Kayser succeeded in reproducing the trumpet note in an excised larynx by pressing the epiglottis downwards and backwards upon the entrance of the larynx, while he blew vigorously from below with a bellows tied in the trachea. The edges of the epiglottis and the ary-epiglottic folds were thrown into vibration.

This was clearly a case of nervous cough, the irritation starting from the hyperæsthetic spot in the lingual tonsil. The depression of the epiglottis was an abnormal associated movement resulting from overflow of nervous energy. By frequent repetition such movements become inseparably connected with voluntary movements, as in this case. V. Schrötter speaks of it as chorea laryngis.

WILLIAM LAMB.

# Abstracts.

## MOUTH, Etc.

**Dr. W. Lublinski.**—*Suppurative Inflammation of the Glosso-epiglottic Fossa (Angina Præepiglottica Phlegmonosa).* "Deutsche Medicinische Wochenschrift," No. 8, 1899.

Caz reported a case in "Archiv. für Laryngologie," vol. viii., part ii. Lublinski has seen three cases. At first there was discomfort on swallowing and dryness at the affected part, which increased with depression towards evening, disinclination for work, loss of appetite, fever. Swallowing became very disagreeable, with pain in the ear. Pain was increased by hawking up the accumulated saliva and mucus. Speech was like that in phlegmonous tonsillitis.

The pharynx and tonsils were free from inflammation; the tongue and lingual tonsil were normal. Unilateral inflammation of it, going on to suppuration, may occur, and shows the same symptoms as inflammation of the glosso-epiglottic fossa. Diagnosis is impossible without a mirror. If the lingual tonsil is swollen, it lies against the epiglottis and obscures the fossa; in angina præ-epiglottica phlegmonosa it is filled up with a grayish-red shining tumour, which is intensely painful on probing and feels pasty. The swelling only comes a little forward, becomes more and more raised, and shows fluctuation. It lies on one side close against the lingual tonsil, on the other against the epiglottis, which does not resist the pressure, and is forced over the laryngeal entrance. At the same time, the anterior surface of the epiglottis is seen to be swollen, its free edge on the affected side is thickened, and its mobility is interfered with. There was no œdema of the laryngeal rim or its interior, as in submucous suppurative inflammation of the epiglottis. The left side alone was affected in all three cases.

Laryngeal examination is difficult, but by drawing the epiglottis slightly to the right, it was seen that neither the left arytenoid nor the aryepiglottidean fold was affected. Spontaneous evacuation does not occur easily. Interference with respiration might occasion tracheotomy.

*Guild.*

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**Richards, G. L.**—*The Technique of Tonsillotomy.* "Charlotte Med. Journ.," October, 1898.

When hæmorrhage occurs after tonsillotomy, all the usual hæmostatics are nasty and unsatisfactory, except hot water and ice. If there is simply persistent oozing, use a gargle of a 25 per cent. solution of peroxide of hydrogen in hot water. If this is insufficient, soak a pledget of cotton in pure peroxide and apply pressure directly to the cut surface of the tonsil. If there is spurting of blood, wipe the surface quickly with a bit of cotton and seize the bleeding-point with long-handled hæmostatic forceps. Should no hæmostat be at hand, pressure of a piece of cotton under the thumb with the corresponding finger on the vessels of the neck will usually suffice to quickly stop the bleeding.

*Middlemass Hunt.*

## NOSE.

**Ball, James B.**—*The Indications for Operation in Cases of Adenoid Vegetations of the Naso-pharynx.* "The Clinical Journal," December 28, 1898.

Any one of the following conditions constitutes an indication for operation: (1) Habitual mouth-breathing in a child, which has been going on for a considerable period and shows no sign of improvement. (2) Noisy, laboured breathing, or suffocative attacks at night, especially in young children, even though not habitual mouth-breathers in the day. (3) If a child is deaf, or subject to attacks of deafness or earache, or has a chronic otorrhœa. (4) Repeated attacks of bronchitis, or the presence of asthmatic symptoms. (5) A persistent cough without bronchial symptoms. (6) Repeated colds in the head of a severe and prolonged character, or a chronic nasal catarrh, or purulent rhinitis not yielding to simple treatment. (7) Paroxysmal sneezing and hay-fever symptoms. (8) In nocturnal enuresis, chorea, and epilepsy, although none of the foregoing indications are present, operation may sometimes be done, rather to remove all possible sources of irritation than with any distinct promise of benefit. *Middlemass Hunt.*

**Brown.**—*Bleeding Polyp of the Nasal Septum.* The "Laryngoscope," March, 1899.

The author reports a case of daily epistaxis due to a polyp as large as a pea attached to the anterior part of the septum by a small pedicle. The growth was snared and the base cauterized. *R. M. Fenn.*

**Fisher, J. H.**—*A Case of Diffuse Cellulitis of the Orbit, secondary to Empyema of an Ethmoidal Air-Cell.* "St. Thomas's Hospital Reports," 1897.

Despite a statement by Caldwell in the *Medical Record* for 1893 that "numerous cases are recorded of orbital periostitis and cellulitis from extension or infection from purulent ethmoiditis," Fisher is only able to find one authentic case recorded.

The present case is one of a labourer, aged seventeen, who came to St. Thomas's Hospital with a brawny hard swelling and dusky-red discoloration of the upper lid of the left eye and marked proptosis, the globe being displaced downwards, forwards, and slightly outwards.