adeno-chondroma, probably of the parotid. In the second case the tumour nearly filled the mouth ; was hard, nodular, and covered with mucous membrane ; it was easily removed, proving to be two and a half inches in diameter, and of the same nature as the former. *StGeorge Reid.*

Spire.—*Lupus of the Tongue.* "Archiv. Clin. de Bordeaux," Dec., 1895.

A CAREFUL study of the recorded cases of lupus of the tongue with details of three new cases—fourteen in all. It is never an isolated lesion, being most generally associated with lupus of the face. The lesions generally occupy the posterior portion of the base of the tongue. The condition is always a mammillated plaque, raised and of a greyish red colour, hard and indolent. There are not three different clinical types, there being only the different stages of evolution of one type—the lupoid plaque. Lingual lupus has little tendency to ulcerate, and when this occurs it is only in cases where treatment has been long neglected. Enlarged glands are not constant and not diagnostic. The tubercular nodule is the first stage ; conglomeration of these produces the lupoid plaque ; left to itself it increases, ulcerates, and cicatrises spontaneously, only rarely invading and destroying the organ. Very simple treatment is usually sufficient to arrest the progress. Carbolized glycerine, salicylic paste, are good applications. Curettage with Volkmann's spoon may cause dangerous hæmorrhage. Galvano-cautery is good for large nodules, but seldom necessary. The author prefers ignipuncture as generally very satisfactory. Tuberculine injections have been disastrous.

R. Norris Wolfenden.

Woakes, E.—*A New Tongue Depressor.* "Brit. Med. Journ.," Feb. 29, 1896.

THE instrument, somewhat similar in form to Fraenkel's, terminates in a blade, which is provided with a central obliquely-grooved midrib, bounded by two large fenestræ. The former, when the blade is applied far back on the tongue, sinks into the central râfle, and gives a firm grip on the organ, so that forward traction is possible at the same time as depression, and the sensation of choking is avoided.

Ernest Waggett.

Woodbury.—*A Case of Urticaria Œdematosa, with involvement of the Air Passages.* "The Philadelphia Polyclinic," Feb. 15, 1896.

THE case of a boy who, after being stung by a hornet, had a sharp attack of urticaria, accompanied by great swelling of the face and lips, with œdema of the turbinate bone, laryngeal cough, with difficulty of articulation and swelling of the velum and fauces. The breathing was a little distressed for a short time, but the boy made a rapid recovery, convalescence being accompanied by copious nasal discharge. *StGeorge Reid.*

NOSE AND NASO-PHARYNX, &c.

Bark, J.—*Rhinoliths.* "Liverpool Med. Chirurg. Journ.," Jan., 1896.

SOME general remarks on rhinoliths, with notes of a case in which nucleus consisted of a small piece of slate-pencil. *Middlemass Hunt.*

Boulay.—*Causes of Nasal Obstruction in Children.* "Revue Mens. des Mal. de l'Enfance," Mar., 1896.

ADENOID vegetations are the principal factors of nasal obstruction in children, but they are not the only cause. One finds in early life other causes of blocking, especially

hypertrophy of mucous membrane of the turbinated bodies, foreign bodies, and malformation of the septum. Some cases of these diseases are given.

A. Cartaz.

Brimon.—*Nasal Chancre.* "Thèse de Lyon," 1895.

A GOOD pamphlet on chancre of the nasal fossæ. The author has collected thirty recorded observations. The ulcer, which is generally situated on the floor of the nasal fossa, is frequently unnoticed, and the diagnosis is sometimes difficult from tertiary lesions of that region and gummatous tumours. The course does not differ from the ordinary. Sometimes trivial infections occur through the pathogenic nasal microbes. *A. Cartaz.*

Coulter, J. Homer.—*Purulent Rhinitis of Children.* "Chicago Med. Recorder," Mar., 1896.

