

contraction. *We also do the same operation and try to get the same results, but the fact remains that we do get deformities in many instances. Someone in New York reported 100 dissections with 80 per cent. of deformities of the palate. We do not all do the beautiful operations which some do, and unless we are very careful we will get these unfortunate results. That is why I have suggested the technique detailed in this paper.

Abstracts.

PHARYNX.

Gile, Ben C.—The Indictment of the Tonsil.—"Annals of Otology," etc., xxiv, p. 747.

An interesting paper showing how the tonsil may be the *fons et origo* of acute nephritis, rheumatism, arthritis, goitre, tuberculosis, deafness, and various neuroses, such as œsophageal spasm, recurrent cough, spasm of the glottis, lingual neuralgia, and blepharospasm. That chorea and epidemic cerebro-spinal meningitis may also be traced to a tonsillar focus of infection is not mentioned, but, as the author remarks, the charges in the indictment might be multiplied. *Macleod Yearsley.*

Certel, T. E.—Eye Adenoids and their Relation to Throat Adenoids. The Author's Modification of the Adenotonsillectomy Operation. "Annals of Otology," etc., xxiv, p. 763.

The author concludes that: (1) Eye adenoids (follicular conjunctivitis) indicate the existence of throat adenoids. (2) Hasty and rough surgery in the throat is productive of irreparable damage. (3) Adenectomy should be performed, as far as possible, under direct observation. (4) The roller forceps for diffuse pharyngeal adenoids is of value, because it removes them with a minimum amount of damage to the mucous membrane. (5) The silver clip is the best general method of controlling tonsillar bleeding. *Macleod Yearsley.*

Burns, L. J.—The Use of Quinine and Urea Hydrochloride as a Local Anæsthetic in One Hundred and Forty-eight Cases of Tonsillectomy. "Annals of Otology," etc., xxiv, p. 841.

The author considers that the value of this mixture as an anæsthetic is established for the following reasons: (1) Rapidity of action. (2) Absolute non-toxicity in even as strong solutions as 10 per cent. (3) Always producing sufficient anæsthesia to complete operation without the necessity of stopping to make further application or injection. (4) Marked diminution of after-pain and discomfort. (5) Superior advantages over cocaine and its derivatives, due to its nonsystemic action. (6) Absolute absence of troublesome primary or secondary hæmorrhage; this being one of the frequent and dangerous drawbacks of tonsillectomy under local anæsthetic. (7) Readiness with which the solution may be sterilised, frequently repeated high temperature producing no chemical or physiological change. *Macleod Yearsley.*

NOSE.

Roy, J. N.—*Ozæna and the Different Races of the World*. “*Annales des Mal. de l’Orière, du Larynx, du Nez, et du Pharynx*,” vol. xl, no. 8.

In this article the author relates his experiences on the bearing which enology has to *ozæna*. During the past ten years he has, through a series of tours, been brought into contact with the principal races of the globe. He divides the races concerned into three groups—white, black, and yellow. The Malays and Redskins are really descendants of Mongols; the pigment of their skin, form of eyelids, development of malar bones, flattening of the base of the nose, and thick hair all support this view. Moreover some Indian tribes of South America have linguistic expressions much resembling portions of the Japanese language, and there are ruins in Mexico with inscriptions, which are vestiges of Buddhist temples. With regard to the white race, the author only relates what he has observed when it has been blended with one of the other two. During a voyage around the Dark Continent, about 5000 Negroes in twenty-five different colonies were examined. In several parts the author penetrated the interior at a great distance from the coast, and was enabled to scrutinise 100 tribes. After careful research amongst the natives of Africa no *ozæna* was discovered. Especial care was devoted to the examination in mixed races, *e. g.* Mulattos, the Mauri of Mauretania, Berbers of Arabic origin, Peulhs, Foulahs, descendants of the Fellahs of Egypt, Hottentots, Bushmen with Mongol blood, Danakils, Somalis and Gallas with Arab intermixture, and lastly, the Abyssinians who have come into contact with the Egyptians at periods of their history. Atrophic rhinitis was absent in all these races.

