

Thoyer-Rozat.—*Retro-Pharyngeal Abscess in Children.* "Thèse de Paris," 1896.

IN this thesis Thoyer studies specially the idiopathic abscess, leaving apart the symptomatic. These suppurations are more frequent than is supposed; the insidious origin, the serious complications, make these abscesses a dangerous lesion. He relates numerous cases of sudden death. This accident is due to spasm, caused by compression of nerves, or by reflex action.

After describing the symptoms he discusses the treatment, and advises incision through the mouth, the external opening being reserved for abscesses deep or laterally situated, or in case of spasm of jaws preventing opening of the mouth.

A. Cartaz.

NOSE AND NASO-PHARYNX, &C.

Bayer (Brüssel). — *Ozæna: its Etiology and Treatment by Electrolysis.* "Münchener Med. Woch.," 1896, Nos. 32 and 33.

THE author concludes:—Ozæna is a tropho-neurosis, consisting in—(1) An anomaly of secretions of the nose, naso-pharynx, and pharynx. This secretion favours development of the specific microbe which produces the characteristic factor. (2) Disturbances of nutrition and atrophy of the mucous membrane. (3) A rhinitis consequent upon the secretions. The best treatment of ozæna is electrolysis; but this treatment is not without danger.

Michael.

Black, A. M. (Denver).—*Nasal Sarcoma cured by Operation.* "New York Med. Journ.," Aug. 15, 1896.

THE patient, a woman of thirty-eight, was brought to the author by a medical man on account of an unaccountable rise of temperature, 101 degrees Fahr., the fever being of ten days' duration, and combined with frontal headache, with right-sided nasal occlusion of the same duration, which had been complete for eight days. There was a history of slight right-sided nasal obstruction and nasal hæmorrhage, but the duration of the trouble was not known. A hardish lobulated mass occupied the right side of the nose, causing deviation of the septum and general enlargement and redness of the nose; the growth also projected into the naso-pharynx. Under ether most of the growth was removed with snare and curette, and what was left was removed subsequently under cocaine anaesthesia, and trichlor-acetic acid was used as a caustic. The case had been under observation for two years, with no sign of recurrence. The bulk of the tumour consisted of rather large round and oval cells, showing an alveolar arrangement in parts, and was considered an undoubted sarcoma.

K. Lake.

Chapard.—*Relation of Rachitic Deformities to Chronic Obstructions of Superior Respiratory Tract.* "Thèse de Paris," 1896.

IN this very interesting pamphlet, Chapard notes the great influence over the thoracic development of chronic obstructions of respiratory tract (hypertrophied tonsils, adenoid vegetations, nasal obstruction, etc.). By diminishing the amplitude of breathing, the lung is atrophied, the thorax is less opened, and little by little is deformed, and these deformations become more and more marked, especially if the child is rachitic. These deformations are not characteristic of the nature of obstructions. He studies each variety, and advises early treatment of the etiologic factor and after-treatment of spine deformations—lordosis or scoliosis.

A. Cartaz.

Escat.—*Congenital Stenosis of the Nasal Fossæ and of the Naso-Pharynx.*
 “Arch. Internat. de Lar.,” May and June, 1896.

ALTHOUGH adenoid vegetations are frequently present in children affected with congenital deformity of the facial skeleton, the result possibly of the necessary habit of mouth-breathing, these hypertrophies are nevertheless found to be absent in a certain number of individuals presenting an appearance resembling that of the adenoid facies. It is of this class that the author gives a clinical sketch, illustrated by three cases. Ruault has reported an instance occurring in a girl of thirteen, in whom the transverse diameter of the face was atrophied, the nasal fossæ narrow, and the palate arched, but in whom the pharyngeal tonsil was unusually small. The mental development was in a state of arrest in this case, and a review of writings concerned with congenital mental degeneracy shows that a similar facial deformity has been frequently noted in such cases.