MANY of the standard authors do not so much as mention the occurrence of purulent rhinitis in children, while others give it only a passing notice. Its recognition and treatment are of importance, as it most frequently ends in ozæna. Its etiology is not well established; it is attributed to uncleanliness, syphilitic, tubercular, or scrofulous diathesis, and leucorrhœa in the mother. The voice is frequently affected. Pharyngitis, tonsillitis, and bronchitis are usual concomitants. Swallowing such a large amount of septic material has a serious effect on the digestive apparatus and general health of the patient. For treatment the author favours the thorough use of an alkaline spray, followed by one containing eucalyptol and thymol.

Oscar Dodd.

Du Fougeray, Hamon.—*A Case of Acute Primary Infantile Purulent Staphylococcal Rhinitis cured by the Use of Menthol Oil of Ten per Cent.* "Ann. des Mal. de l'Oreille," Dec., 1895.

CASES of purulent rhinitis fall under two heads: 1, those occurring immediately after birth; 2, those occurring at a later period. The author enquires if the purulent rhinitis of the new-born infant is always blennorrhagic, and if at a later age the child is always the victim of gonococcal contamination. He relates the case of a child, thirteen months old, in which bacteriological examination showed the purulent rhinitis to be due to staphylococcus albus et aureus, and in which the gonococcus was absent.

He insists on vomiting as an important symptom. It occurs at each attempt to swallow liquid. He extols ten per cent. menthol oil for its prompt action and simplicity of application. *R. Norris Wolfenden.*

Moure, E. J.—*Du Catarrhe Naso-pharyngien.* "Archiv. Clin. de Bordeaux."

THIS is a careful study of chronic catarrh of the naso-pharynx. Only a few points need be noted. This disease is very common among infants, and at that age deserves more attention than it generally receives. Infection has not been proved, and may be disregarded. Occipital headache is a symptom of importance. There may be granulations, the mucous membrane may be dull red to very pale, and may be slightly eroded in places; but ulceration at once excludes the diagnosis of simple naso-pharyngeal catarrh. Beverley-Robinson's theory, that the alterations of voice that occur are due to chronic inflammatory changes in the pneumo-gastric nerve, is, for various reasons, untenable.

Treatment is best carried out by cleansing with alkaline solutions applied by a post-nasal spray; followed by Dobell's solution, or some astringent powder This can be done by the patient once or twice daily. Further, the parts should be painted with iodized or slightly caustic solutions, such as nitrate of silver 1·5, or

zinc chloride 1·30 to 1·15. Prominent follicles, or the remains of adenoids, etc., must be scraped out. Lastly, hydropathic treatment (sulphurous waters, the waters of Salies-de-Béarn, arsenical waters, living by the seaside, etc.) may be usefully employed.

Of course any complications must be treated. *A. J. Hutchison.*

Myles, Robert C.—*Diagnosis of the Diseases of the Accessory Sinuses and their Treatment.* "New York Polyclinic," Feb. and March, 1895.

AFTER giving a short description of the anatomy and physiology of these parts, the author proceeds to consider diagnosis and treatment of their diseases, and concludes with a report of twenty-four cases treated. In diagnosis much stress is laid on transillumination; in treatment the curette is freely used. A few of his cases were cured by simple irrigation through the natural openings, after removal of polypi, cauterization of hypertrophied tissues, etc. In other cases the cavities had to be opened and curetted. The frontal sinus was opened and curetted in several through the infundibulum and anterior ethmoidal cells, in others from in front. The antrum was opened through the alveolus, or above the alveolus, or per canine fossa, or intranasally after sawing and cutting away the anterior end of the inferior turbinated body. Needles or trocars introduced through the wall of inferior meatus did not prove satisfactory. Ethmoidal and sphenoidal disease were treated, after removing most of the middle turbinated body, by carefully opening the floors of the cells with fine drills or trephines, then using curettes and strong applications on cotton wool—besides, as in all cases, the use of irrigation.

A. J. Hutchison.

Ortega, S.—*Empyema of Frontal Sinus.* "Thèse de Paris," 1895.

