Lumbar puncture: Report on cerebro-spinal fluid.—The sediment consists of large numbers of polymorphonuclear leucocytes, a few desquamated endothelial cells, and scanty Gram-positive diplococci. The patient's condition improved for two weeks, when he became restless and temperature became irregular. The drainage-tube, which had been shortened, was reintroduced deeply, and after a week he again improved and made an uninterrupted recovery.

Dr. J. S. FRASER said drainage-tubes were used in this case. He did not know what the experience of other members was as regards tubes in abscess cases, but his own was limited and bad. On removal of the drainage-tube a flow of pus follows; just what one would expect. The brain is a very soft structure, and the intracranial pressure forces the brain up against the wall of the drainage-tube so that half an hour after insertion the tube ceases to be a tube and becomes a plug. Gauze is the best material for draining brain abscesses.

Dr. LOGAN TURNER remarked that this was a very important case for inner-ear investigation, but that had not been done.

Dr. WHITEHOUSE replied that gauze was passed through the tube.

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# Abstracts.

## PHARYNX.

**Strauch, August.—Cough Arising From a Persistent Thyro-glossal Duct.** "Munch. Med. Wochenschrift," Nr. 8, 61 Jahrgang.

Though no mention is made of it in the literature of the subject the author shows conclusively that an irritable condition of a persistent thyro-glossal duct may be responsible for the production of a so-called nervous cough, and that in cases of this nature in which other causes have been excluded the surgeon should never fail to examine the foramen cæcum with a probe. Bochdalek found a persistent lingual duct twelve times—often with branched ramifications—amongst fifty tongues specially examined. This factor in the ætiology of reflex cough was first described by T. W. Lewis, of Chicago, who demonstrated three cases in which the cough persisted—in one case for many years—in spite of every effort made to cure it, but in which it finally and completely disappeared after the disinfection and cauterisation of a persistent duct. The author adds an equally conclusive case in which, however, it was necessary to totally destroy the duct. *J. B. Horgan.*

**Greene, J. B.—Diagnosis and Treatment of Diphtheria.** "Annals of Otology, etc.," xxii, p. 782.

The author emphasises the following points: (1) The diagnosis of diphtheria depends primarily on finding the organism. Cultures should be taken of every sore throat in children, and likewise suspicious nasal discharges. But in the absence of a positive finding, if the symptoms point to diphtheria, antitoxin should be given. This is particularly important if the symptoms are severe. (2) Much larger doses of antitoxin should be given in diphtheria. Text-books have been misleading in this respect. (3) Laryngeal cases are serious partly from mechanical obstruction, requiring prompt relief of the stenosis, and large doses of antitoxin. Intubation in the main is preferable to tracheotomy. Laryngologists should perfect their technique in this operation until it becomes a fairly

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simple one. (4) Epidemics of diphtheria are kept up largely by "carriers." They should be sought out, isolated, and the abnormality treated. Diseased tonsils and adenoids may require removal. *Macleod Yearsley.*

**Layton, T. B.—Tonsils and Adenoids in Children: A plea for fewer Operations.** "The Lancet," April 18, 1914, p. 1106.

The author starts with the safe assumption that the two indications for removing tonsils—faucial and pharyngeal—are because they are the cause of some inflammatory lesion, or because they are causing some mechanical obstruction to the functions of the nose, mouth, or ear. In estimating, the latter two fallacies must be eliminated, the arrival at a conclusion just after an acute attack has got better or before any other source of septic infection has been removed. Both these fallacies are the cause of a large number of unnecessary operations.

The importance of carious teeth is dwelt upon, as well as of breathing exercises and attention is given to the risks of operation. The paper is a well-thought-out and common-sense contribution to the subject.

*Macleod Yearsley.*

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## NOSE.

**J. Christ (Wiesbaden).—Nose and Ear in cases of Congenital Defect of the Sweat Glands (A Contribution to the Ozæna Question).** "Zeitschr. f. Laryngol.," Bd. 6, Heft 3.