The first illustrative case is that of a youth of twenty-two, an imbecile and epileptic, with well-marked microcephalus, lateral flattening of the facial skeleton, and a facial angle of sixty degrees. The nose, prominent in profile and arched, was extremely narrow. The alæ were but slightly indicated, and the levator muscles appeared to be atrophied. The mouth was kept widely open, both upper and lower sets of teeth were irregular, and the chin of the “runaway” order. The palate was markedly arched and narrow, and the lack of lateral development was very noticeable in the thorax. The naso-pharynx, of the full height, was much diminished in sagittal and lateral diameter, but no hypertrophy of the soft structures was present.

In the second case—that of a boy of eleven—a similar facial construction was evident, and mental torpor was marked. The choanæ, though very narrow, were quite free from obstruction by the pharyngeal tonsil, which was of normal size. At the instance of the parents the latter was removed, but without any modification of the oral respiration necessitated by the narrowness of the nasal fossæ.

In the third case—that of a man of fifty-six, who suffered from childhood with great difficulty of nasal respiration—a similar conformation was remarkable. The pharynx in particular was extremely narrow, and the bucco-pharyngeal isthmus had the appearance of that of a child of five or six. No trace of hyperplasia or of cicatrization of the soft tissues was present.

Speaking generally, the appearance of cases of congenital stenosis is analogous to that due to acquired stenosis, the result of adenoid vegetations; but, in addition to the facial and thoracic deformity, mal-developments of the cranium (particularly micro- and dolicho-cephaly), and also of the auricles, and of the limbs, are frequently met with. In a few instances naso-pharyngeal stenosis has also been associated with macro- and brachy-cephaly.

As in the first case described, the nasal fossæ may be reduced to a mere slit without any abnormality of the septum. The pillars of the fauces are situated unduly near the middle line. The posterior pillars are very short, being attached unusually high up, while the inferior border of the velum, when fully relaxed, closely approaches the back wall of the pharynx. The latter circumstance renders posterior rhinoscopy difficult, and digital examination is necessary in order to establish the absence of adenoid hypertrophy.

The symptoms noticeable in this class of case are respiratory, auditory, vocal, and intellectual. Although middle ear derangement is observed, the deafness frequently present is in a measure attributable to psychic debility. The voice lacks timbre and sonority, and is to be distinguished from that characteristic of adenoid vegetations, in which the nasal vowels “an,” “en,” “on” are suppressed.

The intellectual symptoms are due to a primary congenital psychic debility,

and, unlike the aprosexia of adenoid subjects, are in no way modified by the efforts of the rhinologist.

Finally, heredity is an important factor in the pathology of the disease, and not only is there frequently a family history of mental unsoundness, but even of similar facial deformity in the forebears.
Ernest Waggett.

Gardner, Bellamy.—*A Note on the Administration of Nitrous Oxide Gas, with Oxygen, for the Removal of Adenoid Growths.* "The Clin. Journ.," Sept. 2, 1896.

THE advantages claimed for this anæsthetic are: (1) It is not attended with danger to life; (2) no preparation for an operation is required; (3) hæmorrhage is not affected by it; (4) jactitation and cyanosis produced by pure nitrous oxide are absent; (5) any position desired by the operator may be safely assumed; (6) the available anæsthesia is ten or fifteen seconds longer than that yielded by gas alone; (7) unpleasant after effects are of very rare occurrence.
Middlemass Hunt.

Gillette, A. J.—*Torticollis due to Adenoid Vegetations and Chronic Hypertrophy of the Tonsils.* "New York Med. Journ.," Aug. 1, 1896.