Negroes examined in Oceania and the Antilles Archipelago were also exempt. In Brazil, where the black element makes up three-quarters of the population, in Central America and the United States, cases were found both in subjects of pure race as well as Mulattos and Zambis (the result of the intermixture of negro and redskin). Dr. Chardwick, Rio Janiero, and Dr. Jones, Newport News, Virginia, colleagues of the author, have treated blacks affected with *ozæna*, and in their experience the disease is less frequent in Negroes and Mulattos than in the white and yellow races; in this the author concurs. The mucosa of the Negro is exceedingly resistant to infection. Races of yellow Asiatic blood are especially predisposed to atrophic rhinitis: the author observed it not only in Chinese and Japanese, but also in Indo-Chinese with Mongolian intermixture, in Esquimaux, Laps, Finlanders, Malays, Philipinos, Hovas, and Redskins. The author believes with Bosworth that *ozæna* is not preceded by hypertrophic rhinitis. He has made researches amongst the Chinese, both in their own country and living in a cold climate like Canada in winter, and has found that climatic conditions do not influence the frequency of the affection. Mongols in general have a great tendency to atrophic rhinitis of the anterior third of the inferior turbinated body, but unattended by symptoms; this is especially marked if they inhabit a warm country, and in a cold climate hypertrophic rhinitis is occasionally met with. American Indians are very prone to this form of atrophy. In any case the increased size of the inferior turbinated body does not appear to influence *ozæna*, the frequency of which varies directly with the contamination of the environment. Moreover African Negroes frequently suffer from hypertrophic rhinitis if

subjected to a cold and moist climate, and in them atrophic rhinitis does not exist. The author was struck with the number of septal deflections in the yellow race, especially amongst the Indians, 40 per cent. of whom were affected. The mixed breeds are also more prone to this malformation than the whites. In Mongols compensatory hypertrophic rhinitis was scarcely ever present in the larger nasal fossa, but rather the presence of muco-purulent matter and crusts without fœtor were noticed. In this race true ozæna is not accompanied by the fœtor met with in whites and negroes, and this the author ascribes to physiological increase of the nasal secretions common to this type of man, which lessens the tendency to inspissation of discharges and acts in a salutary way against bacteria and other toxins. Deflection of the septum in Mongols, associated with the formation of non-ozænatous discharge in a large fossa, is an argument against Zaufal's theory, which ascribes the ozæna to undue patency of of the nasal fossæ; besides, negroes of Africa, who possess extremely roomy fossæ, do not suffer from the disease. As to the theories of Siebenmann, Zarniko, Cholewa, and Grünwald the author does not insist on any dissent; he contents himself by again repeating that there is no atrophic rhinitis amongst the natives of the Dark Continent. The infectious theory of ozæna seems to the author to alone meet all exigencies. He believes the specific agent to be the cocco-bacillus of Perez (Buenos Aires). This bacillus introduced into the veins of an animal induces atrophic rhinitis with the characteristic fœtor. Other microbes in the nasal discharges only play a secondary rôle. After having examined a multitude of Indians in both Americas, belonging to twenty-seven separate tribes, the author found that the frequency of the disease varied with the surroundings. Rare on the higher plateaux, where the natives live sparsely in the open air, it was, on the contrary, much more common in the villages, where they live huddled together and breathe a contaminated atmosphere. In the latter 6 per cent. were affected, and the women leading an indoor life were more often affected than the men. The same facts were observed in Malaysia, China, and Japan. The redskins and mixed breeds are equally prone to ozæna; nevertheless the yellow race seems more predisposed to this disease than the white. The reason, the author thinks, is due, not only to uncleanness of certain branches of Mongols, but also to the asymmetry of their nasal fossæ—conditions which favour the production of a suitable soil for the culture of Perez' bacillus. The author arrives at the following conclusions: That ozæna is an infectious disease which is met with in all races. Nevertheless the incidence of affection is less in the case of the blacks than the whites, and falls with greatest frequency on the yellow races. The very large number of septal deviations in the latter, coupled with an almost constant state of uncleanness and nasal irritation, prepare these mucous membranes for microbic growth.

H. Clayton Fox.

ŒSOPHAGUS.

Lyon, B. B. V. (Philadelphia).—A Consideration of Cardiospasm, with Report of a Case. "Amer. Journ. Med. Sci.," March, 1916.

The commonest causes of cardiospasm are, in the first place, a functional condition constituting a local neurosis or a local manifestation of a general neurosis, the so-called primary cardiospasm, and, in the second place, primary œsophagitis. When cardiospasm and œsophagitis

are both present, it may be very difficult to decide which is primary and which secondary. Among other causes are congenital disposition, primary atony, and kinking at the hiatus œsophagi.

