

ABSTRACTS.

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PHARYNX.

Focal Infections in Childhood.—Sandford Blum. "Amer. Journ. Med. Sci.," November, 1918.

The theory of focal infections is by no means new, but unfortunately attention has recently been concentrated upon certain potential foci of infection to the practical exclusion of others at least equally important. It follows that avoidable mistakes in locating the focus are frequently made and the results of treatment are correspondingly disappointing. Much attention has been directed toward endocarditis in relation to foci of pathogenic bacteria in the mouth and fauces. The presence of such foci with the subsequent development of endocarditis is by no means conclusive evidence of a causal relationship, and the complete absence of reports of identification in endocardial lesions of the specific bacilli present in the suspected foci constitutes a deplorable breach in the chain of reasoning. That under proper conditions endocarditis can originate from these sources may without question be assumed; but the frequency in childhood of alveolar disease and tonsillitis when contrasted with the rarity of endocarditis justifies the conclusion that such a sequence is certainly exceedingly rare. The assumption that streptococci harboured in the tonsils possess especial selective powers against the endocardium and joints seems unjustified. The presence of pathogenic micro-organisms in a certain locality does not constitute it an infective focus. Colon bacilli in the intestines may remain indefinitely and cause no infective process; pyogenic bacteria may be present in the middle ear for years without producing secondary disease; streptococci, staphylococci and diphtheria bacilli may be indefinitely harboured in the tonsils without deleterious effect. Recovery of the same type of bacillus from the primary and secondary lesion will prove the connection. But it is possible for the primary focus to be healed when the secondary lesion is discovered; under these circumstances the association is incapable of positive proof—it can only be conjectured. Further, to assume that in cases in which a distinct metastatic bacterial process has been established, as in endocarditis or arthritis, eradication of the primary focus will cure the secondary lesion is fallacious; the most that can be expected is that further deleterious increments from the original source may be excluded. Evacuation of abscess-cavities, removal of diseased appendices, surgical relief for otitis media and mastoiditis require no comment for their approval. Far differently must be viewed the promiscuous practice of tonsillectomy. The common practice of tonsillectomy as a diagnostic measure is reprehensible and should be discontinued, because it is unscientific in that it is a surgical procedure undertaken without definite indication, and diverts attention from other diagnostic procedures which not infrequently would disclose the obvious cause of the disease. Moreover, focal infections may actually be created by operative procedures such as tonsillectomy and orthodontia.

Thomas Guthrie.

NOSE.

The Vaccine Treatment of Ozæna.—Otto Glogau. "The Laryngoscope," May, 1918, p. 380.

Glogau states that the history of the study of the aetiology and treatment of "ozæna" is full of jubilant enthusiasm and bitter disappointment. He cannot endorse the triumphant statements of Perez the prophet, and of Hofer and Horn, his most ardent worshippers. Hofer prepared an ozæna vaccine consisting of the cocco-bacillus of Perez, found in the above-described way and derived from seven different strains, to which he added a culture from the nose of healthy dogs. Hofer and Kofler injected a number of ozæna cases and published a report of almost marvellous cures. Kofler examined the patient's nose and throat and dictated the statements to Hofer, who wrote them into the patient's history and then injected the patient with the increasing doses of vaccine. "Less odour, decreased number of crusts, pharyngitis turning moist" are very vague statements. The wish is often father to the thought. Glogau admired his former colleagues, Hofer and Kofler, for their optimism. After watching scrupulously for a number of weeks Glogau could not be convinced that even one case had been cured. All the American sceptics could notice was the presence of fœtor, mostly of the severest type, and of crusts in all noses.

The *Bacillus bronchisepticus*, which was proven to be the specific organism of canine distemper, is morphologically almost identical and in many cases biologically similar to the Perez organism. Let us bear in mind (1) that Hofer could not isolate the Perez bacillus from the crusts, but had to inject animals and then isolate it from their nasal discharge; (2) that Hofer adds to his vaccine a strain from the normal discharge of the dog; (3) that Perez claims the cocco-bacillus to be normally present in the nasal cavities of the dog; (4) that McGowan has shown that rabbits are specially liable to distemper, and he holds that the rabbits used in Perez' experiments were suffering from distemper.

