ABSTRACTS

EAR.

On the Pathology of the Malleo-Incudal Articulation. GEORGE KELEMEN. (*Archiv. für Ohren-, Nasen-, und Kehlkopfheilkunde*, Band cxxxiv., Heft 3-4, January 1930.)

From the investigations he has carried out Kelemen considers that, apart from its accepted resistance to disease, the malleo-incudal articulation must be accredited with a far-reaching individual pathology. Whilst it may remain intact in the presence of severe destruction in its vicinity, it may on another occasion show extensive disease in an otherwise normal ear.

Both phylogenetic and ontogenetic factors are observed in the presence of periarticular foci of disintegration.

The most resistant part of the joint is formed by the capsular band, which is able successfully to prevent the entry or the egress of pathological conditions. When it is finally destroyed it is possible to observe three well-limited stages:—

1. Swelling and collateral proliferative changes in the mass of connective-tissue, which extends outwards from the capsule and which is pyramidal on cross-section.
2. In suppurative cases there is round-celled infiltration beginning at the periphery.
3. Œdema of the central portion, which is the most resistant, and the individual fibre-bundles of which are the first to disintegrate.

The extreme pathological independence of this articulation should serve to remind us that the condition of the chain of auditory ossicles may serve to explain a seeming incongruity between the pathological-anatomical changes and the auditory perception in any one case.

Many excellent microphotographic illustrations accompany this article. J. B. HORGAN.

Subdural Abscesses in Middle-Ear Suppuration. E. HENS. (*Zeitschr. für Laryngologie, Rhinologie, etc.*, Band xix., January 1930.)

Isolated and circumscribed subdural abscesses are rare complications of suppurative otitis media. When a subdural abscess is found at a distance from the middle ear with a healthy tegmen and normal dura intervening, and no sign of sinus thrombosis, its origin is difficult to explain. In the author's case a large subdural abscess lying over the right cerebral hemisphere was found *post-mortem*, and there appeared to be no connection between it and the middle ear. An acute suppurative otitis had occurred seven months previously.

The author's explanation is as follows: The pus forces a passage upwards between dura and bone, stripping the dura away from the inner table irrespective of bone sutures. The Pacchionian bodies, however, represent a *locus minoris resistentiae*, as there is an intimate connection between the arachnoid and the dura at these points. Infection is liable to settle in a Pacchionian body, granulations penetrate into the subdural space, and slowly an abscess forms between the dura and the surface of the brain. The pus which lies between the dura and the inner table disappears; it flows into the new abscess or drains away via the middle ear. The dura comes to lie once more against the inner table, the tegmen tympani may heal over, and at the post-mortem it is difficult to see how the subdural abscess arose. J. A. KEEN.

NOSE AND ACCESSORY SINUSES.

Unpleasant Experiences attending Local Anæsthesia of the Nasal Septum by Injection. P. H. G. VAN GILSE. (*Acta Oto-Laryngologica*, Vol. xiii., Fasc. 4.)

Ever since anæsthetising solutions began to be used by the method of submucous injection, cases have occurred of sudden blindness or even death, nor has the substitution of novocaine for cocaine been followed by complete freedom from such disasters.

The author reports two illustrative cases. In the first, about fifteen minutes after the submucous injection of a novocaine-adrenalin solution for resection of a deviated septum, the patient became suddenly blind in both eyes, with dilated fixed pupils and marked pallor of the face and mucous membrane of the mouth and conjunctivae, but no loss of consciousness. Ophthalmoscopic examination showed the optic nerve papilla extremely pale. The vision began to return after a few minutes, but the retinal vessels did not regain their normal calibre for some hours.

In the second case there occurred about fifteen to thirty minutes after a similar injection, paralysis and cutaneous anæsthesia of the left arm and leg with loss of patellar and Achilles' tendon reflexes. Recovery began about fifteen minutes later and was complete on the following day.

The author believes that in each of these cases there occurred a localised vascular spasm affecting in the first case the retinal vessels, and, in the second, those of the region of the pons, and causing temporary damage to the parts affected. He thinks moreover that the spasm was due to the adrenalin, and that in some of the reported cases of sudden death or permanent blindness following the injection of solutions for local anæsthesia containing adrenalin, the spasm of

the vessels supplying the retina or some vital region, like the medulla, may have been sufficiently prolonged to cause irreparable damage.

