

frequency of such accidents in Sicily, for of sixteen Italian cases thirteen belong to the island. The leech remained in the larynx for ten days. *Massei.*

**Pyncheon, E.** — *Dobell's Solution.* "Ann. of Ophth. and Otol.," Oct., 1896.

THE author has collected the following twenty-one solutions, giving their source. No. 14 is the original solution, but he himself uses No. 1, using the following prescription:  $\zeta j.$  to  $Oj.$  of water.  $\mathfrak{B}.$  Sod. bibor., sod. bicarb.,  $\bar{a}\bar{a}$   $\zeta ij.$ ; listerine Oss., glycerine  $Ojss. m.$

FORMULÆ FOR DOBELL'S SOLUTION AS GIVEN BY VARIOUS  
AUTHORITIES.

	Sodæ, Bibor.	Sodæ, Bicarb.	Acid, Carbolic.	Glycerine.	Water.
1	Grs. 30	Grs. 30	Grs. 15	Drm. 4	Pt. 1
2	32	32	16	8	1
3	32	32	16	16	1
4	32	32	16	$21\frac{1}{3}$	1
5	40	40	32	8	1
6	60	30	12	16	1
7	60	60	45	8	1
8	60	60	45	...	1
9	71	71	14	14	1
10	78	78	21	4	1
11	96	96	38	$2\frac{1}{2}$	1
12	96	96	32	$5\frac{1}{3}$	1
13	116	116	23	$4\frac{1}{2}$	1
14	120	120	48	$3\frac{1}{5}$	1
15	120	120	24	4	1
16	120	120	24	8	1
17	120	120	24	...	1
18	127	127	27	$6\frac{1}{2}$	1
19	240	240	80	14	1
20	240	240	120	14	1
21	480	480	180	29	1

*R. Lake.*

**Thelwall, Thomas.**—*Exostosis of Frontal Sinus.* "Brit. Med. Journ.," Oct. 17, 1896.

A REPORT of a case in a woman of forty-six, who ascribed the trouble to a blow thirteen years previously. The growth was an ivory exostosis springing from the inner wall and herniating into the orbit. Dura mater formed the roof of the sinus. *Ernest Waggett.*

## LARYNX.

**Biaggi, C.**—*Some Considerations on so-called Eunuch's Voice.* A Paper read before the Lombard Medical Association, May 30, 1896. "Bollet. delle Malatt. dell' Orecch.," Oct., 1896.

DUE to some change or arrest of development of the larynx at the period of puberty, the voice retains its infantile character, or presents alterations more or

less marked, according to the duration of the abnormal condition. The voice resembles the characteristic quality of those individuals castrated before puberty, and thus justifies the appellation. The author distinguishes two varieties: vocal disturbances occurring in normal persons, and in those following castration. He further describes two cases in which complete cure followed the removal of obstructions to free nasal respiration.

*Jefferson Bettman.*

**Chosen, L.**—*Upon the Value of Calomel Subcutaneous Injections for Laryngeal Syphilis.* "Arch. Ital. di Laring.," fasc. 4, 1896.

A VERY instructive case, in which the great efficacy of the above-mentioned treatment is clearly shown. The patient had severe stenosis of the larynx, which seemed to require tracheotomy, and not only was this avoided, but the patient completely recovered under the treatment.

*Massei.*

**Downie, J. Walker.**—*An Account of Eight Consecutive Cases of Thyrotomy (Crico-Thyrotomy), with One Death, for Removal of Intralaryngeal Growths, etc.* "Glasgow Med. Journ.," Oct., 1896.

THIS short paper is accompanied by a table giving particulars of the cases under the headings of sex, age, occupation, history, etc., of which the following is an abstract.

Of the eight cases three were forty-two years old and upwards; the rest were ten years and under, the youngest being one year and eleven months.