In order to control the claims made by Hofer, Guggenheim and Horn, Glogau undertook an investigation to prove or disprove the therapeutic value of the ozæna vaccines in vogue. If the Wassermann test was positive the patient was excluded from vaccine treatment. Wherever there was a suspicion of tuberculosis or sinus involvement, the patient was also refused vaccine treatment. The following types of vaccine were used: Hofer's original, used in two cases, with negative results. Auto-genous vaccine, employed twelve times; one case transient improvement eleven cases negative result. Polyvalent vaccine, prepared from seven strains. Stock vaccine Perez (Horn), used in five cases; three cases negative result, one case slight improvement, another showed a loosening of the crusts. These results were, however, only transient. Mixed Perez vaccine (Horn). Parke Davis ozæna vaccine (Perez). Parke Davis ozæna vaccine (combined) used five times; negative result in three cases, and slight transient improvement in two cases. Glogau states that his statistics lack enthusiastic exaggeration. Bacteriological examination gave the following results: Out of seventeen cases injected there was demonstrable in the nasal crusts—bacillus Perez, five times; bacillus Abel, once; bacillus Friedländer, three times; pure staphylococci, twice; staphylococci and Gram-negative bacillus, twice; staphylococci and Friedländer bacillus, twice; *Micrococcus catarrhalis*, once. The pathological changes on the turbinals of the injected rabbits showed nothing characteristic of

ozæna. Clinically, the noses of the injected rabbits resembled very much the conditions found in those suffering from distemper.

Glogau concludes that ozæna is no clinical entity. In those cases where the *Cocco-bacillus fetidus* (Perez) is found, there has been transmitted directly or indirectly from the animal's nose (dog, rabbit, etc.) the *Bacillus bronchisepticus* upon a previously predisposed soil. There is no doubt in Glogau's mind that ozæna will outlive its vaccine treatment.

J. S. Fraser.

Röntgenological Interpretation of Accessory Sinus Variations.—H. J. Prentiss. "Amer. Journ. of Röntgenology," August, 1917, University of Iowa Monographs, vol. i, No. 3.

A careful article demonstrating the numerous variations in the anatomy of the accessory sinuses. Illustrated by numerous semidiagrammatic drawings of specimens in the anatomical laboratory of the Iowa State University. Unsuitable for abstracting. J. K. Milne Dickie.

Perineural Anæsthesia for Radical Surgery of the Maxillary Sinus.—Gatewood. "The Laryngoscope," August, 1918, p. 616.

The infra-orbital and posterior superior dental branches of the superior maxillary are the nerves supplying this region. Before entering the canal the maxillary nerve gives off the posterior superior dental nerves, which pass forward above the molar teeth. They supply the oral mucosa, the molar teeth, the mucous membrane which lines the maxillary sinus and the periosteum. In passing through the infra-orbital canal the nerve gives off the superior dental branches. The middle and anterior superior dental branches supply the alveolar process, sending small twigs to the teeth. The infra-orbital nerve divides into from two to four branches, which send off finer branches to the oral mucosa, the floor and lower lateral aspect of the nasal cavity, and the incisor and canine teeth. Anæsthesia of this region may be easily brought about by the injection of a local anæsthetic into the vicinity of the infra-orbital and posterior superior dental nerve-trunks. The technique for blocking these nerves is as follows:

(1) **Infra-orbital:** The infra-orbital canal is palpated with the index-finger, which is kept on this point. With the thumb of the same hand the lip and cheek is drawn up to expose the field of operation. The needle is inserted into the buccal fold slightly distal to the apex of the canine teeth, passed upward and slightly inward for three-fifths of an inch, infiltrating the tissues slowly as the needle is advanced. We are now in the region of the infra-orbital canal; here the remainder of the anæsthetic solution is deposited. Gentle massage of this area will hasten the absorption of the anæsthetic.

(2) **Posterior superior dental nerve:** This injection is guided by the condyle of the palatal process of the maxilla. The point of insertion of the needle is in the buccal fold corresponding to the middle of the disto-buccal root of the second last tooth from the condyle, this being the first or second molar respectively depending upon the presence or absence of the wisdom tooth. The needle is now passed upward, backward and slightly inward, passing over the apices of the buccal roots of the second or third molar, "using an angle of about forty-five degrees to the acclusal plane of the teeth." The tissues are infiltrated slowly as the needle is pushed forward, and the remainder of the anæsthetic solution is deposited after the needle has disappeared for about four-fifths of an inch. Two c.c. of a 2 per cent. solution of novocaine is used in each of the above injections.

J. S. Fraser.

An Operation for Bony Occlusion of the Posterior Nares.—Leon E. White. "The Laryngoscope," August, 1918, p. 571.

