examination there was only slight retraction of the tympanic membrane. After application of cocaine and adrenalin Citelli observed a diffuse tumour in the right fornix of the naso-pharynx; the swelling had a reddish colour and a regular surface. *J. S. Fraser.*

EAR.

Urbantschitsch, Victor.—"**Hyperacusis Willisii.**" "Monats. f. Ohrenh.," Year 46, No. 6.

The author has been continuing his researches into the conditions which regulate this phenomenon, and here relates the results of his examination of some forty patients in this respect. The voice, tuning-fork and watch were used for estimating the duration of bone-conduction and range of perception *viâ* air, details of the methods used being described.

As a stimulus to the production of the phenomenon the tuning-fork was used either *viâ* the bone or air and also Bárány's noise apparatus.

From his investigations he concludes that "hyperacusis" can be demonstrated in those with normal hearing, in cases of both catarrhal and purulent affections of the conducting apparatus, in cases where the malleus and incus are absent and even in disease of the cochlear nerve (in addition presumably to oto-sclerotic conditions).

Similar accentuation of perception can be shown in relation to other senses, especially that of vision, as he has elsewhere pointed out. Shaking the head or whole body was found to produce an increase in the hearing which would correspond to the temporary improvement in some cases whilst travelling by rail, and during the application of vibratory massage. This latter fact would appear to suggest that the increased perception thus produced is dependent on an increased mobility in the sound-conducting apparatus and is thus of a physical nature. Urbantschitsch, however, considers there is good reason to regard the improvement as due to a stimulation of the sense of perception only. *Alex. R. Tweedie.*

Bruehl, Gustav.—**Notes on Pathology of the Ear.** "Laryngoscope," October, 1911.

(1) Gummatous invasion of the mastoid process: A pathological specimen without any clinical history shows an excavation of the mastoid process down to, and exposing, the sinus groove. The loss of bone is most marked on the inner surface of the mastoid process and the antrum is not exposed. The surrounding bone shows a marked formation of osteophytes. The author suggests that this condition is similar to one observed by him clinically in which a man, thirteen years after syphilitic infection, while under observation for nerve-deafness with a normal drum, developed a fluctuating tumour the size of a hen's egg over the mastoid process combined with facial paralysis and ataxia. After fourteen days' anti-specific treatment the tumour and facial paralysis had disappeared but complete nerve-deafness persisted.

(2) A specimen of an adult temporal bone, showing complete petro-squamosal squamo-mastoid sutures so that the bone is divided into two independent parts: There are a few small cells developed in the portion of the squamosal covering the mastoid.

(3) Two specimens of atresia of the meatus: The first, of which the history is unknown, shows an occlusion of the bony external meatus by a broad, thin, bony lamina arising from the posterior wall and leaving two

small apertures above and below it about $1\frac{1}{2}$ millimetres in diameter This lamina is probably the result of ossification of granulations due to an external otitis. There are no apparent deep-seated changes.

The other specimen, a left temporal bone, was removed from a female, aged eighty, whose meatus was seen during life to be occluded by an epithelial covered membrane. The ear was totally deaf, and from examination of the specimen the occlusion is seen to be due to an atrophic epidermal layer lying on, and continuous with, some fatty connective tissue which occupied the site of the middle ear and could be seen passing deeply into the situation of the vestibule, which was disorganised. No trace remained of the semicircular canals and the mastoid cells were full of solid connective tissue. The cochlea was much disorganised, the spiral ganglion being the only remnant of normal structure, the basal coil being filled with new bone and the remainder with fibrous tissue. The bony new formation seems to have arisen from the endosteum of the labyrinth. The specimen probably demonstrates the spontaneous recovery of a suppurative labyrinthitis. *A. J. Wright.*

PHARYNX AND ŒSOPHAGUS.

Gastinel, P., and Pelissier, Andre (Paris).—Syphilis, Diphtheritic Paralysis, Palatine Herpes. "Gaz. des Hop.," October 5, 1911.

The authors remark that ulcero-vesicular eruptions are recognised facts and generally involve no difficulty in diagnosis. There are, however, cases where such conditions occur in subjects of infection, apart from neuritis, and then it is a delicate matter to discriminate between trophic phenomena and what may be due to infection. The following case affords an example. In August, 1910, a woman had a vulvar chancre which had never been treated. In October of the same year she had diphtheria and was treated with Roux's serum. Paralysis of the soft palate ensued and lasted three weeks. At the end of November small vesicles appeared on the velum, which ulcerated and shortly cicatrised, but reappeared some days afterwards. Similar recurrences took place six times in two months. The patient's attention was only drawn to them by slight dysphagia. When seen in January there was a diffuse redness of the entire pharynx and velum. On the latter, and quite limited to its posterior part, a crop of vesicles was observed, some pearly, others had burst. They extended on to the anterior pillar of the fauces, but respected the tonsils, posterior pharyngeal wall, cheeks and tongue. The eruption was unaccompanied by fever, headache or functional symptoms, except slight dysphagia. There was no spontaneous pain. Paralysis of the palate had disappeared and its sensibility was intact. At this time the patient manifested secondary syphilitic symptoms. The trunk and limbs were covered with a maculo-papular rash, and hypertrophic mucous plaques were present on the vulva. There were no mucous patches on the lips, tougue or pharynx. Some days afterwards the vesicles had completely disappeared, giving place to polycyclic erosions. The pharynx was red, but no lesions were present. The syphilides had the same distribution and always respected the bucco-pharyngeal cavity. The nature of this herpetiform eruption occurring in a syphilitic subject, on a territory previously attacked by neuritis, and also the relation which the specific infection and nerve lesion may have had to the eruption, are fully discussed.

H. Clayton Fox.