THE author quotes three cases of torticollis in which the sole probable cause was either adenoids or enlarged tonsils. Two cases, aged respectively seven years and sixteen months, were both subject to adenoids, and the former also to enlarged tonsils. Tonsils were removed with a slight improvement in the latter case, the former being cured by the usual operation, and the other will require operation. In the third case the torticollis was of about six weeks' duration and had not yielded to ordinary remedies. The author was unable to discover any cause except a large quantity of adenoid vegetations, and the only history was one of a cold some six weeks before, just previous to the commencement of the torticollis. The adenoid vegetations were removed, and in two or three days the deformity had entirely disappeared.
R. Lake.

Keen, W. W.—*Three Cases of Plastic Nasal Surgery.* "Therapeutic Gazette," July 15, 1896.

1. CASE of saddle-shaped nose, the result of fracture eighteen years previously. A transverse incision was made just above the alæ, and the superficial tissues loosened as far as the border of the frontal bone on each side. An artificial bridge consisting of two plates of silver soldered together and gold-plated was then inserted, and the opening closed by Halsted's subcuticular suture. The result has been excellent, and the gold plate has never caused the slightest inconvenience.

2. Case in which entire nose was removed for sarcoma. An artificial nose of silver, with a flange below which hooked behind the bone and held it in place, was constructed to hide the large hole left after the healing of the parts. The new nose was painted to resemble flesh colour as near as possible.

3. Case in which a markedly arched Roman nose was converted into a straight Grecian nose, by chiselling away the prominence of the bones after dissecting up the soft parts. A very good result was obtained, the scar being scarcely visible.
Middlemass Hunt.

Mackenzie, Hunter.—*A Case of Diffuse Papillomatous Degeneration of the Nasal Mucous Membrane.* "Lancet," Aug. 15, 1896.

OCCURRED in a man, aged thirty. There was no history of syphilis, but he was somewhat alcoholic. The mucous membrane of both nostrils was studded throughout by numerous sessile growths, varying in size from a pin's head to almost a grain of rice. They were most abundant on and about the upper regions.

Several of the larger growths were removed with the cold snare, but the greater number could be detached only with the nasal curette. Four months afterwards there was no recurrence. Microscopical examination showed the undoubted papillomatous character of the growth. *StClair Thomson.*

Massei.—*A Case of Caseous Rhinitis.* “Arch. Ital. di Laring.,” April, 1896.

A CASE of caseous rhinitis, lately observed and cured, formed the basis of a clinical lecture, in which the author discussed (1) the symptoms and (2) the different opinions. Coryza caseous may be dependent upon different causes—as in growths, etc. He believes the name of “caseous” more suitable than that of “cholesteatomatous”; and having confided the bacteriological researches to one of his assistants, Dr. Guarnania, he announces that the micro-organism which Sabrazès considered as a filamentous bacterium is, on the contrary, the streptothrix alba, already isolated, cultivated, and examined by Prof. de Giaxa, of Naples, while studies and experiments are still in course. He believes that three elements are necessary for the production of the caseous rhinitis—(1) an abundant purulent secretion in the nose; (2) an obstacle to its free issue; (3) the presence of the streptothrix alba, which finds a favourable *terrain* for its germination. Further relations by Dr. Guarnania are promised. *Massei.*

Moizard.—*Treatment of Whooping Cough by Nasal Insufflations.* “Journ. de Méd. et Chir. Pratiques,” Aug. 10, 1896.

SINCE Michael suggested this method of treatment, Moizard has employed, with great benefit, nasal insufflations of antiseptic powders. He uses this powder:—

Benzoin (pulv.)	10 parts.
Salicylate of bismuth	10 „
Quinine (sulphate)	2 „

The insufflations are made five times a day. In a week, and less, the fits of coughing are reduced in number and intensity and the cure is rapid. *A. Cartaz.*

Piaget.—*The Self-Defence of Nasal Cavities against the Bacterial Invasion.* “Thèse de Paris,” 1896.