The bane of operations for bony occlusions of the posterior nares has been the difficulty of obtaining a permanent opening. Loeb says: "Bony occlusion of the posterior nares may be relieved by removing the bony mass by means of chisels or burrs driven by a dental engine. After the opening is made it may be enlarged by cutting forceps." The submucous resection method is, however, given the preference by most of the later writers. The muco-periosteum is raised on the septum down to the obstructing plate, from the anterior surface of which it is gradually separated until its outer border of attachment is reached. The flap is then thrown well outward and the bone plate is removed by chisels and conchotomes. After the bone-partition is thoroughly removed the flap is replaced and an incision is made vertically through the middle of the muco-periosteal flap, which covers the nasal surface of the obstructing plate. Expanding forceps are now introduced, and the redundant muco-periosteal flap is made to coapt and cover the whole margin of the bone wound. After a failure in his first operation it occurred to White that, if the raw surfaces were further apart, the danger of closure would be greatly lessened. As perforations in the septum usually stay open, White decided to make such a perforation including the previously obstructed choana. He prefers general anaesthesia. After the septal operation has been completed the obstructing bony plate can be readily perforated with a long, flat chisel held close to the septum. A triangular section is first removed, the forefinger being placed in the posterior nares to guard against accident. The bone is next punched out as thoroughly as possible. The posterior end of the septum is then removed by rongeurs or curette. The edges of the bony opening are smoothed off carefully and covered by the mucosa, which has been previously cut and elevated. Each nostril is then packed with a strip of gauze covered with rubber tissue. The packing should be removed in twenty-four hours, and the subsequent treatment is only such as is needed to keep the nose clean and free from crusts. If the operation has been done thoroughly no further packing is necessary.

CASE.—Female, aged eighteen, suffering from congenital bilateral atresia. The face was symmetrical, and, although the patient was a mouth-breather, the high palate was not high. The hearing had always been good and both drum-membranes were normal. There was some lack of resonance in her voice. The nose was rather narrow, but the mucous membrane was fairly normal. The choanal obstruction could be seen both anteriorly and posteriorly. After successful operation (as above) the patient stated that food tasted "much better," and that she could now smell as well as anyone and breathe freely through both nostrils. She thought her memory was better.

J. S. Fraser.

Diseases and Deformities of the Nose versus Neuralgia of the Head.
—Stauffer. "The Laryngoscope," September, 1918, p. 698.

Stauffer holds that when all the head-pains or neuralgias occurring as a result of diseases and deformities in the nose and its accessory sinuses are accounted for, there will be but few to attribute to other causes. A knowledge of the origin and distribution of the trigeminus is imperative for a proper understanding of the various obscure reflex pains associated with diseases in the head. It is difficult to conceive of pain in the course of a nerve as a pure neurosis without a lesion either in the nerve-endings or nerve-fibres. Stauffer believes that a very large majority of these

obscure neuralgias (so-called) in the head have their origin in diseases of the accessory sinuses or in deflections of the nasal septum or enlarged middle turbinals.

J. S. Fraser.

Decompression Operation on the Hypophysis by the Nasal Route.—

Otto J. Stein. "The Laryngoscope," May, 1918, p. 376.

The author approves of the technique advocated by Oscar Hirsch, which gives ample room for working with the minimum of tissue loss. Stein believes the ideal anæsthesia to be morphine-hyoscin or scopolamine-morphine with flake cocaine locally on the septum and sphenoid. Hurried operations should be deprecated. The only case Stein lost from operation was of this nature: Male, aged forty-seven, had only central vision. Both fundi showed beginning peripheral atrophy; headaches; no perverted pituitary symptoms. Owing to certain circumstances no routine physical examination (including urinalysis) was made in the hospital. On entering right sphenoid Stein encountered a cyst, which did not rupture until he entered the left sphenoid. Two drachms of straw-coloured fluid, slightly blood-stained, escaped. The patient had a restless night, vomited constantly, and had severe headache; the temperature later, rose to 102° F. Acidosis was diagnosed from the vomiting, pulse, headache, urine examination and breath. Death on the second day following operation. [Meningitis?—Abs.]

A good X-ray picture will show the size of the sphenoidal cavities, a widening and deepening of the sellar floor, even a shadow outline of the glandular mass; enlargement or absorption of the clinoid processes and increase or decrease of the diaphragm opening. Ordinarily the floor of the sella presents at about the superior posterior angle of the inner wall of the sphenoid cavity. The bone at this point is usually quite thin and easily broken through. Occasionally one finds a hard and thick wall in the region of the promontory. It is always necessary for the operator to keep working in the median line to escape injury to nerve, artery and cavernous sinus. This in itself is a strong argument in favour of the septal route. The entire operation is confined between two muco-periosteal flaps, and with proper aseptic technique these flaps can be brought together at the end, thereby avoiding any danger of after-infection. Most of the tumour cases involve the anterior lobe first, and in their growth seem to meet least resistance at the floor of the sella. The dural diaphragm above appears to offer greater resistance than the bony floor. One of Stein's cases showed the two types of pathology: the adenoma appeared first, later the cyst. Cushing has found that cysts, even if exposed and evacuated, tend to refill with return of the pre-existing visual defects.