The one fatal case was that of a labourer aged fifty-three. The operation was done to relieve urgent dyspnoea. The laryngeal growth was a fibroma. Death occurred on the fourth day after operation from septic pneumonia. Of the other two old cases, one, aged forty-two, suffered from slight cough, hoarseness, and shortness of breath on exertion; later, urgent dyspnoea. The tissues removed were oedematous granulation tissue from subglottic region, and muscular and cicatricial tissue. This the author considers was probably a case of inherited syphilis. The patient died twelve months later from oesophageal stricture. The third old case was one of typical epithelioma (published already in "Brit. Med. Journ.," Vol. I, 1894). Since the operation he has been steadily at his work (*i.e.* three and a half years). The voice is rough, but good and strong.

Of the cases in children three were cases of papilloma, one of hypertrophied and oedematous mucous and submucous tissue, and one of mucous polypus arising from trachea about level of second ring. Owing to the length of the pedicle the polypus was very freely movable, and gave rise to inflammation and spasm of the larynx, which, on two occasions, nearly ended fatally.

The youngest case, a child one year and eleven months old, suffering from papilloma of larynx, was operated on on 25th January, 1895; again on 8th February, on 21st May, on 6th September, on 27th November, and on 2nd December. The age of the patient, the size of many of the growths removed, the extent of the surface affected, and the rapidity and frequency of recurrence of the growths, make the case a remarkable one.

In all the cases except one tracheotomy was performed, without much preparation, to relieve urgent dyspnoea, and not as a special preliminary to thyrotomy. Nevertheless, the author looks upon a preliminary tracheotomy as a wise procedure, as it permits the patient to become accustomed to the use of the tube some days prior to the performance of the major operation.

The tracheotomy wound is continued upwards through the cricoid and part of the thyroid in the middle line; then the incision is carried obliquely into one ala, near the upper border, and back to the middle line again; so that, by dovetailing

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the parts together after the operation, an accurate reposition of the cords is secured.

The author prefers the use of small sponges or gauze, to mop up the blood, to the use of Trendelenburg's or Hahn's tubes, during the operation.

After carefully removing all the growth, etc., the larynx is packed with gauze and held together with strips of adhesive plaster, and the tracheotomy tube reintroduced. Next day the packing is removed, all suspicious points are cauterized, the cut edges of the cartilages brought accurately together and fixed in position by one or more sutures; then the skin incision is stitched. If all is well, the tracheotomy tube may be removed on the second or third day.

*A. J. Hutchison.*

**Downie, J. Walker.**—*A Pin in Larynx, localized by the Röntgen Rays and removed by External Operation.* "Glasgow Med. Journ.," Nov., 1896.

THIS was the case of a lad, aged nineteen, who had put a pin into his mouth while in bed, and had forgotten about it till he swallowed the first mouthful of his breakfast next morning. He then felt a sharp, tearing sensation in the back of his throat; then continuous pain deep in right side [of neck, at level of and behind upper border of the cricoid. Laryngeal symptoms were very slight; swallowing produced sharp pain, and for some days slight hæmorrhage. Examination revealed swelling and redness of right side of œsophagus, of right pyriform sinus, and of right side of larynx. No foreign body could be found.

A transverse photograph by X rays showed a pin, but an antero-posterior photo could not at that time be obtained. The level of the pin was indicated by the photo; the patient referred all his painful sensations to the right side of the neck; an exploratory operation was therefore carried out there, but nothing found.

Later on, with better apparatus, both a transverse and an antero-posterior photo were obtained, and the position of the pin accurately determined. It lay in the ventricle of the larynx, the head anteriorly and the point in the fourth intervertebral disc. The thyroid was then cut down on in the middle line, the head of the pin, which was ulcerating its way through the cartilage, was seen and grasped, and the pin removed.

The X rays produced no discomfort at the time, but ten days later pricking and heat were complained of over the back of head and neck, then followed vesication and sloughing of the skin, and falling out of the hair over a large area.

*A. J. Hutchison.*

**Escat.**—*Laryngoscopy in Children.* "Arch. Internat. Lar., Otol., et Rhin.," No. 5, Tome IX.

THE author describes the method of examining, by the classical laryngoscopy, young children who are frightened or rebellious. His special instrument is conceived on the principle of a retractor, and serves, by pulling forward the base of the tongue, to open the pharynx antero-posteriorly.

