Sondermann (Dieringhausen).—*Suction Treatment in Diseases of the Nose.* "Münch. med. Woch.," November 6, 1906.

In answer to criticisms the writer urges the necessity for confining the treatment to suitable cases, eliminating in the first instance those about whose operative treatment doubt may remain, whether it be as to caries or necrosis, new growths, abnormal distension of the cavities, threatening symptoms from extension to neighbouring organs, and so forth. In those cases which do not come under this category it is necessary to draw a wide distinction between the acute and the chronic, the former being those essentially adapted for the suction treatment, the latter much more doubtful. If the suction causes increase of pain rather than relief, it should be stopped. Failure sometimes follows from its not being practised often enough. It may even be necessary for a time to use it every hour. In ozæna it ought to be used with great frequency. For hospital treatment where the same instrument has to be used for many patients, the writer has devised an olive-shaped tip for the nose instead of the "mask," with a view to greater ease in disinfection. For the extraction of fluids from the accessory cavities the head has to be turned in the position indicated by anatomy as being most favourable.

Dundas Grant.

LARYNX.

Wichern, H., and **Loening, F.** (Leipzig).—*Displacement of the Larynx and Trachea in Various Diseases of the Thoracic Organs.* "Münch. med. Woch.," October 16, 1906.

An oblique displacement of these parts may be detected by inspection under good illumination and by palpation. It may be brought about by pressure or by traction, and has been observed accordingly in such diseases as aneurysm, sarcoma, pleurisy, pneumo-thorax, and pulmonary tuberculosis.

Dundas Grant.

THYROID AND TRACHEA.

Diriart and **Rozler.** — *Paralysis of the Recurrent Nerve from Thyroid Compression; Thyroidectomy; Cure.* "Annales des Mal. de l'Oreille du Nez, du Larynx, et du Pharynx," September, 1906.

A woman, aged forty, of delicate constitution, suddenly became aphonic, and shortly afterwards experienced several suffocative attacks. Dr. Diriart found a thyroid tumour occupying the left side of the neck; its upper limit extended to the middle of the anterior border of the sterno-mastoid and its lower pole dipped into the pre-sternal notch. The swelling was mobile, not painful on pressure, and there were no glandular enlargements or accessory growths. A laryngoscopic examination revealed the larynx displaced to the right. The left cord, which was flaccid with concave margin and apparently shortened, occupied the cadaveric position; the right, which was normal, passed over the middle during phonation. A diagnosis of recurrent paralysis from thyroid compression was made and operation advised. The left half of the thyroid, including the growth, was excised in the usual way. Nothing unusual was noted save that a process of the growth extended into the tracheo-œsophageal groove.

The tumour removed was almost the size of the fist, in shape ovoid, pyriform, and elongated from above downwards. An uninterrupted recovery followed, and the left cord completely regained its function. In this case the writers think they had to deal with a thyroid tumour, probably sarcomatous in nature, which developed suddenly, invading the tracheo-œsophageal groove and compressing the nerve, a condition more easily brought about on the left side owing to the nerve not being so well protected by the trachea on that side as on the right.

The authors remark on the rarity of cure in recurrent paralysis by operation, and attribute success in this particular instance to early surgical intervention. *H. Clayton Fox.*

Jaboulay, M.—*A Tracheotomy Cannula fallen into the Right Bronchus.* "Annales des Mal., de l'Oreille, du Larynx, du Nez, et du Pharynx," November, 1906.

A man, aged fifty-nine, had worn a tracheotomy tube for syphilitic stenosis four years, during which time cleansing of the outer portion had been neglected, the result being that it became rusty and worn, broke off close to its flange, and fell into the air-passage. At the time of the accident little distress was experienced, only a little tickling felt, with a transient fit of coughing. There was no dyspnœa. On the following day the patient entered hospital with moderate dyspnœa, temperature 39° C. On auscultation of the chest only feeble breath sounds were audible over the whole of the right lung, the breath sounds over the left were normal; from these findings and the history of the case a diagnosis of a foreign body in the right bronchus was made, which a skiagram subsequently verified. A dark body coinciding in shape with that of the lost cannula lay obliquely across the inner end of the second intercostal space and adjacent portion of the third rib, its upper extremity being close to the right border of the sternum (15 cm. below the infra-clavicular notch) and its lower a finger's breadth outside it. Bronchoscopy instruments not being to hand and the man's condition becoming grave, temperature continually rising, with abundant frothy expectoration continually issuing from the tracheal wound, direct extraction through the latter was tried, but all efforts to locate the tube, both by probing and forceps, were futile. It was then resolved to make a thoracic exploratory incision, not for the purpose of intra-thoracic bronchotomy, but for pressing back the foreign body on to the tracheal forceps in front. An L-shaped incision was made over the inner end of the second and third intercostal spaces, a portion of the third rib resected, and the parietal pleura opened. Pneumothorax immediately followed, with frequent and laborious respiration; the hand was inserted but nothing but the normal outline of the cartilaginous rings was noted. On withdrawal of the hand grave dyspnœa set in; the pleural wound was then rapidly closed. The attempt to mobilise the cannula was a failure. The patient recovered from the shock of the operation and the physical signs of pneumothorax rapidly cleared up, but the temperature continued; during the first two or three succeeding days the evening exacerbations exceeded 40° C. Eight days after the trials at extraction, although the temperature had declined to between 38° C. and 39° C., the pulse was 100, the patient experienced oppression at night, and expectoration was always abundant and frothy.

Bronchoscopy was finally resorted to by M. Garel, with the result that the cannula was removed through a Killian's tube on the first attempt.

H. Clayton Fox.