irrigation of the nasal cavities with a 1-40 carbolic lotion. The result was so successful that the author commends the procedure as worthy of a more extended trial. *W. Milligan.*

ŒSOPHAGUS.

Killian, G.—*A Difficult Case for the Use of the Œsophagoscope.* "Deut. Med. Woch.," December 20, 1900.

The patient, a woman aged fifty-two, swallowed a tooth-plate with two lateral projections. After the use of cocaine an œsophagoscope 9 millimetres in diameter was passed, and soon came in contact with a foreign body. The dental plate could then easily be seen. Attempts were made to extract it, but unsuccessfully, the plate being firmly held by the œsophageal mucosa. Finally, the plate was cut through by a specially-constructed cautery blade and removed in three pieces.

W. Milligan.

EAR.

Aitken, David William.—*Note on the Treatment of Otorrhœa.* "The Lancet," April 20, 1901.

Although the method is quite prompt in its effects upon acute otorrhœa, its benefits are greatest in old-standing cases where the mastoid has become infected. The appliances required are a probe, some antiseptic lotion, and some absorbent cotton. The best probe for the purpose has at the end two spiral teeth which, while they hold the wadding firmly, permit of its easy removal by rotating the stem counter clock-wise. The first step is to pour into the ear some of the lotion. Then take as large a plug of wadding as is deemed sufficient when screwed upon the probe to easily fit the meatus. It is now possible to make the probe and ear canal a suction syringe. The plug of wadding which forms the piston is gently pushed in and then withdrawn. If it is found to be either too large or too small another can be at once substituted which acts both easily and also fits close enough to force some of the fluid before it. This fluid reaches both the attic and also the mastoid recesses. At any rate, on the first withdrawal sufficient vacuum is produced to allow the lotion to enter the accessory cavities. It will surprise anyone who has not carried out this procedure to note how much discharge and débris are brought to the surface, even after syringing and swabbing have been efficiently performed. After several repetitions of the manœuvre, the head each time being turned to the opposite side to permit of emptying the meatus, the lotion will well up clean. Now, one can get any medicament to the clean surfaces. Begin with chinosol, iodoform, or amyloform in alcohol, which, in my experience, is best in the absolute state. It is practically painless in almost all cases, and in the exceptions the smarting is but momentary. Its advantages are: (1) it acts promptly upon the polypoid growths; (2) it is a most satisfactory antiseptic; and (3) as it evaporates it leaves a dry surface. This is most important. When the solution has been poured into the ear the process with the "piston-rod" is repeated several times. Thus the fluid is forced into all the recesses. That this is so is seen by the prompt improvement both in the local condition and also in the constitutional state. Of course, discretion is used

as to the nature of the drug selected in the progress of the cure, according to the requirements—stimulant, astringent, etc.—of the case. It is unnecessary to select examples. Suffice it to say that many cases have been treated, and that in some the patients have probably been saved from the somewhat serious operation of trephining the mastoid. *StClair Thomson.*

Bar (Nice).—*On Ringworm of the External Auditory Meatus.* "Annales des Maladies de l'Oreille," etc., May, 1901.

This is a long and fairly exhaustive paper on the occurrence of tricophyton in the meatus. Two cases are described. The disease is very rare in the ear, and difficult of diagnosis without the aid of the microscope. The signs, prognosis and treatment are discussed, and the author arrives at the following conclusions:

1. Most of the dermatomycoses can attack the meatus and cause a parasitic otitis, important to recognise and difficult to cure.
2. The tricophyton of Malmsten is one capable of causing these inflammations.
3. Tricophytic otites are acute, subacute, or chronic, characterized by a dermatitis which can be extremely violent, with an eruption of vesicles and pustules, or simply erythematous and squamous.
4. Prognosis is good in acute cases, variable as to the integrity of the ear and the hearing in cases which progress slowly.
5. Diagnosis must be made principally from furuncle, otomycosis, impetiginous and squamous eczema, various acnes, syphilitic erythemas and roseolas, and various syphilides. Microscopic examination can alone decide the case.
6. Treatment runs on the general lines which govern those of dermatomycoses, and in the direction which takes account of the etiology, according to the region in which the malady occurs. Among the medicaments and parasiticides which one can employ in such cases, sublimate lotions (1-1000), and naphtholene in vaseline (1-10) are the best. *Macleod Yearsley.*

Courtade.—*On the Treatment of Acute Otitis Media by Insufflations of Air.* "Annales des Maladies de l'Oreille," etc., May, 1901.