J. S. Fraser.

LARYNX.

Treatment of Malignant Disease of the Larynx.—Beck. "The Laryngoscope," March, 1918, p. 131.

Beck states that the reasons why surgery is so often defeated may be stated as follows:

(1) The patients present themselves too late for us to make an early diagnosis; (2) failure to make an early diagnosis when the patients do come in time; (3) timidity in operating extensively, especially in removal of the tributary glands; (4) implantation carcinoma along the field.

Cancer of the larynx is favourable for operation because an early diagnosis is usually possible. Hoarseness in an older individual (particularly in men) that does not disappear with or without treatment within two or three weeks should be looked upon with suspicion and carefully watched for cancer. Cancer of the larynx is usually found in the anterior portion of the cords, and from this region the lymphatic distribution is very small and secondary glandular involvement is a long time in developing. Removal of the larynx is an extensive and, to the patient, a depressing operation. Laryngectomy is also associated with considerable risk to the patient's life from complications such as shock, pneumonia and mediastinitis. In order to overcome some of these great objections to the complete removal, Beck has developed the technique of laryngeal fissure and removal of the neoplasm by means of the Percy coagulation method. Beck considers Percy's method superior to laryngectomy because (1) the patient will consent more readily to an operation when he may be promised that he may have a voice, even though it will not be normal; (2) he may even hope to have a normal breathing-tube and not have to wear a permanent tracheotomy tube; (3) the operation is less dangerous.

Carcinoma of Larynx.—Thirty-seven cases treated; thirty-four operated upon; twenty-six followed up to recent date. Of these five are still alive and apparently without any recurrence. The procedures were three laryngectomies (eight years, five years and three months since operation); one laryngeal fissure (five years since operation); one indirect laryngoscopy (now eleven and a-half years since operation). The remaining twenty-one cases are all dead. *J. S. Fraser.*

Syphilis of the Epiglottis.—Harmon Smith. "The Laryngoscope," March, 1918, p. 175.

CASE 1.—Female, aged thirty-six, denied any venereal trouble; difficulty in swallowing for six months; cough, slight temperature, loss of weight suggesting tuberculosis. The epiglottis was markedly thickened, but had not the characteristic œdematous appearance of tuberculous infiltration. The colour was an intense bluish-red. Wassermann test positive. One injection of salvarsan resulted in the complete dissolution of the epiglottic involvement.

CASE 2.—Female, aged twenty-eight, lost twenty pounds' weight in a year, with difficulty in swallowing, and cough, with blood-tinged expectoration. Examination revealed ulcerative destruction of the soft palate and a deep, ragged ulcer on the posterior pharyngeal wall. The epiglottis was partially destroyed by a large slough. Temperature 100° F. Wassermann positive. Salvarsan, followed by internal treatment, resulted in healing the ulcerative area and extrusion of the broken-down cartilage of the epiglottis. *J. S. Fraser.*

E.A.R.

An Attempt at Simplification of the Physiology of the Vestibular Labyrinth.—Isaac H. Jones. "The Laryngoscope," June, 1918, p. 473.

Perfect equilibration is accomplished through an harmonious co-operation of the eye, the muscle-sense, and the "balance-sense" of the ear. After loss of one of the senses responsible for equilibration com-

pensation may take place to a certain extent; the tabetic may be taught to avail himself of the visual-sense and of the balance-sense of the ear. The blind man is able to walk by the aid of a cane until deprived of the guidance of either the muscle-sense or the balance-sense of the ear. Deaf mutes, in whom the ear-sense is destroyed, are enabled to maintain their balance by means of sight and muscle-sense and develop inco-ordination only in the dark or in the water.

When the human being becomes a bird he suddenly finds himself in an entirely new environment. On what does the aviator rely in order to maintain his equilibrium? When he is sailing through the clouds or in the dark his eyes cannot give him the slightest information as to his position in space—not even whether he is “right side up.” The muscle-sense plays a part, but it is hardly conceivable that the weight of his body could determine his position in space merely by the sense of gravity. It is obvious that he relies primarily upon his vestibular labyrinth. It is easily conceivable that some of the unexplained accidents in aviating may be due to the decrease of the usual air pressure when at great heights. Prudence would suggest a most careful examination of the function of internal ears before taking up flying as an occupation. Every portion of the “balance apparatus” should be declared intact and normally functioning. If after the Bárány tests the candidate shows normal responses in nystagmus, past-pointing and falling, he is fit for the service; if he does not he is unfit. The standard for entrance in the Aviation Section of the Signal Corps of the United States Army has been approved, and is to constitute the requirement for admission into this service.