He urges therefore that the dose of adrenalin, for submucous injection with the anæsthetising solution, be kept as small as possible, or other drugs, such as ephetonin, be used instead.

[No reason is given for the use of submucous injection for septum operations, in preference to the perfectly adequate and safe surface application of cocaine-adrenalin paste.] THOMAS GUTHRIE.

LARYNX.

The Causes, Course and Treatment of Acute Stenosis of the Larynx PAUL FROHN. (*Münch. Med. Wochenschrift*, Nr. 5, Jahr. 77, S. 177.)

The writer fully reviews the pathological anatomy and ætiology of this condition without adding anything new. He describes in detail cases illustrative of the various types of acute stenosis which he has observed. In common with other observers he concludes that the prognosis *quoad vitam* is always very serious and that a conservative treatment should only be carried out in the presence of all the immediate facilities for carrying out tracheotomy. J. B. HORGAN.

A New and Essential Point in the Blocking of the Internal Laryngeal Nerve. LAWRENCE SCHLENEER, St Louis. (*Journ. Amer. Med. Assoc.*, Vol. xciii., No. 24, 14th December 1929.)

In many cases of tuberculous and malignant disease pain cannot be controlled by drugs alone, and successful nerve blocking confers relief for several weeks and often permanently. The author uses 15 minims of the following solution: Cocaine hydrochloride, 1 grain; phenol, 1 minim; water, 20 minims; and alcohol, 80 minims. The patient is placed in a recumbent position with the head moderately extended. The needle is removed from the syringe and firmly pushed into the middle of the thyrohyoid space in a downward and backward direction, towards the superior cornu of the thyroid cartilage. At first some resistance is noted, then the needle drops into a space and is gently pushed deeper until the further resistance of the thyrohyoid membrane is met. The syringe is now attached to the needle. The membrane is transfixed and the solution is injected in the exact plane of tissue in which the nerve lies.

Three days should elapse before blocking the other side for fear of inflammatory œdema. ANGUS A. CAMPBELL.

Tonsil and Pharynx

Biopsy in Cancer of the Larynx. GEORGES CAUNUYT. (*L'Oto-rhino-laryngologie internationale*, 1930.)

Clinical diagnosis in tumour of the larynx can at best be presumptive, and in all cases of infiltration, ulceration, or suspected cases of tumour of the larynx, a portion should be removed for microscopic examination, and this should be done by direct or indirect laryngoscopy.

In the event of one examination being negative, repeated examinations should be made.

A piece for examination may be removed by thyrotomy, but this should be reserved for exceptional cases only.

E. J. GILROY GLASS.

TONSIL AND PHARYNX.

Neurotic Trismus as a Sequel to Peritonsillar Abscess. LEO FORSCHNER. (*Münch. Med. Wochenschrift*, Nr. 48, Jahr. 76, S. 2012.)

The writer records the case of a woman, aged 42, in which trismus persisted for weeks after all the other symptoms of quinsy had disappeared. It was found that the trismus disappeared under, and for a short while after, a general anæsthetic, but it was necessary to resort to psycho-therapy before the symptom could be finally and completely removed.

J. B. HORGAN.

Gas Bacillus Infection following Tonsillectomy. G. A. SMITH, Montgomery, W. Va. (*Journ. Amer. Med. Assoc.*, Vol. xciii., No. 24, 14th December 1929.)

The case reported is that of a healthy woman, aged 31, with a history of recurrent tonsillitis. Tonsillectomy under general anæsthetic was performed without difficulty. Thirty-six hours after the operation headache developed with pain in the left eye, chills, and temperature 103° F. The left side of the face and neck swelled from the malar bone to the clavicle. The swelling was very tender and crepitation was present. Six days after the operation the swelling was freely incised, a large amount of gas and foul pus escaped, the whole area on the side of the neck and face was undermined. From cultures and animal experimentation the laboratory diagnosis was *Bacillus Welchii*. Blood transfusion and intravenous saline were of no avail, and the patient died on the twelfth day. Post-mortem showed a pericardial effusion and purulent bronchitis.

ANGUS A. CAMPBELL.