The author briefly refers to the frequency, symptoms, and signs on examination of attacks of acute middle-ear inflammation occurring in the course of an acute coryza. He dismisses the usual routine treatment of such cases to draw attention to a method which is at once sedative and curative when applied at the outset of the malady, viz., the insufflation of air.

If, he says, on the appearance of pain, such insufflation be practised, the patient is relieved, the head becomes less stuffy, and the deafness diminishes or disappears; at a later stage the sound of coarse mucous râles can be perceived with a diagnostic tube. In most cases, especially in children, one insufflation is sufficient to relieve the pain and arrest the progress of the inflammation. Immediate relief is less often noted in adults, because they do not consult one until they are unable to work or sleep. The less recent the case, the less immediate is the relief, and several insufflations are necessary.

The author cites several cases of his own, and reviews the opinions of various authorities on the subject. He discusses the mode of action of the method. Even when the mucosa is invaded by pathogenic

micro-organisms, he does not think there is any risk in using the air-douche, but antiseptic treatment is necessary to help the recovery of the mucous membrane. *Macleod Yearsley.*

Jakins, Percy.—*A Case of Temporo-Sphenoidal Abscess following Middle-Ear Suppuration; Operation; Recovery.* "The Lancet," March 30, 1901.

A man, aged twenty-four years, had had whooping-cough at the age of four years, and measles when he was a year older; when he was ten years old he had scarlet fever, and three years previous to the time of his admission to hospital he suffered from influenza; the ears had not been affected in any of his illnesses. For two years he had had a discharge from the right ear, the cause of which was unknown. Five months before admission he attended a special hospital for this discharge; a polypus was removed, and he was told to syringe his ear with a lotion, and to have a white powder blown into it, but neither the removal of the polypus nor the treatment prescribed caused any diminution of the discharge, which became offensive.

On admission the temperature was 99·4°, and the pulse was 64. The patient had severe pain all over the right side of the head, the right mastoid was very tender on pressure, and there were marked giddiness and nausea; the complexion was very pale, there were sordes on the lips and tongue, and the breath was decidedly offensive. The patient was heavy and drowsy, his speech was slow, and his body was much wasted. On examination the meatal canal was found to be full of offensive pus, and when this had been removed there was seen to be a distinct bulging of the superior and posterior meatal wall. On the following day (August 22) the patient, whose temperature was 98·4° at 10 a.m., was placed under chloroform, the antrum was explored and was found to contain granulation tissue and cholesteatoma; this was curetted. The attic was found to be in a similar condition, and was treated in the same way, and a communication was found leading to the middle fossa, the dura mater being exposed. The skin incision was carried upwards, the temporal muscle was divided, the periosteum was reflected, and a piece of bone was removed by the trephine. As the dura mater looked healthy and there was no bulging, it was decided not to explore the cerebrum, feeling sure that if an abscess was there it would make its way towards the point of least resistance. The wound was packed with iodoform gauze and the patient was put back to bed. On the next day the patient felt decidedly better, the headache was less, and he had slept fairly well; the highest temperature for the day was 99·4°. On the following day he expressed himself as feeling quite well; the highest temperature for the day was 99°. On the 25th the patient suddenly became exceedingly restless, and complained about noon of severe headache, especially over the occipital region. He soon became drowsy, and then comatose, and the nurse noticed that he did not move his left arm or left leg. The author was sent for, and found that the patient had complete left hemiplegia. Chloroform having been given, on removal of the packing the dura mater was seen to be bulging through the trephine opening. The dura mater was incised, a medium-sized trocar and cannula was then driven into the brain-substance for a distance of 1½ inches, and on withdrawing the trocar a very offensive pus escaped. A Horsley's pus-seeker was next used, and the abscess cavity was emptied of its contents, about 2 ounces. A large drainage-tube