J. S. Fraser.

Contribution to the Study of the Physiology of the Eustachian Tube.—

C. Caldera. “Arch. Ital. di Otol.,” vol. xxix, No. 3, September, 1918.

Following up some experiments by Prof. Dionisio the writer attempted to determine whether the Eustachian tube is normally patent or not. The method he employed was to inflate the tube through a glass catheter by means of a continuous current of air. At the same time a bright light from an endoscopic bulb was held opposite the tubal orifice. The tympanic membrane was observed by a colleague. No light was seen to penetrate to the middle ear even on movements of swallowing, during which act the tube is believed by most otologists to open. In other cases in which air did undoubtedly enter the middle ear no light passed. Caldera accordingly gave up this method of research. He draws attention, however, to some facts which he has observed which may help to settle the question.

He found three subjects in whom there had been formed a cicatricial diaphragm or false tympanic membrane. In all three cases he noticed that the membrane moved alternately inwards and outwards with the movements of respiration. This would seem to demonstrate that in normal conditions the tube is open. Caldera thinks that the objection that the tubes in question were not normal can be ignored. He explains the condition by the fact that the membrane had not the support of the malleus nor of the middle strong fibrous layer of the tympanic membrane, and was therefore much more supple.

The writer maintains that the above facts confirm the contention of Hammerschlag and Lucae that the tube is normally open to currents of air during respiration.

J. K. Milne Dickie.

The Medical Profession and the Deaf.—Morgenstern. "The Laryngoscope," August, 1918, p. 612.

Morgenstern states that only two people out of a hundred who grow hard of hearing or deaf after school age take up the study of lip-reading. Many ear specialists tell their incurably deaf patients that they "ought to study lip-reading," but the advice is not emphatic enough. The average adult who has partially or wholly lost his hearing becomes morbid and indifferent to what is going on around him. The lip-reading deaf person, on the other hand, faces the world with an entirely different attitude. The word "lip-reading" is perhaps not the best name for the study. What it implies, however, is that the eyes have been trained to recognise rapidly the externally visible movement of the speech organs, which appear as an aggregate in word and sentence pictures; and that the mind has been trained to interpret these movements and to construct the word and sentence pictures into spoken language. The most important step is to make the student concentrate, think and listen. Many of the deaf find this irksome at first. *The partially deaf adult should begin the study of lip-reading before his defect in hearing has become noticeable.* The relief that the eyes give to the weakened ears, which suffer under the constant strain of listening, is too obvious to require special mention or explanation. Usually *from three to six months*—in exceptional cases a year—are required to develop skill. Morgenstern herself has travelled for three months alone in Europe, understanding several languages of the continent by sight, and enjoying the experience. Another lip-reader of her acquaintance holds a responsible position in a banking-house, and she knows of boys and girls who lip-read their way through high school or college, often at the head of the class. The adult deaf are now organising in many of the larger cities of the United States in order to assist one another, to provide social life, and to offer opportunities for studying lip-reading.

J. S. Fraser.

The Deaf: Their Education; Improvement of Conditions; Responsibilities and Participation of the Profession.—J. D. Wright. "The Laryngoscope," June, 1918, p. 497.

Education of the public has been so successful that the question of improving speech-teaching conditions by segregating the orally taught from those with whom finger-spelling and the sign language are used is now discussed in every state of the Union. Segregation is being prepared for in a number of states where it had never existed before. We want to plead for greater attention to the training of the pupils to use the powers of sound perception which they possess for the comprehension of language. One-third of the pupils possess sufficient power of perceiving sounds that lie within the range of the speaking voice to enable them to learn to comprehend language through the ear. These children are, however, too deaf to hear speech at ordinary conversational distances. The intensity with which the sound affects the hearing mechanism varies inversely as the square of the distance between that mechanism and the source of the sound. A child who cannot hear a word spoken a yard from his ear may be able to hear that word if it is spoken an inch from his ear, since his ear will then be affected 1296 times as powerfully. A child who is so deaf as to require words to be shouted an inch from his ear will never *spontaneously* learn to understand language or to speak, but he can be taught to do both. It is not a process of increasing the power of hearing, but of training the brain to interpret sounds into ideas.

