ABSTRACTS

EAR.

Further Observations on the Blood-Clot Dressing in Mastoidectomy. Dr G. E. DAVIS. (*Laryngoscope*, Vol. xxxiii., No. 6, p. 442.)

It is absolutely impossible to remove mechanically every particle of infection from bone, but in spite of this an ideal result is possible in a large percentage of cases. In mild cases or those that have gone on for three weeks, or longer, after the simple mastoid operation, the raw surface is treated with 3 per cent. iodine and the wound is wiped dry with gauze. No watery solutions are used. The blood is allowed to flow in and the wound closed completely, with a loop of twisted silk between stitches for drainage for one day only. In fulminating cases or those of short duration the wound is treated with iodine but is packed with iodoform gauze and the wound closed up, except for a narrow opening at the lower end of the incision. In twenty-four hours the gauze is withdrawn when the resulting bleeding fills the cavity. The small opening may be closed with adhesive plaster. To prevent infection of the clot from the middle ear cavity a free incision is made in the drumhead and the tympanic cavity flushed from the aditus with 3 per cent. iodine and warm alcohol. Following the above technique the blood-clot method is not contra-indicated even in cases of extradural abscess. Eighty-five per cent. heal by first intention in five to ten days. There is a great saving in time and suffering for the patient. ANDREW CAMPBELL.

The Present Position of the Surgery of the Labyrinth. Sir WM. MILLIGAN, M.D. (*Practitioner*, May 1924.)

The various routes of infection of the labyrinth are mentioned. Unsuspected erosions found in the course of a radical mastoid operation should be disinfected and left severely alone, lest the erosion be made into a fistula with the possible setting up of a circumscribed or diffuse labyrinthitis. In circumscribed labyrinthitis again, it is best in the first instance to trust to the removal of the septic focus causing it. If the symptoms do not subside or if they actually increase then the infected canal or canals should be opened, disinfected, and drained, care being taken not to interfere with the cochlear segment, because in such circumstances a very useful amount of hearing may be retained. In diffuse labyrinthitis even,

for the same reason, as much of the cochlea as possible should be left, but efficient drainage must be secured.

In the pseudo-Ménière type of case the author has operated twenty times with no post-operative meningitis and no fatalities. With careful operating there is not much danger to the facial nerve. He finds the tinnitus less easily cured than the vertigo.

T. RITCHIE RODGER.

Contributions to the Indications for Operation on the Labyrinth. OTTO BOSERUP, National Hospital, and the Hospital of St Joseph. (*Annales des Maladies de l'Oreille, etc.*, Jan. 1924.)

The statistics quoted are from the above hospitals for twelve years up to 1922, and include 153 cases. The cases are divided into four groups:—

1. Serous labyrinthitis, with the static and acoustic functions diminished.
2. Circumscribed labyrinthitis, with or without a fistula, with the static function suppressed and the acoustic function conserved. or *vice versâ*.
3. Chronic diffuse destructive labyrinthitis, where, in the course of an otitis media, the labyrinthine functions have been entirely suppressed.
4. Acute diffuse destructive labyrinthitis, where an otitis media has set up a rapid destruction of the labyrinth.

To show the frequency of meningitis in the respective groups, the following figures are furnished:—

Group.	Meningitis supervened.	Meningitis did not supervene.
1	1	49
2	1	57
3	4	22
4	16	3

Treatment.—In the first two groups, the great majority of the cases were treated conservatively (presumably the mastoid operation. G. Y.), with good results. In group 3, choice of operation was more difficult, radical operation seeming to be indicated by the presence so near to the meninges, of an infective focus. In four cases of this group, only the mastoid operation was carried out at first, with the result that the labyrinth had to be opened later, on account of symptoms of meningitis; three of these cases died, and the fourth recovered. Altogether nine of group 3 were treated conservatively and five left hospital without recurrence; but as their further history is

unknown to the writer, they cannot be quoted for or against either operation. The other thirteen of this group were treated radically; twelve left hospital cured. The thirteenth showed signs of meningitis a month later, and a lesion involving the internal carotid caused death. Operation on the labyrinth seems indicated for group 3.