having been passed into the cavity, the wound was packed with gauze. The temperature was 97·4° at 6 a.m. The evening temperature (taken at 5·30) was 103·0°. The patient was very restless, continually moving his right leg; in a short time he began to move his left leg. Next day (August 26) he was better, and could move his left arm and leg; the highest temperature for the day was 102·8° at 2 p.m. On the 27th the highest temperature for the day was 101·2°. On the 28th the patient was very restless and almost maniacal. On the next day the drainage-tube was removed, cleaned and shortened, and re-inserted; the highest temperature for the day was 100·4° at 2 a.m., and it was thenceforth normal. The patient made an uninterrupted recovery. The tube was removed on September 20, and he left the hospital two days afterwards, having been resident for thirty-three days. On December 9 he was quite convalescent. To use his own words, "he felt better than he ever did," and he had gained weight and strength.

This case bears out the author's opinion that the presence of a polypus or granulation tissue in the external meatus indicates trouble in the antrum or attic, or both, and that simple removal of the growth through the external meatus in no way touches the disease which is causing the trouble. It also illustrates another point, namely, that in cases of suppuration from the middle ear which do not yield rapidly to treatment the advisability of the radical operation should be seriously considered, not only with the view of arresting the discharge from which the patient suffers, but to prevent deeper mischief, such as cerebral abscess. *StClair Thomson.*

Joachim, O. (New Orleans).—*Two Cases of Otitic Lateral Sinus Disease: Operations with Ligature of the Jugular.* "Arch. of Otol.," vol. xxix., No. 4.

Two typical cases, with death in one and recovery in the other. The vein was ligated in both, the writer being in favour of it whenever a high degree of pyæmia is present. *Dundas Grant.*

Kickbefel, G. (Danzig).—*Examination of the Pupils of the Municipal Deaf-mute School at Danzig.* "Arch. of Otol.," vol. xxix., Nos. 2 and 3.

Thirty-nine were examined, eleven congenital and fifteen acquired, three being doubtful. Bilateral deafness was found in three, unilateral in four, partial hearing in both ears in twenty-two, and partial hearing in one ear in four. In a large number of the cases there were diseased conditions requiring treatment, such as adenoids, chronic suppuration, tubercle, etc. He advocates hearing exercises as part of the general system of deaf-mute education, without superseding the instruction in and by articulation. The details of the methods and results of the examinations are very full. *Dundas Grant.*

Lehr, G. (Rostock).—*Contributions to the Knowledge of Intracranial Complications of Ear Disease.* "Arch. of Otol.," vol. xxix., Nos. 2 and 3.

This paper includes references to ten and reports of nine cases, being the entire number of intracranial suppurations of otogenous origin in Professor Kœrner's Aural Hospital in Rostock since November, 1896. As a rule, he has omitted incurable cases of purulent lepto-meningitis and cases of external pachymeningitis without pus.

In one acute case following influenza paracentesis and mastoid

operation failed to prevent meningeal infection, which seemed to extend from the spongy bone round a hiatus of the Fallopian canal. In another the cause was a gunshot wound, the fatal meningitis occurring more than two years later. In this case lumbar puncture withdrew no fluid. Another was a typical temporo-sphenoidal abscess, recovering after operation. Another case was remarkable for the amount of bone that was destroyed. In another case sinus phlebitis followed scarlatinal necrosis of mastoid and squama. Recovery followed operation with ligature of jugular vein. The early development of the sinus phlebitis was remarkable. Sinus phlebitis in another case of acute mastoiditis was in one case treated by evacuation of the sinus, as far as the clot was disintegrated, without ligature of the jugular vein. Recovery followed. In the last of the cases a perisinus abscess in acute mastoiditis after typhoid was evacuated by operation, recovery ensuing. *Dundas Grant.*

Muck, Dr. (Rostock).—*A New Case of Mastoiditis in a Diabetic Patient.* "Arch. of Otol.," vol. xxix., No. 4.

