue around them. *R. M. Fenn.*

Sympson, E. M.—*Notes of a Case of Chronic Superficial Dissecting Glossitis.* "Brit. Med. Journ.," Sept. 11, 1897.

MALE, aged twenty-one, not syphilitic, not alcoholic, but dyspeptic, with history of relapsing glossitis five or six years; worse during attacks of dyspepsia. Tongue large, swollen, smooth (except for furrows), and glossy red. Whitish leucomatous patches, one on each side of median fissure on dorsum, and two or three at the tip. Tongue invaded for half an inch or so from the borders by deepish fissures, not ulcerated, but as tender as the rest of the surface of the organ. Teeth good.

Treatment.—Simple and unirritating diet. Mouth wash—glycerine and borax—followed later by painting the tongue with chromic acid solution. *Internally,*

chlorate of potash, nux vomica, and gentian, followed later by iron. In less than three months he had almost a normal tongue.

A photograph from a painting of the tongue accompanies the paper.

R. M. Fenn.

NOSE, &c.

Power, D'Arcy.—*Empyema of Antrum in a Child aged eight weeks.* "British Med. Journ.," Sept. 25, 1897.

Boy, eight weeks old, wasting, with history of bruised face in delivery by forceps. At one month of age, difficulty in closing mouth and refusal of bottle were accompanied by swelling and redness below the right eye. The abscess was opened at lower part of right lower eyelid, and pus flowed till seen by the author. Right side of face then seen to be fuller than left, with redness of cheek and lower lid—a little pus exuding from alveolar border of upper jaw. A probe passed along the sinus in cheek showed part of the superior maxilla to be bare. Author enlarged sinus, and made a hole through floor of antrum, and then passed drainage tube from eyelid to mouth. A drachm of thick pus escaped. Child died ten days later. Author then refers to a few recorded cases in young children, and gives references.

R. M. Fenn.

Williams, Campbell.—*Adenoids.* "The Clinical Journal," Sept. 18, 1897.

The author operates under anæsthesia with the A.C.E. mixture, and as many "adenoid" children take anæsthetics badly he makes it a rule to have the body stripped to the waist in case of accidents, so that one can clap on a hot towel over the heart as a cardiac stimulant, or inject ether if required. Cardiac syncope is not an uncommon occurrence during operation in these cases, and it may happen at any period during the administration from the first few whiffs onwards. The author first removes the tonsils in the dorsal position, and as soon as this is done the patient's head s pulled on so that it hangs downwards over the end of the table. The adenoids are then removed with Gottstein's knife.

Middlemass Hunt.

LARYNX.

Alcock, J.—*A Case of Rupture of the Trachea; Necropsy.* "Lancet," Sept. 25, 1897.

The patient was a strong man who received a heavy blow over the trachea. On admission to the hospital he was slightly cyanosed, his breathing being laboured and occasionally stridulous. It was impossible to feel the trachea or larynx owing to surgical emphysema. The treatment was expectant, as the patient—after some pneumonia—continued to improve. He appeared to be entirely out of danger when, eleven days after the accident, he suddenly cried out, two or three pints of blood gushed from his mouth, and in less than two minutes he was dead.

The *post-mortem* showed a complete rupture of the trachea between the ninth and tenth rings. The ends were separated by about two inches, the upper end of the lower fragment being one and one-eighth inches below the top of the sternum. An abscess cavity surrounded the injured parts, filled with blood clot. None of the large arteries were wounded, and it seems probable that the blood came from ulceration of a large vein, possibly the left innominate.

No laryngoscopic examination had been made.

StClair Thomson.

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