

and if this occurred the vessel below would be collapsed. He also stated that although he had several times opened the sinus inadvertently, it had been more frequently done with a probe than a spoon. He had dissected the jugular down to the innominate, and found clot extended into that.

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## Abstracts.

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### NOSE AND NASO-PHARYNX.

**Boulai.**—*Two Cases of Imperforate Right Nostril.* "Archiv. Internat. de Laryngologie," November-December, 1901.

The author has noted, within several weeks of one another, two cases of complete obstruction, or, rather, of imperforate right nares. He has been unable to find similar cases recorded, and he has never seen any case approaching those described.

A further peculiarity lies in the fact that both cases were almost exactly alike. Both occurred in young girls of the same age—viz., fourteen years—in both the same nostril was the seat of obstruction (the right), and the cause of the obstruction was identical in each case.

*Macleod Yearsley.*

**Lichtwitz.**—*Enlargement of the Root of the Nose caused by Nasal Polypi.* "Archiv. Internat. de Laryngologie," etc., November-December, 1901.

The title of the contribution sufficiently explains its nature. Such cases are undoubtedly rare in innocent tumours.

*Macleod Yearsley.*

**Pelaez, P. L.** (Granada).—*Present State of Rhinology as regards Ozæna.* "Revista de Especialidades Medicas," Madrid, July, 1901.

The author contributes a useful review of the work recently done, chiefly on the Continent, in the investigation of the causes of ozæna, but does not offer any solution of the question himself. He disputes the bacillary theory of Löwenberg, Abel, Cozzolino, and others, and considers that it falls to the ground, or at any rate loses much of its value, in view of the fact that, notwithstanding its "copious flora," ozæna has not been reproduced either by inoculations with cultures of the organisms discovered, or with the more or less decomposed secretions themselves. An account of the more recent methods of treatment is given, but the author admits that no specific has yet been found.

*James Donelan.*

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### LARYNX AND TRACHEA.

**Harvey, F. G.**—*Six Cases of Excision of the Larynx.* "Lancet," September 21, 1901.

As the recorded cases of complete excision of the larynx are comparatively few, and the details of the method have not been fully described, the author thinks it may be of interest to publish these cases.

The operation may be performed by separating the trachea and cricoid cartilage from the œsophagus, commencing from above and working downwards, or commencing from below and working upwards. He describes the latter method. He assumes the proper preparation of the patient for a long and serious operation, strict antiseptic precautions, and the proper warming and ventilation of the operating-room, with as little exposure of the body as possible.

The first step, after administering chloroform to the patient, is to make a vertical incision extending from the hyoid bone to a point as low as the fourth or fifth ring of the trachea. A transverse cut should be made along the whole length of the under surface of the hyoid bone through skin and fascia, dividing the anterior jugular veins, which must be tied. The sterno-hyoid, the omo-hyoid, and the thyro-hyoid muscles are divided at their insertion into the hyoid close to the bone, and the flaps thus formed are reflected downwards and outwards to either side. The thyroid isthmus should then be divided between two ligatures, and the lobes of the thyroid separated from the trachea. When the trachea is completely bared it may be divided from before backwards, and the lower portion separated from its attachments to the œsophagus and stitched to the skin. A Hahn's cannula will now be introduced, all bleeding will be arrested, and the parts immediately around the lower portion of the severed trachea will be packed with gauze. It will be found necessary to remove the Hahn's cannula from time to time, and to clear the trachea of any blood which may have found its way into it. The patient at this point must not be deeply under the influence of the chloroform, as we shall then have warning of any blood trickling into the lungs by his coughing; if this occurs it will be well to sponge out the trachea by introducing for some distance a swab or sponge on a holder. The next step will be to dissect off the upper portion of the trachea from the œsophagus and the muscles from the lateral surface of the cricoid. The inferior cornu of the thyroid is next bared by detaching and reflecting the crico-thyroid and inferior constrictor muscles. The muscles and perichondrium in front of the thyroid will now be separated and reflected as far back as the superior cornu, the latter will next be freed by dividing the periosteum on its surface, and pushing it, along with the lateral wall of the pharynx and the loose areolar tissue, backwards until the posterior lateral border of the cricoid is reached. The outer two-thirds of the lateral portion of the thyro-hyoid membrane, which is attached to the superior border of the thyroid cartilage, will then be divided transversely and cautiously at the point of junction of the upper and middle thirds; and when the adjacent mucous membrane is reached this must be picked up with forceps and divided, whereby the upper portion of the epiglottis can be seized and drawn forwards. The anterior wall of the pharynx is thus opened, and by pulling the epiglottis strongly forward, and with it the whole larynx, the knife can be placed on the posterior surface of the cricoid, and by cutting downwards the anterior wall of the œsophagus will be opened. Care must be taken at this point to limit the cut to the parts which are covered in front by the posterior surface of the cricoid; if this is not done the lateral wall of the pharynx and the œsophagus will be unnecessarily encroached upon, and too much of their anterior walls will be removed, thus rendering it difficult to approximate their edges. The whole larynx is thus completely detached, and the defect in the pharyngeal mucous membrane must now be made good by inserting sutures quite close to the cut edges,