This appears to be the first of the papers in connection with the investigation on the subject of ozæna. It has evidently been published in support of the German theory that ozæna is due to a congenital tissue weakness of the bony framework of the nose.

Christ points out that five cases have hitherto been recorded of marked hypotrichosis and hypodontosis (the author is a dentist) combined with congenital defect of the sweat glands. One of these cases (American) was insufficiently described but the other four were recorded by Germans, and, of these, two have had malformation of the auricle and ozæna. Two of the cases showed albinism. Christ points out that ozæna is common in regions where there is endemic cretinism, and further that albinotic animals are almost completely deaf from degenerative changes in Corti's organ due to a congenital trophic disturbance.

The paper is a long one and the reasoning is rather loose, but the idea seems to be that an alteration in the internal secretions due to puberty, bad surroundings, etc., may, through the sympathetic nervous system, bring about trophic changes in various parts, including skin, nose, etc.

*J. S. Fraser.*

**Emerson, F. P.—Atrophic Rhinitis with Ozæna: Its Ætiology and Surgical Treatment.** "Annals of Otology, etc.," vol. xxii, p. 333.

Describes eight cases, and concludes that ozæna is the sequel of a focal infection. Clinically the course of events is: A septal deviation causes a compensatory hypertrophy of the middle turbinal. This is followed by a chronic catarrhal ethmoiditis which interferes with the drainage to such an extent that a subsequent active infection results in a sinusitis. The fœtor and crusting are probably due to the direct action of a specific pus-producing organism on the tissues, without any preceding true atrophic process. The difficulty in establishing free drainage, where there is an abnormal anatomical development of the

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bony cells, makes the cure of certain cases of ozæna impossible without any intra-nasal procedure. Whatever aid bacteriology may give us in curing this disease must follow the free drainage of all foci of infection.

*Macleod Yearsley.*

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## LARYNX AND TRACHEA.

**Panconcellia-Calzia (Hamburg).—The Autophonoscope: An Instrument for enabling the Surgeon and the Patient to observe at the same time the movements of the Larynx.** "Zeitschr. f. Laryngol.," Bd. 6, Heft 3.

Garcia's method of examining the larynx has certain disadvantages, *e. g.* gagging, rapid clouding of the mirror, the method is difficult for the beginner, etc. The direct method of examining the larynx is almost useless for observing phonatory movements.

The writer gives Hays the credit for discovering the endoscopic method and refutes the claims of the Germans who try to make out that Zaufal and Trautmann had already discovered this method. Flatau, Haike, Schmukert, Beck and Kahler have all modified Hays's instrument. Endoscopy has the following advantages: The instrument is easy to manipulate and does not cause retching. The instrument itself acts as a spatula, and the examination, which may last ten minutes or more if necessary, can be carried out with the mouth closed or open. Calzia uses the Flatau model which is now modified so that not only the observer but the patient himself can at the same time observe the movements of the larynx during normal breathing, forced breathing, coughing, swallowing, various methods of attack, chest and falsetto tones, whispering voice, etc. One regrets to note that the instrument has been patented.

*J. S. Fraser.*

**Robert-Leroux.—Autostatic Ortholaryngoscopy.** "Arch. Internat. de Laryngol., etc.," Jan.–Fev., 1913.

The study of Killian's suspension laryngoscopy suggested another method less alarming for the patient, of which the armamentarium is much more simple and correspondingly much less costly. Robert-Leroux, while retaining the principle of Kirstein and Killian's method, dispenses with the upkeep of apparatus and does not employ "suspension."

The necessary instrument for this purpose consists of a self-retaining mouth-gag (by Bruneau, Paris) in combination with a special tongue spatula, the end of which is insinuated as far as the glosso-epiglottic folds. A ratchet movement causes the tongue to apply itself to the floor of the mouth. This draws the epiglottis forwards and gives a clear view of the whole laryngeal region.