After paracentesis on account of acute suppuration of the middle ear, the inflammation increased, and signs of mastoiditis supervened. Operation was performed, revealing pus in the antrum and softened bone. The interior of the mastoid was not so much broken down as in Professor Kœrner's other cases, hence there was no dulness on percussion. *Dundas Grant.*

Schwabach, Dr. (Berlin).—*On Diseases of the Organ of Hearing in Pernicious Anæmia.* "Arch. of Otol.," vol. xxix., No. 4.

One case observed by the author is described, and several from the clinics of Dr. A. Fraenkel and Dr. Stadelmann are shortly reported. When the ear was affected the deafness occurred rather suddenly, and was of the type of obstructive deafness. A microscopical examination in a fatal case showed hæmorrhages into the lining of the Eustachian tube and tympanum, hampering also the stapes in the fenestra ovalis. *Dundas Grant.*

Siebenmann, Professor F. (Bâle).—*Multiple Rarefaction ("Spongiosirung") of the Labyrinth Capsule found at the Autopsy of a Case of Progressive Deafness.* "Arch. of Otol.," vol. xxix., Nos. 2 and 3.

Professor Liebenmann contends that extensive rarefaction of the labyrinth capsule is sufficient, independent of an involvement of the bony nerve-canals, to produce a decided diminution of bone-conduction. According to its localization, it may produce a bony stapes ankylosis, or progressive nerve-deafness. A minute report is given of a case in which a dulness of hearing (considerable in the right ear, slight in the left) gradually developed. Rinné for the *a*-fork was positive and Weber negative. There was found post-mortem on both sides areas of rarefaction in the bony capsule of the semicircular canals, the vestibule and the cochlea. There were osteophytes on the vestibular and tympanic surfaces of the oval window margin, commencing ossification in the cartilaginous covering of the stapes, and, on the left side, commencing ossification of the annular ligament. Minute details of the nature and situation of the osseous changes are given, and the author apparently explains the diminished bone-conduction by variation in density of the labyrinth fluid. (He does not explain the

" positive " Rinné in face of a partial ankylosis of the stapes.) In the way of treatment he suggests the internal administration of phosphorus.
Dundas Grant.

Stetter, Professor (Königsberg).—*Report of the Out-patient Department for Diseases of the Ear and Mouth for the Years* 1898, 1899. " Monatschrift für Ohrenheilkunde," March, 1900.

The first two decades of life furnish almost as many cases of ear-disease as the last five.

Professor Stetter emphasizes the great importance of early and free paracentesis in acute otitis media, and narrates a case with severe local and general symptoms which was cured as by the stroke of a magician's wand by free incision. The membrane was thickened, and the quantity of matter that escaped indicated a considerable focus, which could only have been the antrum; and yet there were no symptoms indicating implication of the antrum or calling for its exploration.

Pure trichloracetic acid is strongly recommended for the destruction of granulations. It is applied daily at first, and is very slightly painful.

Professor Stetter maintains a conservative attitude regarding the radical mastoid operation. He believes that many cases of acute otitis and mastoid periostitis can be cured by the timely performance of Wilde's incision.

Epithelioma of the Lobule.—A woman of fifty-four had her ears pierced for ear-rings. An ulcer formed at the site of one puncture—a painful, suppurating sore, which when seen in the third year of its existence had become epitheliomatous.

Hardened cerumen may be softened in a few minutes by menthol-vasogen.
W. Lamb.

Suarez de Mendoza.—*Untoward Consequences of Clumsy Attempts at the Extraction of Foreign Bodies in the Ear.* " Archives de Médicine et de Chirurgie Speciales," February, 1901.

An article which reiterates much that has been said before as to the danger of unskilled endeavours to extract foreign bodies from the ear. The most pregnant remarks are those put in italics—namely, that before all things it is necessary to be certain that the foreign body is in reality in the auditory meatus. One should never attempt the extraction of a foreign body without previous minute examination of the ear with a mirror and speculum.
Macleod Yearsley.