It is only that the child's brain has now been educated to associate ideas with the sounds that he was just as capable of hearing at the beginning as at the end of the course of instruction. If the reader were suddenly transported to a country of whose language he was ignorant he would understand nothing of what was said to him, because his brain had never been educated to associate those sounds with ideas. If he hears the words and sentences often enough he will learn to understand. Deaf children who yet have some slight power of sound-perception never get a chance to develop this association of ideas with sounds, because they do not hear well enough. Their actual physical deafness is increased by what we might call a psychological deafness. This means of access through his ears is the line of least resistance—the line of inherited tendencies. When it is not open to us we must use the untrodden and unfamiliar road of the eye in comprehending spoken language. The superintendents and teachers must be made to believe it can be done and that it is desirable to do it. [Recently the abstractor advised the use of a hearing-tube in these cases at a deaf and dumb school. The head-master reports good results.—J. S. F.]

J. S. Fraser.

A New Ear Test for Malingering.—Frederick F. Teal. "The Laryngoscope," August, 1918, p. 615.

The person is blindfolded and told in a friendly manner that if he is really deaf there is no disposition on the examiner's part to overlook it. But he is also warned that if he tries to behave dishonestly he is sure to be "tripped up." Air-conduction is tested and of course is negative. The Weber test is then used, and usually (though reluctantly) he hears the fork in the deaf ear. Bone-conduction over the mastoid is next tested, and again he admits hearing the fork. He is then commended for his answers and assured that he has answered as he should.

The real test is now used. After saying you want to try the last test (bone-conduction) once more, a non-vibrating fork (or lead pencil, flat end) is placed over the mastoid to make him think he is being tested in the same manner, but *at the same time* a vibrating fork is brought close to the auricle with the other hand to test the air-conduction. If he is simulating deafness he will of course answer that he hears the fork (under the impression that he hears the sound through the bone), and the fact of a normal path of air-conduction is established. If he is really deaf he will, of course, not hear the vibrating fork.

J. S. Fraser.

Lateral Sinus Thrombosis: Three Cases.—D. H. Ballou. "The Laryngoscope," June, 1918, p. 464.

Ballou records three cases of lateral sinus thrombosis following chronic middle-ear suppuration. The thrombus was on the right side in all cases. The symptoms were characteristic, showing the usual triad: chills, intermittent fever and sweats. There was a marked flush of the right cheek only, *i. e.* the side of the lesion. Blood-cultures, eye grounds and lumbar puncture were negative in all cases. X-ray showed small sclerosed mastoid, sinus far forward, but no thrombus. Operation: In all cases the mastoid was sclerosed, but vascular. Pulsating pus under tension was present. The lateral sinus was superficial, very far forward, gangrenous, or covered with lymph and granulations. After the radical mastoid operation all diseased bone was removed until apparently healthy sinus was reached in both directions. Ballou holds that where the

thrombus can be removed and free bleeding obtained at both ends, the jugular vein need not be ligated. This was the treatment in two cases.

J. S. Fraser.

Radium in Diseases of the Ear.—**T. J. Harris.** "Annals of Otology," xxvii, p. 986.

The author is forced to conclude that radium, up to the present time, has failed to be of any considerable benefit in the treatment of diseases of the ear. In chronic deafness it is virtually a failure. In rare cases of intractable tinnitus and excessive vertigo it can be employed "with a reasonable hope of relief" by its power of destroying the labyrinth. In superficially seated malignant growths it is valuable, but of no use if they are deep. A further investigation, however, is advised by other observers in order that radium may be tried exhaustively. [Papers of this kind cannot be too widely promulgated, in order that patients may be warned against the many unscrupulous aural quacks who are making real or pretended use of radium.]

Macleod Yearsley.

MOUTH.

Macroglossia Lymphangioma with Report of Case.—**Sleight and Haughey.** "The Laryngoscope."

Sleight and Haughey give the case of a female, aged six. Teeth badly decayed and foul. No history of tuberculosis or syphilis. When six months of age the patient had the frænum linguæ clipped. Following this her family noticed that her tongue enlarged, and seemed to have a growth on it. This condition has been present ever since. *Examination:* The tongue protruded from the mouth about an inch, and could not be returned. The whole surface was covered with vesicles from the most minute to the size of a small pea. Many were of a purplish colour, appeared distended, and ruptured at the slightest provocation, filling the mouth with bloody serum. The parents said the tongue had been in similar condition a number of times, but always got better in about a week. The child was placed on ergot internally, with cold boracic packs to the tongue and cleansing of the mouth and teeth. After four days the tongue had returned to the mouth, was soft to the touch, and was nearly normal in size. The pathologist's report on a piece removed from the tongue was "macroglossia lymphangioma simplex cystica congenital." There was a new formation of connective tissue with lymph-spaces of irregular and racemose shape scattered all through.

Several of the recorded cases have been associated with congenital hygroma in the neck, or lymphangiectasis in the floor of the mouth. The analogy to elephantiasis still seems the most likely explanation.