It consists of a tongue depressor, of which the extremity has a downward bend to adopt it to the outline of the dorsum of the tongue. To the extremity is fixed a two-pronged fork, which is curved in such a manner that the knobbed ends of the prongs can reach the sinus pyriformis on either side of the larynx. When in position the fork does not touch the epiglottis, but closely hugs the root of the tongue. Forward traction is then made, while a mirror—preferably a square one with a rigid shaft—is firmly pressed back against the posterior wall of the pharynx. An assistant to hold the child is, of course, indispensable.

The author has employed the instrument for two years, and with success, in the most rebellious cases.

*Ernest Waggett.*

**Getchell, A.** (Worcester, Mass.).—*A Contribution to the Study of Laryngeal Vertigo.* "Boston Med. and Surg. Journ.," Nov. 5, 1896.

THE notes of two cases of laryngeal vertigo. In the first case, that of a man, aged fifty-four, who complained of intense headache, the vertigo was accompanied by fits of coughing and a tickling sensation in the larynx. Sometimes the paroxysms would be of considerable severity, but they were not accompanied by loss of consciousness or falling. On examination, in the nose was found a deviated septum with exostosis; there was chronic naso-pharyngitis, relaxed uvula, and inflamed tonsils, the left being covered with a greyish exudation. The vocal bands met in the median line in phonation; the left seemed thinner than the right, and was more overlapped by the ventricular fold. There were a few bronchial râles in the chest. He improved under treatment, by astringents to the naso-pharynx.

In the second case, a male, aged twenty-nine, the duration of the cough was six weeks. It was very violent at times, and once he lost consciousness, and fell. There was a tickling sensation in the throat, just below the larynx. On examination, in the nose there was a prominent exostosis, with inflammation of the mucous membrane. There was also chronic naso-pharyngitis, enlarged tonsils, enlarged lymph follicles at the base of the tongue, and hyperæmia of the larynx.

*St George Reid.*

**Heymann.**—*A Contribution to the Study of Toxic Paralysis of the Larynx.* "Arch. Internat. de Lar., Otol., et Rhin.," No. 6, IX., 1896.

THIS extensive *résumé* of the literature of laryngeal paralysis due to poison, containing references to over fifty papers, will be of great value to students of the subject. Lead poisoning is responsible for the majority of the cases, and the author adds three to the number already published. Contrary to the opinion expressed by Mackenzie (whose reported case contrasts with the rest in this respect), the author shows that it is the abductor muscles which are mainly affected. In his own cases these alone were paralyzed. Poisoning by copper, antimony, phosphorus, and arsenic has been responsible for a small number; and the author has met with three instances of arsenic paralysis which, after temporary disappearance, recurred on re-exposure to the influence of the poison. Laryngeal palsy has also been attributed to various organic poisons—such as, cannabis indica, atropine, morphia, alcohol, etc.

*Ernest Waggett.*

**Hillis, T. J.**—*The Technics of Intubation in Children; some Remarks on the Time for Operation and After-Treatment.* "New York Med. Journ.," Dec. 5, 1896.

THE author recommends wrapping the child in strong muslin, as it affords more room than the blanket. In introducing the tube the horizontal position often economizes room whilst passing it through the mouth. Also in children under one year old the tube can be expressed from without. One should err on the side of keeping the tube in rather too long than the reverse. In after-feeding the best position is lying on the stomach, and the next best lying on the back with the head lower than the body.

*R. Lake.*

**Jousset.**—*Cystic Tumour of the Epiglottis.* "Nord Médical," Oct. 1, 1896.

DETAILS of a case of cyst in the glosso-epiglottic fold in a patient sixty-nine years of age. The tumour was as large as a small nut, and compressed the epiglottis; it caused hoarseness, dyspnoea. After incision, a discharge of yellow, gummy fluid followed, formed of fatty detritus. Rapid cure.