There are no practical details in the present paper, but one of the illustrations shows the patient with the head inverted and the jack-mouthgag *in situ.* Robert-Leroux is seated comfortably at the patient's head, which is supported by a rest, and an excellent view of the larynx is apparently obtained. *J. D. Lithgow.*

**Franck, O.—Personal Experiences of the Transverse Incision in Tracheotomy.** "Münch. Med. Wochenschrift," Nr. 17, 61 Jahrgang.

The advantages claimed for transverse incision of the skin and trachea in this operation are that the method is easier and quicker, that the tracheal wound gapes and in consequence allows of an easy introduction

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of the tube—this applies especially to children—that the cosmetic result is better and the dangers of immediate and remote complications from the operation are considerably reduced.

The technique is as follows: After transverse incision of the skin the muscles are separated along the linea alba and the isthmus thyroidea displaced downwards with the left forefinger. Then without employing any special means of fixation, the trachea is incised horizontally directly beneath, and as close as possible to, the lower border of the cricoid. The wound gapes and the tube can be gently slid into position. The skin-wound should be sutured with precision and every effort made to preserve strict asepsis. *J. B. Horgan.*

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## EAR.

**Krüger, Dr.—On the Treatment of Othæmatoma.** "Münch. Wed. Wochenschrift," No. 11, 61 Jahrgang.

After aspirating the contents of the hæmatoma, which he previously paints with iodine tincture, the author overcomes the difficulty usually experienced in applying firm and constant pressure on the injured part in the following manner. A very thin layer of cotton-wool is moulded over the inner surface of the auricle, all depressions being obliterated with a forceps, the whole being then painted over with collodium which latter should extend on to the healthy skin. This dressing, which is repeated when required, renders it impossible for the effusion to reform.

*J. B. Horgan.*

**Schwarz, Adolf.—A Rapidly Acting Inhalation to Relieve Earache.** "Monatss. f. Ohren." Year 48. No. 3.

The author has noticed that the inhalation of the ol. sinapsis æthereum will stop toothache, and arguing from this that pain in other regions also supplied by the trigeminal nerve might be similarly relieved, has investigated its effect on various aural lesions. Brief notes of forty-four cases are quoted which include acute otitis media, external otitis and furunculosis, otalgia in connection with tabes and where no cause could be assigned, tinnitus, and pain associated with the convalescence after radical operations. In all these cases the use of this volatile oil was found to relieve or cure the discomfort and pain, and in the first-mentioned group when paracentesis became necessary it was carried out apparently without feeling.

The method adopted by Schwarz consists in placing some 5 grm. of the oil in a 20 grm. bottle, the opening of which is held under the nostril on the affected side, and the patient is instructed to close the mouth and eyes to occlude the other nostril and then take a short, but strong sniff. The effect, when it does take place, "is immediate." Apart from this latter suggestion that the method may sometimes fail there is no instance given where relief was not obtained. *Alex. R. Tweedie.*

**Bryant, W. Sohier.—Clinical Indications for the Mastoid Operation.** "Annals of Otology, etc.," vol. xxii, p. 482.

Reduces the indications to four: (1) Operate when mastoid abscess is present. (2) Operate on mastoiditis due to streptococcus mucosus. (3) Operate in the presence of intra-cranial or hæmic complication of middle ear infection. (4) Operate on mastoiditis, acute or chronic, when the bone is of the solid variety. *Macleod Yearsley.*

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**Mann, Max.—A New Symptom of Cerebellar Abscess.** "Münch. Med. Wochenschrift," Nr. 16, 61 Jahrgang.

In two consecutive cases of cerebellar abscess Mann has demonstrated a marked disinclination of the patients to use the limbs that were homolateral to the side on which the abscess existed. This was especially noticeable if the patient were irritated in some manner, for instance, by holding the nose, whilst in a somnolent condition and was not demonstrable in cases of cerebral abscess. The suggestion is made that other surgeons who see cases of this comparatively rare affection might ascertain the frequency of this symptom and so establish its importance for the purposes of differential diagnosis. *J. B. Horgan.*

**Kirchner, Carl.—Fractures of the Base of the Skull with Implication of the Mastoid Process and their Treatment.** "Munch. Med. Wochenschrift," Nr. 10, 61 Jahrgang.