Treatment.—Butlin recommended wedge-shaped incisions. Recurrence must be ascribed to insufficient removal. The line of incision should, if possible, run through healthy muscular substance.

J. S. Fraser.

BRONCHI AND ŒSOPHAGUS.

Band of a Gold Crown in the Bronchus.—**Chevalier Jackson and William H. Spencer.** "Dental Cosmos," October, 1918.

Case of a man with history of aspirating the band of a gold crown which had slipped from the hand of his dentist. Later in day had

severe attack of coughing and expectorated a small amount of blood. X ray showed foreign body in right main bronchus. Attempt made to remove it by oral bronchoscopy in sitting position. Foreign body slipped from forceps and fell into left bronchus. Operation lasted six hours. Great swelling of neck and tongue followed with rise of temperature to 101.8° F. Referred to Dr. Jackson.

State on admission: Tongue swollen, pharynx injected, intense laryngitis with exudate and granulation tissue. Expansion of left side of chest impaired. Percussion note impaired in upper right and lower left front. Breath-sounds blowing in right front and left axilla. X ray showed foreign body in bifurcation of lower branch of left bronchus. Evidence of consolidation of right lower lobe. Per-oral bronchoscopy under local anæsthesia. Copious exudate with some granulations in trachea. Band imbedded in left lower lobe bronchus. Removed in 1 min. 49 sec. No after-discomfort. Uneventful recovery.

J. K. Milne Dickie.

Copper Brad in the Left Inferior Bronchus.—McKinney. "The Laryngoscope," February, 1918, p. 89.

McKinney reports the case of a female, aged five, who, four weeks prior to her visit, had inspired into the trachea a copper brad from an old suit-case. For several days subsequently she had cough and some fever. A radiograph showed the brad just at the bifurcation of the trachea. Ether anæsthesia was used. The bronchoscope was passed to the carina and a short distance down both the right and left bronchi without revealing the brad. In the afternoon the temperature went to 101° F., and marked symptoms of acidosis set in with protracted vomiting. This condition was treated with a 5 per cent. soda solution, administered continuously by Murphy drip, and she was given soda-water to drink. In the second radiogram the brad was shown to be lodged in the left main bronchus. At a second attempt two weeks later, under chloroform, it was decided to guide the end of the tube and forceps fluoroscopically. The brad, however, slipped away, so after several failures attempts were given up. At the third sitting the brad was found covered with granulations. Using the Jackson long alligator forceps, McKinney successfully "kicked the brad over," caught it by its edge, and rapidly withdrawing tube, forceps and brad together, pulled the foreign body up into the trachea, where it became dislodged from the beak of the forceps but with a slight cough was expectorated. Recovery.

J. S. Fraser.

Foreign Bodies in the Bronchi and Cæso-phagus.—Ellen J. Patterson. "Pennsylvania Med. Journ.," April, 1918.

The writer reports twenty-two cases of foreign bodies in the bronchi or cæso-phagus. Some of the cases are of considerable interest. The principal point brought out in the paper is that in most cases anæsthesia, whether local or general, is not necessary, and can be dispensed with. In practised hands, also, the duration of the operation may last only some seconds, and no unpleasant after-effects are to be attributed to the absence of anæsthesia. On the contrary, the patient is spared the after-effects of what may be a lengthy narcosis. The patients in this series varied in age from twelve months to eighty-five years. In the only fatal case, a child of two and a-half years had inspired a bean thirty-six hours previously, and was admitted to hospital with deep cyanosis—temperature 102.8° F., pulse 200, respirations 70. Tracheotomy was performed, but

failed to relieve dyspnoea. No time for radiograph. The mucosa of the trachea was found to be so swollen that a 4 mm., bronchoscope could not be passed. Similar cases had been previously noted where the trachea and bronchi were very much swollen and the smaller bronchi completely occluded. This is fortunately rare.

J. K. Milne Dickie.

Report of a Case of Co-existent Carcinoma, Tuberculosis, and Syphilis of the Œsophagus.—L. W. Dean and J. B. Gregg (Iowa City). "Trans. Amer. Laryn., Rhin., and Otol. Soc.," 1917, University of Iowa Monographs, vol. i, No. 3.

The writers discuss carcinoma, syphilis and tuberculosis of the œsophagus, and their co-existence in this organ. They report a very unusual case. From their analysis of the literature of the subject it appears that the co-existence of tuberculosis and carcinoma is more frequent than supposed. The probable sequence of events appears to be the development of a primary carcinoma which becomes secondarily infected with tuberculosis in a phthisical patient. Two or three cases of co-existence of cancer, tuberculosis and syphilis of larynx have been noted.