and so preventing in-turning of the epithelial surfaces. The sewing up must be water-tight, with fine catgut sutures, so as to form a Y-shaped stitched line; then a row of Lembert's sutures must be added, transfixing the muscular and cellular coats of the œsophagus and pharynx. The third layer unites the stumps of the pharyngeal constrictors, and the fourth layer brings together the divided sterno-hyoid and thyro-hyoid muscles. Finally, the T-shaped skin incision will be united, leaving only a three-cornered cavity above, which may be packed with iodoform gauze; thus, only the above cavity and the tracheotomy will remain unclosed. The Hahn's cannula may be removed in twenty-four hours. Nutriment will be administered by the rectum for from twenty-four to forty-eight hours, after which milk may be given by the mouth. Rötter suggests that the trachea should be divided from behind forwards, but the author considers it is far more easy, expeditious, and safe to divide it as he has described. Attention is drawn to the importance of keeping blood out of the lungs, the whole success turning on this point and the accurate suturing of the pharynx and œsophagus. Of the six cases noted, three were treated by this method. Of the remaining three, one was treated by the older method with a preliminary tracheotomy and stitching the pharynx to the skin; the second can hardly be classed as an excision, inasmuch as the whole of the larynx, when the soft parts covering it were reflected, was capable of being lifted off.

Details are then given of six cases. The first (epithelioma) has remained well for six years. The second survived some weeks. The third case died unexpectedly a few days after operation (no autopsy). The fourth was only a partial removal, and the patient survived five months. The fifth case died from acute pneumonia twelve months after operation, with no sign of any recurrence of the disease. The sixth presented an enlarged gland six months after operation. This was removed, and his health at date of publication appeared quite satisfactory.

*St Clair Thomson.*

**Nardi, Jacopo** (Naples).—*Myxoma of the Right Vocal Cord*. "Bolletino delle Malattie dell' Orecchio," etc., Florence, November, 1901.

The author gives a résumé of the principal cases in the literature, and describes the case of a man, aged thirty-one, in the private practice of Professor Massei.

For two years the patient had noticed a gradually increasing hoarseness, and at length became almost aphonic. Three months before he was seen he contracted syphilis. The tumour, about the size of a grape-seed, had a broad base, was smooth and rose-coloured, and on phonation showed a species of fluctuation. It was removed under cocaine by König's forceps. Microscopically there was a corneous layer distinctly marked off from the underlying tissue. There was no *membrana limitans*. The stroma consisted of a finely reticulated tissue with scattered fusiform cells, as well as some round and stellate ones.

The author considers that, if not very rare, myxomata of the larynx are certainly not very common—at least *true myxomata*. He gives at some length the microscopic appearances which distinguish these from mucous polypi, which correspond to a type of œdematous fibroma infiltrated with mucin, as well as from cysts. Certain diagnosis can be made only with the microscope.

*James Donelan.*