A basal fracture involving the mastoid or petrous bone is more liable to occur if the injured skull is inelastic or the mastoid process sclerotic. Such a fracture remains a potential source of infective meningitis or sinus thrombosis for a considerable time, the exuded blood in the tympanic cavity, which is slow of absorption, being infected by way of the Eustachian tube or the ruptured tympanic membrane. This infection may remain latent until the occurrence of a sharp rise of temperature and violent headache point to the seriousness of the patient's condition. Such cases with a fatal termination have been observed several months and even years after the injury.

The diagnosis is often difficult. Apart from rupture or hyperæmia of the tympanic membrane and the exudation of blood in the tympanic cavity the patient complains of headache, vertigo on stooping or exertion, general lassitude and marked tinnitus. There is, further, in some cases, marked photophobia and dread of noise, a burning feeling in the face and accelerated pulse—symptoms which Friedmann has described as a vasomotor symptom complex. Müller's symptom, which consists in a hyperæmic condition of the tympanic membrane and the deep parts of the external auditory meatus, is present according to Rhese in 65 per cent. of these cases for months or even years after the injury. Radiography will furnish some information and Gœbel states that the percussion note is duller on the affected side.

The author puts forward a strong plea for immediate operation in all cases of basal fracture in which there is any question of the fracture implicating the middle or inner ear. In the former case a simple antrotomy will suffice, in the latter the complete radical operation with labyrinthotomy. *J. B. Horgan.*

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## ŒSOPHAGUS.

**Amersbach, K. (Freiburg i Br.).—Injuries of the Gullet during Œsophagoscopy.** "Archiv. für Laryngol.," vol. xxviii, Part 3.

The writer gives a detailed report, with post-mortem examination, of a case of carcinoma of the gullet at the level of the bifurcation of the trachea, in which a perforation occurred at the upper end of the œsophagus during an œsophagoscopic examination, carried out apparently with all due care by an experienced surgeon. A retro-œsophageal abscess developed and the patient died of inhalation pneumonia.

While accidents of this kind are certainly not very rare (according to Jackson, 1 per cent. during simple œsophagoscopy), it is to be regretted

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that the number of published cases is even smaller than might have been expected; in this way is lost much information that would doubtless prove to be of great interest and value. *Thomas Guthrie.*

**Janeway, H. H. (New York).—The Early Symtomatology of Cancer of the Œsophagus.** "Amer. Journ. Med. Sci." April, 1914.

The writer has been impressed with the difficulty which is experienced by the profession in recognising the early symptoms of this disease. Richard Cabot recently stated that among 3,000 cases coming to autopsy a greater proportion of mistakes was made in the diagnosis of cancer of œsophagus than in any other condition. And yet we have in œsophagoscopy a means of arriving at a correct diagnosis of œsophageal affections immediately their presence is suspected.

Dr. Janeway has operated on four patients with cancer of the thoracic portion of the œsophagus, and in each of them he was strongly impressed with the idea that, had they been examined at an early stage of the disease, favourable conditions for resection would have been found. If, therefore, any advance is to be made in the treatment of this disease, early diagnosis is of the greatest importance, and in this connection it is of interest to consider what are most commonly the first symptoms of the disease. The author's statistics bear out the usual statement that dysphagia is the earliest symptom, but it is not generally appreciated that the dysphagia may be at first only temporary, and that after being present for a short period it may disappear for a considerable length of time before becoming permanent. In other cases dysphagia is neither an early nor a prominent symptom, and exceptionally it may be absent throughout the whole course of the disease. The early symptoms, then, consist either of constant dull pain behind the lower end of the sternum, a tickling sensation in the throat, cough and increase of the amount of mucus in the throat, or in some cases anorexia alone.

*Thomas Guthrie.*

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## MISCELLANEOUS.