The first symptom is usually a sensation of dull aching pain behind the lower end of the sternum. As compensatory hypertrophy of the musculature of the lower portion of the œsophagus develops, in order to overcome the increasing obstruction, a second symptom appears, namely, regurgitation of food shortly after ingestion. Later, when the muscles yield to the strain, dilatation occurs, and the almost constant presence of decomposing food gives rise to secondary œsophagitis. A continual sense of burning pressure behind the sternum is complained of, and only small quantities of food can be taken at a time, so that there is a rapid loss of weight, and the patient may develop profound cachexia, and finally die of starvation.

The diagnosis is made by means of the X rays, the passage of bougies of the Plummer type in which the olive tip is threaded over a swallowed string, and by means of œsophageal lavage, the degree of dilatation being estimated from the amount of the injected fluid which can be recovered from the œsophagus. Lavage also gives important information as to the presence of œsophagitis, and the author describes in detail, with microphotographs, the œsophageal sediments obtained by the method already described by him in the September number of the same Journal.

In the treatment of the earlier cases, antispasmodics such as belladonna and atropin pushed to the limit of tolerance, together with general hygienic measures, may suffice. If they do not, dilatation by means of the instruments suggested by Plummer or Bassler may be required. Œsophagitis, when present, must be treated by lavage with germicidal solutions, such as potassium permanganate, silver nitrate, argyrol, etc., until the bacteria have disappeared from the inflammatory desquamation, when normal saline solution may be substituted. Autogenous vaccines also facilitate recovery. The intra-œsophageal use of the sinusoidal or faradic current may be required to overcome atony and dilatation. In very late cases, with extreme starvation, it is best to do a gastrostomy before proceeding to other treatment.

In advanced cases, particularly those with much œsophagitis, the treatment may need to extend over long periods; but, if properly dealt with, the patients eventually make good recoveries.

A full account is given of a severe case which was studied and successfully treated by the author.

Thomas Guthrie.

E.A.R.

Perkins, Chas. L.—The Chorda Tympani Nerve in Otolology. "The Laryngoscope," 1915, p. 341.

Perkins has collected the following cases: (1) During a radical mastoid operation there were repeated facial contractions due to irritation transmitted through the chorda. (2) Fraction on chorda at operation caused facial paralysis. (3) Facial paralysis just after operation—Was this due to division of nerve at tip or some lesion higher up? Perkins holds that the chorda is really an external branch of the facial. To test the sense of taste he uses (a) syrup (sweet), (b) 25 per cent. solution of tartaric acid (acid), (c) 25 per cent. solution of common salt (saline), and (d) saturated solution of quinine sulphate (bitter). The solutions are

applied with a cotton applicator. The patient is supplied with a chart showing the words sweet, sour, salty, bitter, and is directed to point to the sensation experienced. He must not speak, as this spreads the solution over other parts than the anterior two-thirds of the tongue. Between each test the mouth is washed out and the taste allowed to pass away. Children under ten years cannot be accurately tested.

Cases after the radical operation show complete loss of taste in the chorda area on the operated side, and in about one-third of the cases there was loss of taste on the posterior third of the tongue, soft palate, or fauces. This is supposed to be due to involvement of the tympanic plexus. In chronic suppurative otitis media, ageusia from involvement of the chorda is present in more than 50 per cent. In acute cases before paracentesis Perkins found perversion or loss of taste in 20 per cent. of cases. After myringotomy the cases showed no change. Perkins believes that the chorda is not severed during paracentesis.