The case reported by the writers is that of a man, aged sixty, with history of difficulty in swallowing, weakness and cough. Twenty-eight years before had had dysphagia, which began suddenly and ended suddenly five weeks later. For about four months had increasing difficulty in swallowing, frequent choking and coughing. No blood. Lot of slimy mucus. Had lost 50 lb. in weight. Examination of lungs showed tuberculosis of both apices. Throat showed copious mucus in lower pharynx and larynx. On swallowing fluids he coughed and choked. No fluid heard entering stomach. Radiogram showed S-shaped stricture of œsophagus. Stricture began at lower edge of cricoid. Œsophagoscope showed nodular mass $1\frac{1}{2}$ in. below cricoid. Piece removed. Report: Connective tissue and muscle invaded by numerous masses of epithelial cells of squamous type with cornified whorl-formation. Considerable round-celled inflammatory infiltration. Other bits of tissue contained distinct tubercles with giant-cells and caseation. Some tubercle bacilli found. Wassermann positive. Tubercle bacilli found in sputum.

Put on antiluetic treatment and improved markedly in a month. Microscopic examination demonstrated both carcinoma and tuberculosis. Positive Wassermann and improvement under treatment suggested syphilis.

J. K. Milne Dickie.

MISCELLANEOUS.

Tic Douloureux Treated by the Avulsion Method of Laplace.—Holbrook Curtis. "Laryngoscope," December, 1917, p. 891.

Curtis records the following case: Female, aged sixty-one, first suffered from pain in the supra-orbital branch of the trigeminus seven years ago. Later the intra-orbital branch became affected, but never the inferior maxillary. For days the patient had to go without food or drink because the contact of a tumbler or opening the mouth brought on a paroxysm of such frightful pain that she was absolutely unable to endure it. Curtis had therefore to introduce a small catheter through the nose and inject a pint of milk into the stomach. In May, 1915, alcoholic injections were made in the region of the Gasserian ganglion. These did no good, and a removal of the ganglion was contemplated. Curtis, how-

ever, placed the patient under the care of Laplace, whose method of operating he describes as follows: The supra-ciliary ridge and the superior maxillary region were cleansed and painted with iodine. A crescentic incision was made just below the border of the orbit, and the infra-orbital nerve was exposed at the exit from the infra-orbital foramen and freed, in order to allow a long-bladed hemostatic forceps to pick it up. After engaging the nerve and freeing it from the artery, the forceps was firmly held and rotated in the manner of a corkscrew from left to right. After one complete rotation, very slowly made, the minute branches of the nerve could be seen as a white filamentous tree on the upper lip and region of the alæ of the nose, the face being very congested from the anæsthetic. One or two minutes were allowed to elapse between every slow rotation of the forceps, and the nerve wound round the instrument from the central and distal extremities. About four and a half revolutions of the forceps were necessary before the nerve was wrapped on the forceps, freed in its entirety. Dr. Laplace then unwound the nerve under water in a glass dish, and laid it out on a dark background to be sure that every filament was intact. The evulsion of the superior orbital branch was carried out in the same manner. The incisions healed in a few days. Since the operation the patient has not had a twinge of pain in her face, and has gained 20 lb. in weight.

J. S. Fraser.

A Sociologic and Medical Study of 400 Cigar Workers in Philadelphia.

—**T. G. Miller** (Philadelphia). "Amer. Journ. Med. Sci.," February, 1918.

This paper includes a review of the literature and a detailed study of the employees in twenty-five of the larger cigar factories in Philadelphia, the investigation being undertaken at the instance of the Industrial Board of the Pennsylvania State Department of Labour and Industry, in order to decide whether or not children under sixteen years of age should be allowed to work in the banding and packing rooms of cigar factories. The literature upon the effects of working in tobacco favours the view that it predisposes the worker to pulmonary tuberculosis, gastro-intestinal disturbances, anæmia, genital abnormalities and nervous conditions. The author's investigations, however, lent no support to these contentions, although he did find some wearing of the teeth and some pharyngeal and conjunctival congestion, which he believed to be dependent on faulty personal and factory hygiene.

Thomas Guthrie.

Persistent Thymus in Exophthalmic Goitre.—**A. H. Tebbutt.** "Med. Journ. of Australia," November 23, 1918.

A woman, aged twenty-two, had right lobe of thyroid gland removed for relief of well-marked symptoms of Graves's disease. Twelve hours later she became cyanosed, and artificial respiration failed to restore her. Autopsy: Persistent thymus of unusual size. Tebbutt offers conjectures as to cause of death. Was it due—(1) to tracheo-stenosis from pressure, (2) hyperthyroidism, (3) status lymphaticus. He does not attempt to solve the problem.

A. J. Brady.