In group 4, the tendency to develop meningitis is most marked, and there is no doubt as to the best treatment to employ here. Symptoms must be watched carefully so that operation may be undertaken at the most favourable moment. Two cases in group 4 were not operated upon. One was a hæmophiliac, the other recovered without operation. Seven patients arrived with meningitis declared. All underwent the labyrinth operation. Six died. One patient suffered from chronic nephritis and died without suffering from meningitis, though autopsy revealed a cerebellar abscess. Another patient developed meningitis twelve days after operation and died. Eight patients were operated upon on the incidence of signs of meningitis. Six died; two were cured. GAVIN YOUNG.

PHARYNX.

A Symptom of Chronic Tonsillitis. WALTHER BLUMENTHAL. (*Münch. Med. Wochenschrift*, Nr. 11, Jahr. 71.)

The writer draws attention to the constancy with which those lymph glands which lie below and behind the submaxillary gland are found to be enlarged and tender in cases of chronic tonsillitis. In doubtful cases of this affection in which carious teeth, inflammatory conditions of the mandible, and systemic glandular diseases can be excluded, the presence of palpable tender glands in the above region may be considered of decisive importance in estimating the condition of the faucial tonsils. This applies even though the so-called "tonsil" lymph glands may not be palpably diseased. In making the examination it is necessary to keep the patient's head bent well forward and to palpate the medial surface of the mandible.

JAMES B. HORGAN.

The Rapid Control of Diphtheria Outbreaks in Institutions. Messrs C. C. OKELL, A. J. EAGLETON, and R. A. O'BRIEN. (*Lancet*, 1924, Vol. i., p. 800.)

The writers state that testing by the Schick method and active immunisation are of little value in dealing with an active epidemic. They recommend the following procedure in an outbreak of diphtheria: (1) Schick test all patients. (2) If possible swab all

patients, throat and nose. (3) Next day, isolate in one ward all "Schick negative" patients. (4) For a few days, see twice daily all "Schick positive" reactors. (5) Test for virulence all positive swabs from "Schick negative" reactors; release "avirulent," but rigidly isolate all "virulent carriers." (6) Commence at once to inject toxin-antitoxin mixtures into all "Schick positive reactors." The plan depends upon the truth of certain "propositions" as to the Schick test, and the advocates are fully aware that it may be contested; they ask that it may be given a thorough trial. MACLEOD YEARSLEY.

A New Method of Hypopharyngoscopy. BRÜGGEMANN. (*Zeitschrift f. Hals-, Nasen-, Ohrenheilk.*, February 1923.)

The method consists in transfixing with a stout needle and silk thread the anterior layers of the cricothyroid ligament after local injection of novocain. The thread is grasped by an artery forceps and held crosswise so that it forms a convenient handle. The throat is examined in the ordinary way with a laryngeal mirror and when traction is made on the silk the whole hypopharynx is thoroughly opened up to view. The advantages claimed for this method are its simplicity, and that no costly instruments are required and no cocainising of the throat is necessary. The patient can even apply the necessary traction himself. Introduction of an œsophagoscope is rendered more easy. It is necessary to be sure of having transfixed the ligament and not merely the skin or the traction will not take effect. The mucous membrane at this level is some distance from the ligament itself, and even if the subglottic space is punctured no ill effects will result. J. K. MILNE DICKIE.

Right-sided Pharyngeal Diverticulum. J. B. HORGAN, M.B., Ch.B., D.L.O. (*Brit. Med. Journ.*, 15th March 1924.)

The case is reported as unusual in respect of the early age of incidence and its position on the right side. The pouch was on the right wall of the œsophagus at a level corresponding with the crest of the first rib and was about the size of a marble. Small mouthfuls of semi-liquid food passed easily as seen under X-ray examination, but a larger mouthful caused the pouch to fill. Before operation a Hill's feeding tube was passed beyond the pouch through the œsophagoscope, the upper end being brought forward through the nose, and the patient who was extremely emaciated was fed in this way for several days preparatory to operation. The diverticulum was exposed by an incision on the right side, from the great cornu of the hyoid bone to the sterno-clavicular articulation. The inferior thyroid artery was ligatured and divided and the recurrent laryngeal nerve was seen and isolated. The base of the sac was clamped and the sac removed, the

opening into the pharynx being closed by three superimposed layers of chromic gut sutures. There was a slight rise of temperature after the operation, and some surgical emphysema for some days, but a good result was obtained. T. RITCHIE RODGER.