*A. Cartax.*

**Masini, Prof. G.**—*Hypoesthesia of the Larynx.* “*Bollet. delle Mal. dell’ Orecchio, etc.*,” June, 1896.

THIS term was first applied by Elsberg to a condition of diminished functional sensibility of the larynx, independent of any impairment of the peripheral nerves, or symptomatic manifestations of disease of other organs. It is a neurosis so rarely met with and observed that few of the modern writers, such as Mackenzie, Gottstein, and Schmidt, ever allude to it. Experimental studies of the state of sensibility of the larynx in various individuals and in its various parts have still to be made, which may serve as an index in judging of physiological and pathological variations.

Past observations, however, suffice to distinguish, to a certain degree, between the two extremes. Elsberg, in his experimental researches, devised a sort of estesiometer, based on Weber’s principle. With this he conducted a series of observations with a view of establishing—1st, the normal and pathological tactile sensibility; 2nd, the sensibility to pain; and, 3rd, the reflex sensibility.

A case of hypoesthesia observed in the Polyclinic of Genoa afforded Masini a good opportunity to continue these researches. He modified Elsberg’s estesiometer, basing his observations, however, on the same general divisions. His conclusions were as follows: greatest tactile sensibility in the inter-arytenoid portions, especially of the mucous membrane investing the cartilages of Santorini, whilst the vocal cords, both in their anterior and posterior sections, showed a marked reduction of sensibility. This was even lower in the epiglottis, whilst the sensibility of the ary-epiglottic ligaments seems to be midway between that of the vestibular and arytenoid portions of the larynx. Accepting the tactile sensibility of the mucous covering of the Santorini cartilages as standard and expressed in fractions, the relation would be as follows: Santorini cartilages, ten-tenths; vestibule of the larynx, eight-tenths; vocal cords and ary-epiglottic ligaments, five-tenths; epiglottis, one-tenth. Attempts to establish the degree of caloric sensibility were rather unsatisfactory, but the inter-arytenoid area appeared most sensitive to such influences. As regards sensibility to pain, results were quite similar, the inter-arytenoid and vestibular sections of the larynx being sensitive in comparison with ary-epiglottic ligaments, vocal cords, and epiglottis. The reflex sensibility which is principally involved in hypoesthesia presented varying phenomena, according to the part of the larynx examined. The vestibular and inter-arytenoid portions were most sensitive, even to the slightest irritation, whilst the vocal cords and the epiglottis presented the contrary state. Excluding their posterior attachments, reflex sensibility is quite reduced in the vocal cords, very much accentuated, however, in the subglottic region. The various functions of these structural parts will readily account for the differences in sensibility. The relations existing in the normal state are frequently altered, even inverted, in pathological conditions. The author demonstrates this in a clinical case of aggravated hypoesthesia, in which there existed great reduction of sensibility of the inter-arytenoid, the vestibular, and the subglottic parts of the larynx. That of the epiglottis was markedly heightened, as if to replace, compensatorily, the lack in the first mentioned areas. The main symptoms she complained of were those arising from disturbances of deglutition, and the entrance of food or liquid into the respiratory tract. Electric treatment, the application of the constant current, massage, and hydro-therapy seem to have been followed by some improvement. The author then calls attention to the etiology occurring both in hysteria and due to grave infections, as in cholera, diphtheria, typhus, small-pox, and erysipelas, and attempts to draw the lines of distinction between these and the subject in discussion. From a physiological standpoint the case presented is of some interest. The fact of

anæsthesia without any motor disturbances of the laryngeal muscles does not confirm Exner's experiments on animals, nor corroborate Ziemssen's clinical experiences. The author attributes this variation, however, to differentiations in the etiology of hypoesthesia. *Jefferson Bettman.*

**Moncorgé** (Mont-Doré).—*On Three Cases of Laryngeal Ictus.* "Arch. Internat. Laryng., Otol., Rhin.," July-Aug., 1896.

**CASE I.** A man of forty-six, with nervous and catarrhal family history, but none of epilepsy. The patient highly neuropathic and impressionable, with a history of rheumatism, but none of syphilis, alcoholism, or malaria. Winter cough for some years. During the last two years, after influenza, subject to severe coughing fits. While taking a walk the patient became aware of a tickling sensation in the throat; this was followed by a very gentle cough, and consciousness was lost and a fall to the ground resulted. Consciousness was immediately regained, and the patient asked what had happened. It appears that during the previous eighteen months, on four or five occasions, a similar tickling and gentle cough had been followed by vertigo and sense of pressure at the temples, but not by loss of consciousness. Violent fits of cough had caused no vertigo. On examination, though carefully looked for, no signs of tabes were present, except absence of knee jerks. There was some albuminuria, and the arterial tension was slightly in excess. Upper air passages healthy. For a few days after the attack described the tickling and cough were followed by slight vertigo.