AFTER an elaborate review of StClair Thomson’s, Wurtz’s, and Lermoyez’s papers, the author relates the numerous experiments which he has conducted for the study of bacteria of the nose. In the normal state the nasal cavities are free from microbes, except the anterior part and vestibule. The culture of nasal mucus collected in the remote parts is sterile; the nasal cavities are normally aseptic. That asepsis is the result of the structure of the canal, of the ciliated epithelium, and specially of the bactericidal properties of the nasal mucus. That bactericidal action is absolute for carbuncle bacteria, very marked for Loeffler’s bacillus, and less marked for staphylococcus and streptococcus. This asepsis explains to a certain degree the immunity of nasal operations. *A. Cartaz.*

Waterhouse, H. F.—*Adenoid Vegetations in the Naso-Pharynx, and their Treatment.* “Clin. Journ.,” Aug. 26, 1896.

ADENOIDS are more common in boys than girls—in the proportion of two to one—and are as frequently met with in healthy and vigorous as in strumous children. Heredity plays an important part in their causation. For purposes of diagnosis posterior rhinoscopy can only be used in less than half of all cases, and in children under six is practically useless. Digital examination is to be preferred. If growths have given no trouble before puberty there is little probability of their causing symptoms later in life.

In adults one may use galvano-cautery with cocaine anæsthesia, and two or

three sittings will be sufficient to remove growths safely and efficiently. In children always use a general anæsthetic to save shock, and complete operation at one sitting. If tonsils also enlarged, remove them without an anæsthetic a few days before, especially in young and weakly children. In older and stronger children, may first remove tonsils and then adenoids under one administration of anæsthetic. The safest position and the most convenient for operation is with the hanging head. Dalby's position is also safe if using gas. Any other position is unsafe.

Of anæsthetics, chloroform is the most handy and the most easily administered, but even in careful hands so many deaths have occurred in this operation that the author, though he has used it hundreds of times "with fear and trembling," has now taken to nitrous oxide. Given with oxygen it is the best anæsthetic for most cases of adenoids.

With regard to instruments, Gottstein's curette is the most generally useful, but when growths are firm forceps must be used. Of these, Löwenberg's remains the best. In weakly children use forceps for whole operation, as hæmorrhage is less than when curette is used.

Middlemass Hunt.

LARYNX.

Kirstein, A.—*Autoscopy of the Upper Air Passages.* "Therap. Monats.," July, 1896.

To see directly into the larynx and trachea the observer, wearing a frontal mirror, or, still better, a frontal lamp, and sitting opposite the patient, places the patient in such a position as to bring the axis (theoretical) of the mouth (with the tongue removed) and that of the trachea as nearly as possible into a straight line. The tongue and epiglottis alone obstruct his view of the larynx. He must therefore make a depression in the tongue reaching as far backwards and downwards, and as exactly in the axis of the trachea, as possible. In doing so he will at the same time pull the epiglottis out of the way. This can be done with a long, narrow tongue depressor, slightly bent downwards at its distal extremity. Care must be taken not to produce retching. By this means he will be able to see: (1) in very numerous cases, the posterior wall of the larynx; (2) often, the posterior two-thirds of the vocal cords; (3) seldom, the whole larynx, including the anterior commissure of the cords. The amount of the trachea visible will vary correspondingly. The part most easily seen, viz., the posterior wall of the larynx, is the most difficult to observe accurately with the laryngoscope. Little children are most difficult to examine with the laryngoscope, most easy by the direct method.

This method is of great service in finding and removing foreign bodies in the air passages. It is also often of great value in laryngeal operations (specially polyphi), permitting the complete removal of even large tumours in one sitting (Bruns).

The larynx and trachea can be very easily and thoroughly examined in all children deeply under chloroform. If the anterior commissure is not visible, it can easily be brought into view by gently pressing the thyroid cartilage backwards.

The importance of this simple procedure in children suspected to have papilloma of the larynx is at once apparent. Should papilloma be found, it would be wise to at once tracheotomize, and either then or later proceed to operate.

In little children good results are often obtained even without narcosis.

Arthur J. Hutchison.