**Freudenthal, W. (New York).—A New Method of producing General Anæsthesia.** "Archiv. für Laryngol.," vol. xxviii, Pt. 3.

While all forms of inhalation anæsthesia present greater or less inconvenience in connection with throat work, the author has used with much satisfaction the method of intratracheal in sufflation by means of Charles Elsberg's apparatus. The latter is, however, expensive and cumbersome, and therefore is less suited for private practice than for a large hospital.

He was in consequence glad to meet with a new method devised by Dr. J. T. Gwathmey, of New York, which resembles the intravenous method in that the air passages are not interfered with, and has the additional advantage that a single application is sufficient to render the patient insensitive throughout the whole duration of the operation. This is a form of rectal etherisation, not, as in the method of Cunningham, by the continuous insufflation of ether vapour, but by a single injection of a mixture of ether and olive oil.

An hour before the operation a subcutaneous injection of morphia and atropin is given, and this is followed in half-an-hour by a rectal injection of ·3 to ·6 grams of chloretone. The apparatus for the induction of anæsthesia consists of a narrow catheter with glass funnel attached, through which the fluid is poured. The catheter is passed 8 or 9 cm. into the rectum, and a mixture of 2 oz. of olive oil and 6 oz. of ether allowed

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to run in very slowly, so that the process occupies at least five minutes. In from ten minutes to a quarter of an hour later anæsthesia is complete, and the catheter is withdrawn. An operation lasting one and a half to two hours may now be performed without a further administration. Should the patient become at all cyanotic, or his breathing laboured, a catheter is passed into the rectum and 60 c.c. of the fluid allowed to escape, on which he rapidly returns to normal. When the operation is completed the fluid remaining in the rectum is removed by re-introducing the catheter and, if necessary, employing some form of suction apparatus,

The method proved an ideal one in most of the writer's cases. In one or two, however, it had to be supplemented by a small quantity of chloroform given in the ordinary way, and he has not usually found it satisfactory in children. *Thomas Guthrie.*

## REVIEW.

*The Diseases of the Nose, Throat and Ears of Children in Daily Practice.* By Prof. Dr. F. Goppert. Berlin: v. Springer. Pp. 166.

The title will probably at once raise the question in the minds of most as to the necessity for such a treatise, all the more so as it forms a special volume in the "Encyclopædia of Clinical Medicine." It is certainly difficult to realise that there is so much peculiar to children in aural and naso-pharyngeal ailments as to warrant a special work on the subject, and one's opinion will not probably be affected after reading this book. Those general practitioners who are not overcome by the terrifying series of maladies here described as affecting the child's nose, throat or ears, may easily slip into the error of thinking that they possess special knowledge of pathology and treatment of these parts, if they happen to overlook the occasional warning that under such and such conditions the case should be handed over to the aurist or rhinologist. This is the result of the *vade mecum* style on which the book is arranged, though this is more or less concealed by lengthy descriptive efforts. For instance, under "Naso-pharyngitis in Infants at the Breast," to which over thirty pages are devoted, there is a special chapter on the "Constitutional Effects of Naso-pharyngitis"; under this again there are other headings, the first mentioned being naso-pharyngitis and the nervous system, and finally this is divided into the subsections loss of rest, loss of appetite, habit spasm, to the first two of which are attached clinical notes of cases to illustrate the condition. On the other hand, the chapter on "Surgical Treatment of the Complications of Middle-ear Suppuration" describes polypi, mastoid disease, extradural abscess, sinus thrombosis, brain abscess and labyrinth disease, all within a page and a half! And one breathes a sigh of relief to find here a suggestion that treatment for these conditions should be confined to the aural surgeon.

It may be uncharitable to judge the work with no knowledge of the rest of the series of which it forms a part, but taken itself anyway it cannot be recommended either for purposes of reference or as a practical guide. *A. R. Tweedie.*

## NOTES AND QUERIES.

Dr. John Macintyre, of Glasgow, has been promoted a Knight of Grace of the Grand Priory of the Order of the Hospital of St. John of Jerusalem in England.

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