NOSE.

Leroux, R.—*Paraffin in Nasal Prosthesis.* "La Presse Médicale," January 25, 1908.

In this paper the author passes in review some of the methods in vogue for restoration of the nasal contour. He prefers a paraffin of high melting point, 78°, and introduces it in the cool state. Briefly the technique of the operation is as follows: No anæsthetic is required. With the patient in the recumbent position the nasal integument is sterilised; an incision is made through the skin at the lower third of the nose with a furunculotome; then a long, narrow spatula is inserted through the opening into the subcutaneous tissues, in such a manner as to prepare suitable receptive beds for the paraffin; great care is taken not to burrow beyond the region to be restored, so as to avoid unnecessary diffusion of the wax. The writer attaches great importance to this stage of the operation, and considers that success depends in no small measure upon the way in which it is carried out. The paraffin is warmed sufficiently to bring it to a doughy consistence for introduction into the cannula of the instrument, which is a sinusitis trocar. The tube containing the wax is then introduced high up into the preformed cavity, and as the paraffin is pressed out of the cannula by the introduction of the mandrin with the index finger of the right hand, it is moulded as required by the fingers of the left; after withdrawal of the tube the skin opening is sealed with collodion. Although it is possible to complete the operation at one *séance*, the writer prefers to introduce the paraffin at intervals of eight days, believing that by adopting this course the tissues become habituated to tension and the presence of a foreign body. The advantages which the author claims for this method are, briefly, freedom from embolism, sloughing of tissues and diffusion beyond the needed area—conditions likely to follow hot injections. Moreover, satisfactory encapsulation is more likely to result from his method.

H. Clayton Fox.

Bucklin, C. A. (New York).—*Hypertrophic Nasal Catarrh and Complications, with Clinical Illustrations.* "Arch. of Otol.," August, 1907.

The writer considers that nasal catarrh is occasioned by obstructions to nasal inspirations. He estimates the vacuum formed within the entire respiratory track with each forcible inspiration in patients suffering from this disease as 1·36 lb. to the square inch, and finds that when this vacuum is diminished to about one half the symptoms of catarrhal disease and their complications disappear within ten days. The means for effecting this consist in the removal of the main bulk of the inferior turbinal by means of a saw. He considers this of the greatest curative value in pulmonary tuberculosis as well as in asthma, hay-fever, catarrhal otitis media, and chronic lacrymal disease. He measures the amount of the vacuum by the "respirometer," in which a column of water is raised in a tube held in the patient's mouth during deep inspiration through the nose, and the capacity of the chest by the "displacement vessels" into which the patient blows after a full inspiration. The writer has long been known as the earliest advocate of the nasal saw, and he reports a number of illustrative cases from his large clinical experience. *Dundas Grant.*

Gaullieur L'Hardy.—*Pignet's Numerical Index in Adenoid Subjects.* "Gaz. des Hopit.," January 22, 1908.

This index, which has been adopted by the writer as a test for the robust-

ness of the subject, is arrived at by subtracting the sum of the major peri-thoracic circumference and the weight from the height. The following table gives the results of its application in the case of ordinary individuals:

Numerical index below 10 = very vigorous constitution.
„ „ from 11 to 15 = vigorous „
„ „ „ 16 „ 20 = good „
„ „ „ 21 „ 25 = pretty good „
„ „ „ 26 „ 30 = feeble „
„ „ „ 31 „ 35 = very feeble „
„ „ above 35 = weakly „

Dr. P. Nodestini has applied this test to those suffering from adenoids, and the results are shown in the table appended:

In 7·7 per cent. of cases the index varied between 16 and 20, constitution good.
„ 46 „ „ „ „ 21 „ 25, „ pretty good.
„ 30·76 „ „ „ „ 26 „ 30, „ feeble.
„ 15·39 „ „ „ „ 31 „ 35, „ very feeble.

The writer noted from these observations that the index varied directly in proportion with the adenoids and the results accruing therefrom; thus where there was a high index the vegetations were plentiful, with pronounced aural, respiratory, and circulatory troubles, whilst the reverse obtained with a low index. Another observation by Dr. Modestini was that, contrary to that which obtains in a well-developed body, the measurement between the finger-tips with the arms outstretched horizontally exceeded that of the height in adenoid subjects. This he ascribes to the fact that owing to fluttering the transverse diameter of the throat is increased in such individuals. *H. Clayton Fox.*

LARYNX.

Horn, O., and **Moller, J.** (Copenhagen).—*A Case of Hæmangeioma of the Left Vocal Cord.* "Arch. für Laryngol.," vol. xx, Part I.

Hæmangeiomata, although much less rare than lymphangeiomata, form hardly 1 per cent. of the benign new growths met with in the larynx. The author of this paper adds another case to the thirty-five which have been already recorded.

The patient was a man, aged forty-four, the subject of pulmonary tuberculosis, who had been hoarse for a long time. When first seen the left vocal cord was intensely red and presented on its margin two somewhat œdematous swellings, the surfaces of which were ulcerated. Under treatment that swelling which involved the posterior part of the cord became flattened and less prominent, while the other swelling which was attached to the anterior part of the cord became pedunculated and movable and assumed a bluish-red colour. The lung disease proved fatal after the patient had been under observation for seven months.

Examination of the larynx after death showed a smooth reddish polyp, hardly as large as a pea, attached to the anterior third of the left cord by a flattened pedicle. Beneath the free margin of the posterior part of the left cord were several deep ulcers, which, as microscopical examination showed, were typically tuberculous. The tumour consisted of large blood-filled spaces whose walls were separated from one another by thin connective-tissue septa.

The true nature of the tumour in this case was at first marked by the associated tuberculous disease, and only became evident about one month before death, when the local tuberculous condition had greatly improved under treatment. *Thomas Guthrie.*