In cases of nuclear facial paralysis taste is not affected, and there is no paresis of the scalp and forehead muscles, because the nerve supply to the latter is from the nucleus of the third. If the lesion is in the Fallopiian canal, there is ageusia, even if the nerve be involved at the stylomastoid foramen. Pathological conditions peripheral to the above foramen give absence of ageusia. This group includes cases of so-called Bell's palsy, due to draughts, rheumatism, etc. All agree that the taste path for the anterior two-thirds of the tongue is through the chorda tympani and facial to the geniculate ganglion, but opinions differ as to its path from this point to the central connection. The most direct path from the geniculate ganglion would be by way of the pars intermedia of Wrisberg to the glosso-pharyngeal nucleus. Against this view are the following: (1) Facial paralysis from basal lesions without ageusia. (2) Lesions affecting the fifth nerve at or near the Gasserian ganglion are accompanied by chordal ageusia. (3 and 4) Experimental work on dogs and operative removal of Gasserian ganglion. (5) A patient with chordal ageusia was found, *post-mortem*, to have exostosis of Vidian canal and degeneration of great superficial petrosal. [The abstractor can add another proof. Case of facial paralysis due to neuritis in the internal meatus: There was *no* chordal ageusia on the affected side. The late Dr. Alexander Bruce wrote as follows: "The absence of middle ear disease and the retention of the sense of taste, and the associated deafness, giddiness, and facial paralysis, indicated that the lesion was probably situated between the side of the pons and the bottom of the internal auditory meatus" (JOURNAL OF LARYNGOLOGY, RHINOLOGY, AND OTOLOGY, August, 1910).] The chordal taste fibres probably go from the geniculate ganglion through the great superficial petrosal and vidian nerves to Meckel's ganglion, and thence in the second division of the fifth to the brain, and perhaps a part also through the small superficial petrosal to the otic ganglion, and thence in the third division of the fifth. The work of Gowers, Horsley, and Ballance confirms this indirect path.

J. S. Fraser.

Beck, Joseph C.—X-ray Diagnosis in Otosclerosis. "Laryngoscope," 1915, p. 154.

Beck has examined twenty-seven cases of otosclerosis by the Röntgen rays—stereo-radiograms of both temporal bones being taken in each case. In addition he photographed normal cases, as well as cases of nerve deafness and of chronic catarrhal and suppurative otitis media. Beck finds that in marked progressive cases of otosclerosis the dark areas (in the

negative) in the region of the promontory are markedly enlarged. This indicates a deficiency in lime salts. In one case of active syphilitic labyrinthitis, Beck found a large area of rarefaction, probably due to syphilitic osteo-porosis. These areas of rarefaction were not found in the chronic catarrhal cases. Beck believes that otosclerosis is similar to the osteo-malacia found in other bones, and holds that it is due to a disturbance (hypo-action) of internal secretion, especially of the adrenals and pituitary. He treats his cases with adrenalin and pituitrin, and seems to be pleased with the result.

J. S. Fraser.

MISCELLANEOUS.

Bowman, Frederick B.—Ultero-membranous Stomatitis and Gingivitis among Troops: its Cause and Treatment. "Proceedings of Royal Society of Medicine, Medical Section," February, 1916, p. 113.

The author states that the number of cases of severe ulcerative conditions of the throat and mouth seen at Moore Barracks Pathological Laboratory would seem to warrant a report on their cause and treatment. He summarises his report in the following way:

A very severe form of communicable mouth and throat infection is common among the Canadian troops in England, and from reports is also widespread among the British troops in France.

Clinically, cases of this nature are diagnosed as syphilis, mercurial stomatitis, diphtheria, pyorrhœa alveolaris, etc., according to the form assumed. Apparently they are due to Vincent's organism (*spirochætæ* and *fusiform bacilli*). Although *amœbæ*, *streptococci*, etc., are also found present, it is only when Vincent's organisms have disappeared that the condition undergoes cure.

When the gums are attacked the disease is more acute than ordinary pyorrhœa, and in some instances the gums and mouth appear much the same as in scurvy.

The throat condition sometimes cannot be diagnosed clinically from syphilis, and in all suspicious cases a Wassermann reaction should be done before a definite diagnosis is made or treatment is begun. The therapeutic test is valueless, as one full dose of salvarsan will usually clear up a badly ulcerated throat due to Vincent's organism.

The disease may be coincident with any other throat infection. It is sometimes chronic and may persist for months. A striking feature consists in the accompanying great depression and even vague constitutional disturbances which utterly unfit the man as a fighting unit.

The infection in the gums is very persistent, but may be ameliorated and is usually cured by the use of a simple prescription composed of arsenic and ipecacuanha solutions. The throat, even when deeply ulcerated, may be healed in a short time with the same solution.

Archer Ryland.

OBITUARY.

DR. JULES BROECKAERT.

THE premature death, in the forty-ninth year of his age, of Dr. Jules Broeckært, of Ghent, in London on July 17, 1916, deprives Laryngology of one of its most industrious and enthusiastic scientific workers.