**Case II.** A man of sixty, subject to winter cough from youth. Albuminuria, arterial hyper-tension, cardiac hypertrophy, emphysema, chronic pharyngo-laryngitis. On four occasions, the first at the age of fifteen, a tickling of the throat, accompanied by attacks of excessive coughing, was followed by loss of consciousness, without convulsions. After prolonged attacks of cough vertigo was frequently experienced.

**Case III.** An attack witnessed by the author in a lady of forty-five, subject to sneezing, winter cough, and asthmatic attacks for two years. While under treatment with morphia injections for an attack of paroxysmal asthma, the author was able to observe the patient go into a series of short attacks of jerky cough, which appeared to leave her asphyxiated. The face became purple with congestion, but a pallor suddenly supervened, and consciousness was lost for thirty seconds, during which time the lips and fingers of the left hand moved convulsively. Careful examination revealed no disease of the kidneys, heart, or upper air passages.

The author proceeds to point out the essential differences in the pathogeny of these three cases. No classification can, however, be based on the pathogeny, which is as yet wholly obscure, the sole constant phenomenon being a reflex in which the superior laryngeal nerve is concerned. Classification by symptomatology, based on a congestive syncopal, convulsive, etc., character of the attacks, entirely fails to satisfy. Etiology alone presents some basis for classification. In the same manner that asthma may be divided into true nervous asthma and the pseudo-asthmas dependent on Bright's disease, cardiac disease, etc., etc. (and he draws attention to the paradox that some pseudo- or symptomatic asthmas more closely resemble the typical nerve asthma than do some of the unusual forms of the latter), the author proposes the following classification of ictus:—

I. Essential laryngeal ictus (type, Charcot).

II. Pseudo-laryngeal ictus—

In nerve disease.	{	Neuropathy Hysteria Tabes Epilepsy	}	with laryngeal spasm.
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Disease of the air passages.	{ Nasal Laryngeal Broncho-pulmonary	{ (Polypi, etc.) (Inflammatory and organic.) Emphysema, whooping cough, asthma, bronchitis.
Digestive passages.	} Bucco-pharyngeal.	
General dyscrasic diseases		{ Albuminuria Diabetes

*Ernest Waggett.*

**Riehl** (Leipzig).—*Lymphendothelioma Cutis Multiplex*. “Wiener Klin. Woch.,” 1896, No. 46.

IN a seventy-five-year-old patient affected with this disease, tumours were also observed on the velum, uvula, tonsils, and in the larynx. At the *post-mortem* examination tumours were found on the anterior surface of the posterior laryngeal wall between the cartilages. Two other tumours were embedded in the substance of the vocal bands. A round, hard tumour of the size of a bean was found in the left pharyngeal wall. An exhaustive description of the microscopical examination of the tumours shows that it is a lymphendothelioma of the skin and mucous membrane.

*Michael.*

**Scheier**.—*Photography of the Cavities of the Nasal Fosse and of the Larynx by means of Röntgen Rays*. “Arch. Internat. Lar., Otol., et Rhin.,” No. 6, IX.

THE author demonstrates the practicability of obtaining photographs, by means of the X rays, of all the accessory cavities of the nose, including the sphenoidal sinus. Foreign bodies in the nose can be detected by this method; and two cases of gunshot injury are here related, in which the bullets were located by means of photographs taken in two or more positions. Three excellent photographs of the larynx (from the cadaver) accompany the paper, and show, not only a pathological condition of the organ and a foreign body, but also the presence of abscess in a mass of cervical glands.

*Ernest Waggett.*

**Sendziak, J.** (Warsaw).—*An Unusual Case of Thrush of the Mouth, Naso-Pharynx, and Larynx*. “Archiv für Laryng. und Rhinol.,” Band 4, Heft 3.