THE author distinguishes two forms of frontal sinusitis: acute, with cephalalgia, fever, distension of orbital wall, fœtid and purulent nasal discharge, unilateral abscess of the orbito-nasal angle, fistula, etc.; the other, chronic, latent, characterized only by the unilaterial discharge of the nose. Description of the symptoms, complications, diagnosis. He believes that surgical intervention is necessary early by the trepanation of the frontal, curettage, and fronto-nasal drainage.

A. Cartaz.

Permewan, W.—*The Naso-Pharynx in Relation to Voice.* "Liverpool Med. Chirurg. Journ.," Jan., 1896.

AFTER referring to the importance of the naso-pharynx as a resonating cavity, the author points out how hypertrophy of the pharyngeal tonsil in adults may interfere directly with resonance, or may cause a reflex paresis of the larynx. He gives two examples of the latter occurring in young women, and remarks that "the same condition of nervous instability which underlies true hysteria" is probably present in such cases. He believes reflex disturbances from the naso-pharynx to be very rare.

Middlemass Hunt.

Ranglaret.—*Anatomy and Pathology of the Ethmoidal Sinus.* "Thèse de Paris," 1896.

A VERY interesting study of ethmoidal sinusitis. In an elaborate and perfectly clear anatomic demonstration the conformation and disposition of ethmoidal cells are described. They form three groups: two anterior, one dependant from the infundibulum, another from the ethmoidalis bulla; the third, posterior, constituted by larger cells, opening in the superior meatus. The description is similar, with exception of some details, to that of Zuckerkandl. Clinically, the ethmoidal sinusitis is acute or chronic, and in the latter form purulent or latent. The

diagnosis is sometimes difficult from the other sinusitis, the more so as they are frequently connected—anterior ethmoiditis with frontal, posterior with sphenoidal. The author believes that lavage and medical treatment are insufficient; he advises surgical intervention and curettage, viâ the nares, or preferably through the orbit. *A. Cartaz.*

Ripault.—*A Case of Rhinolith.* "Annales des Mal. de l'Oreille," Dec., 1895.

THE rhinolith contained as a nucleus a cherry stone, which had been introduced into the right nostril several years before. The patient was a girl, aged eight. *R. Norris Wolfenden.*

Ripault.—*A Case of Confluent Papillomata of the Nasal Fossæ.* "Annales des Mal. de l'Oreille," etc., Nov., 1895.

IN a man of thirty-six the right nostril was obstructed by a solid, grey-red tumour, bleeding easily, and composed of a number of isolated lobes, of which the greatest number were situated on the septum, some on the floor, and others on the internal skin of the nasal ala. It was removed with the cutting curette. Histologically it proved to be a papilloma. *R. Norris Wolfenden.*

Ripault.—*Three Cases of Empyema of the Frontal Sinus.* "Annales des Mal. de l'Oreille," etc., Nov., 1895.

THREE cases are recorded in detail. In each the sinusitis was on the right side, which accords with the experience of others. Whenever there is purulent discharge of the right nostril, migraine, right-sided facial neuralgia, without apparent cause, frontal sinusitis should be thought of.

Vertigos and epileptiform crises accompany certain sinusites, and disappear after treatment. Energetic pressure over the sinus, especially its lower part, evokes pain, or marked sensitiveness in all cases. Transillumination has not been of any service to the author. Pus may be found in the middle meatus anteriorly, though the author has not seen it on posterior rhinoscopy.

As the sinus extends frequently to the external angle of the orbit, fistulæ may open at any part of it, and there may be slight and painless œdema of the upper eyelid, which, coinciding with neuralgia, indicates sinusitis. These signs are of more importance when they affect the right side than when they are on the left. When a suspicious orbital phlegmon has been opened, and the bone is found to be denuded, but without fistula, exploratory trephining of the sinus ought to be performed.

Wherever there is an orbital collection it ought to be largely opened and drained, but we ought to beware of injections, which easily diffuse the infectious elements into the loose tissue of the back of the orbit.