LARYNX.

The Mechanism of the Larynx. V. E. NEGUS. (*Lancet*, 1924, Vol. i., p. 987.)

The author in his important Arris and Gale Lecture, delivered at the College of Surgeons in April on the Evolution of the Larynx, has brought forward fresh facts which require consideration; indeed he introduces fresh problems. We know that the larynx came into existence not for the production of sound but as a sphincter at the entrance to the lungs. Larynges are possessed by animals which make no use of them for the production of any range of tones; the reason why they do not, while man does, lies in the nervous connections and the mentality rather than in the instrument. That is to say, the larynx, originally meant for another purpose, has been adopted by the higher senses for an additional function, which has overshadowed in our conception of its uses its original and still highly important one. This is supported by a study of its comparative anatomy from the sphincter of the lung-fishes to man, which shows its primitive simplicity. The supra-glottic part of the larynx (a modified part of the floor of the pharynx) is a secondary and later formation and was, according to Mr Negus, evolved in connection with increasing efficiency in olfaction and deglutition after mastication. It is impossible to do justice to the lecture in an abstract; it should be studied *in extenso*. MACLEOD YEARSLEY.

Multiple Papillomata of the Larynx. H. BALDWIN GILL. (*Medical Journal of Australia*, 24th November 1923.)

The patient, a girl aged 6 years, had a history of eight weeks partial aphonia and increasing dyspnœa. Under rectal anæsthesia an attempt was made to examine, by means of Brünings' tube. The breathing became so hampered that tracheotomy had to be performed. A large papilloma was seen in the subglottic space. Thyrotomy was performed. The growths, which were largely attached to the depths of the sacculi, and the margins of the vocal cords, were removed, and the points of attachment very lightly touched with the galvanocautery; the larynx was sutured; the tracheotomy tube removed two days later. The child has recovered a hoarse whisper. The case is too recent to judge of the final result. A. J. BRADY.

Abstracts

Contribution to the Development of Malignant Tumours of the Larynx. DR MED. BIRKHOLZ. (*Archiv für Ohren-, Nasen-, und Kehlkopfheilkunde*, Band iii., Heft 2, December 1923.)

Birkholz discusses modern cancer theories in the light of a case of carcinoma of the larynx. A man, aged 43, after having aspirated some benzine developed chronic laryngitis; four years later carcinoma supervened and terminated fatally. Among interesting features of the case were that the krysolgan test for tuberculosis was negative, injection of neo-salvarsan produced a local reaction so severe as to necessitate tracheotomy, and the vaccine "antimeristem" prepared from "Mucor Racemosus" was employed in the terminal stages. Birkholz concludes that it may ultimately be possible to mobilise by means of non-specific agents the normal protective forces of the body. WM. OLIVER LODGE.

Radium in Cancer of the Larynx. Dr W. M. NEWCOURT. (*The Surgical Clinics of North America*, February 1924.)

The three different methods of application are noted:—

1. "Cross fire of the neck."
2. Application of radium capsule to interior of larynx.
3. Embedding active capsule or emanations directly into the growth.

The writer points out the disadvantages of 2 and 3, and claims that he has had equally good results, without any disagreeable features, by the first method. Also it irradiates the disease from the base outward, *i.e.*, reaching the more active portion.

The only difficulty in the "cross fire" method is to get effect on the growth without producing a too active dermatitis.

This is achieved by moving the small capsule (*e.g.* 50 mg. screened by 1 mm. lead 1 cm. wood) from position to position on the side of the neck. A case is quoted wherein the first treatment consisted of eleven different positions of two hours' duration each, thus giving twenty-two hours. There is no discomfort on the part of the patient beyond a slight dryness of the throat coming on a few days after treatment and lasting a week. This degree of reaction is desirable, and is found to be produced by 1200-2400 millicurie hours at one application over a number of areas well screened. Treatment may be repeated in six weeks as indicated. J. B. CAVENAGH.