A GIRL, aged fifteen, complained of difficulty in swallowing, nasal speech, and occasional regurgitation of fluids through the nose. These symptoms had been present for two weeks. A month before, the patient had had a severe attack of diphtheria, which had left her very weak. On examination the author found considerable redness and swelling of the mucous membrane covering the entire soft palate, faucial pillars, and uvula. A number of white spots, varying in size from a pin's head to half a centimètre in diameter, were seen scattered over the surface. The larger patches were evidently due to the coalescence of two or more spots. These were especially abundant on the faucial tonsils, where they formed almost entire membranes, similar to those of diphtheria. The posterior pharyngeal wall was but slightly affected. The roof and lateral wall of the naso-pharynx also presented here and there small isolated white spots; the mucous membrane of this region was red and swollen. The posterior ends of the middle and inferior turbinates and the edge of the vomer were similarly affected. Spots, or rather membranes, were observed on the lingual tonsil, also on the anterior surface of the epiglottis, the ary-epiglottic folds, the posterior wall, and the pyriform sinuses; the underlying mucous membrane was red and swollen. The cervical glands on both sides were somewhat enlarged, but not painful. The appetite was poor.

The appearances suggested a mycosis. The patches could be easily and almost

bloodlessly removed, leaving the mucous membrane red and slightly irregular. On microscopic examination the deposits presented numerous epithelial cells and masses of fungus, which proved to be made up of branched cylindrical filaments, consisting of elongated superposed cells, with granules. The sporangia and individual spores were also visible. In short, the appearances were typical of the *odidium albicans*.

Arsenic was given internally, and gargles of menthol. The general condition began to improve. The regurgitation through the nose and the pain on swallowing ceased. The number of deposits and the redness and swelling of the mucous membrane diminished. After two weeks there were traces of the disease only on the faucial and lingual tonsils, and at the end of two months these had completely disappeared.

The author refers to a few somewhat similar cases that have been recorded.

*A. B. Kelly.*

**Shield, A. M.**—*A Case of Fractured Larynx. Tracheotomy; Thyrotomy; Recovery.* "Lancet," Nov. 14, 1896.

FRacture of the larynx is a rare accident and a dangerous one. Durham, in his well-known article in "Holmes's System of Surgery," collected sixty-nine cases, and no less than fifty-three ended fatally. In this case a woman, aged twenty-three, while walking in her sleep, stumbled and fell, striking her throat against the top rail of a chair. On admission to the hospital there was considerable dyspnoea, but very slight cyanosis. There was great swelling of the neck about the region of the thyroid gland, and, on examination, distinct surgical emphysema could be detected. No crepitus could be made out, owing, no doubt, to the swelling about the parts. The patient could only speak in a hoarse whisper; but any attempt at speaking aggravated the dyspnoea and brought on a copious expectoration of blood and mucus.

The night after admission to the hospital, in consequence of an attack of sudden dyspnoea, tracheotomy was performed. Nineteen days afterwards she left the hospital, apparently perfectly well; but three days later she was brought back, suffering from urgent dyspnoea, cyanosed, and evidently in a worse condition than she was in on her first admission. Tracheotomy was required at once. The patient was relieved; and laryngoscopic examination showed stenosis of the larynx and subglottic obstruction. Laryngo-fissure was, therefore, performed; and a tough cicatricial web was found, stretching across the larynx, below the level of the vocal cords. This tough cicatricial mass in the larynx was very peculiar; and the explanation of its formation could only be that the mucous membrane below the vocal cords was extensively rent, and the plastic exudation and subsequent cicatrization excessive. The tissue was so tough that no efforts at intubation or stretching from above could have been of any permanent avail. No displaced cartilage could be felt, and the exact site of the fracture remains uncertain, except that it was below the vocal cords.

A patient suffering from fracture of these parts is in momentary danger of suffocation from displacement of the fragments or from œdematous swelling; and it is probably wiser to perform tracheotomy in such cases whenever dyspnoea becomes urgent.

*StClair Thomson.*