Incision ought to be made by preference over the anterior wall, immediately over the frontal prominence, and the opening ought to be large, so as to expose the whole sinus. Curettage ought to be thorough, and destroy the fibro-mucosa, as well as the vegetations, and the orifice of the naso-frontal canal and its course should not be overlooked. Chloride of zinc is preferred for swabbings. A long drain should be introduced through the naso-frontal canal into the nasal fossæ, as large as possible. Drainage of the sinus is indispensable for cure. A stylet should traverse the drain. Irrigations should be made with boiled water or dilute sublimate, and salol gauze is preferred. The first dressing should not be removed for several days, when irrigation with boiled water or boracic acid should be performed. This should be repeated two or three days after, and at the end of fifteen days, if there is no further suppuration, the drainage tube may be removed. If suppuration persists, irrigations should be made daily. At the end

of a few weeks, if suppuration is not arrested or notably diminished, it is preferable to advise the patient to undergo a second operation, rather than submit him to irrigations for several months with uncertain results. *R. Norris Wolfenden.*

Vansant.—*Operation for Synechia of the Nasal Fossæ.* "The Philadelphia Polyclinic," Jan. 25, 1896.

RECOMMENDS the excision of the whole of the cicatrix. The cicatricial band is seized with a pair of strong clamp forceps, and crushed, the attachments being then severed with the knife or scissors; the raw surface is then touched with trichlor-acetic acid, and a solution of cocaine prescribed. In some cases a diaphragm of ivory or celluloid is inserted. *StGeorge Reid.*

LARYNX. TRACHEA, &c.

Angelesco.—*Epithelioma of the Epiglottis.* Soc. Anat., Paris, Dec. 20, 1895.

A WOMAN, aged sixty-three years, was admitted into hospital for some difficulty of respiration and deglutition, and with bronchitis. There was a tumour of the epiglottis the size of a nut, irregular, dense, and without glandular infection. Extirpation by subhyoidean laryngotomy, after preliminary tracheotomy. Death on the twelfth day from broncho-pneumonia and pulmonary gangrene. The tumour was an epithelioma. A small cretaceous mass in the trachea, at the bronchial division, was also seen. *A. Cartaz.*

Bunch, J. L.—*A Case of Bilateral Paralysis of the Abductors of the Vocal Cords, due to Syphilis.* "Lancet," Feb. 29, 1896.

SHORT review of the subject, with some bibliography, and account of a case where a final acute attack necessitating tracheotomy had been preceded by three others during the previous eight months, from all of which the patient recovered without surgical interference. He had no symptoms during the intervals. The signs of secondary syphilis were obvious on admission to hospital. It is probable that some cases recorded as spasm of the glottis were really cases of abductor paralysis. *StClair Thomson.*

Cheyne, W. Watson.—*The Objects and Limits of Operation for Cancer.* "The Medical Society's Transactions," Vol. XIX., 1896. "Lancet," Feb. 22, and Mar. 14, 1896. And the Lettsomian Lectures.

As compared with the breast, cancer in the mouth and throat is more favourable as regards the glandular deposits, for the glandular area is more exposed to view and metastatic deposits are quite infrequent. With regard to cancer in the tongue, if the disease is superficially and laterally placed, it is sufficient to remove half the organ. When the tongue is deeply infiltrated it should be removed in its entirety, together with the large lymphatic plexus, which is not unilateral, so that enlarged glands are frequently found on both sides. In all cases it is well to take away the sublingual and submaxillary glands on the affected side, along with the lymphatic glands so closely connected with them. Hence in the cases of superficial cancer he ties the lingual artery in the neck and clears out these glands and the fat, even although no glands can be felt, and then clips out the tongue from the mouth. In these cases the wound in the neck does not communicate with the mouth and remains aseptic. In the deeper form of tongue cancer Kocher's operation is advised. The limits of the operation for cure are: very extensive infiltration of the tongue muscles, especially downwards towards the hyoid bone