Waterhouse, H. F.—*Lateral Sinus Pyæmia and Cerebellar Abscess with Cheyne-Stokes Respiration; Recovery.* Medical Society of London (from the " Lancet," March 30, 1901).

The patient was a dental surgeon admitted into Charing Cross Hospital on April 17, 1899, with lateral sinus pyæmia. He had been for many years a sufferer from chronic tuberculous abscesses in the region of the right hip, and had had a purulent discharge from both ears for the greater part of his life. In 1895 Mr. Waterhouse had operated upon him for a large supramastoid abscess on the right side, and shortly prior to admission Dr. Green had opened two abscesses of the right hip. On April 11 the patient felt ill; the temperature was 100° F., and the pulse was 100. An April 12 he had a rigor in a train. On April 13 he had a rigor of half an hour's duration and a temperature of 103°. On April 15 Mr. A. M. Sheild saw the patient and diagnosed

lateral sinus septic thrombosis, but was unable to decide upon which side the condition was. On admission to Charing Cross Hospital the patient's temperature was 104·2°, the pulse was 100, and the heart and lungs were normal. There were no pupillary changes and no optic neuritis. From this time to April 28 the patient had repeated rigors, the highest temperature was 105·2°, and a systolic heart murmur developed after continuous pain over the base of the heart whilst he was in hospital. Cough was noticed a few days later, and the sputa was of prune-juice colour. His condition became profoundly toxæmic and apparently hopeless. Much valuable time was of necessity lost in waiting in the hope of determining upon which side the sinus was affected. At last, on April 28, when it became clear that the time for operative interference with any hope of success was rapidly passing away, Mr. Waterhouse operated upon the left lateral sinus and internal jugular vein, dividing the latter between two ligatures and incising and clearing out the septic thrombus in the former. Recovery took place; nevertheless, on May 1 Dr. J. W. H. Eyre, bacteriologist to the hospital, found streptococci in the blood. Everything went well until June 7, when the patient was allowed to get out of bed On June 8 complaint was made of headache, vomiting occurred, and the pulse fell to 56. Drowsiness increased, until on the evening of June 10 the patient was comatose, and there were double optic neuritis, Cheyne-Stokes respiration, and a pulse of only 50. It was then decided to explore the temporo-sphenoidal lobe and the cerebellar fossa on the left side. Unfortunately, the former was first attempted, with negative result. Respiration ceased entirely under even partial anæsthesia. Owing to the patient's condition vigorous artificial respiration had to be resorted to, and the movement thus caused some laceration of the cerebral substance by the exploring-needle. Soon the pulse ceased to be perceptible, and, as the patient was obviously very near death, the exploring syringe was made to perforate the tentorium cerebelli from above. Immediately an ounce of fœtid pus was obtained, the respiration and pulse recovering at the same instant. The left cerebellar fossa was now rapidly trephined and several drachms of pus were evacuated. Progress was henceforth most satisfactory, although there was for many days much word-deafness owing to injury to the temporo-sphenoidal convolutions. The patient was at the present time in better health than before his illness, and was in full practice as a dental surgeon. Speech was nearly perfect; he could now manage a gas and ether extraction, comprising from sixteen to twenty teeth and stumps, and could walk ten miles, in spite of his lameness. Mr. Waterhouse alluded to the extreme difficulty that had existed with regard to the decision as to which lateral sinus was affected and the hesitation he felt in risking operating upon the wrong side. He considered that the endocarditis having developed whilst the patient was under observation, and the presence of streptococci in the blood, proved it to be of pyogenic origin. He regretted that he had not at once, in the second operation, trephined for cerebellar abscess, but gave cogent reasons for acting as he had done. Remarks were also made as to the difficulty in locating intracranial abscesses, and another case was related in which Mr. Waterhouse had first explored the cerebellum for an abscess which was situated in the temporo-sphenoidal lobe. This case fortunately also recovered. *StClair Thomson.*