ABSTRACTS.

Abstracts Editor—W. Douglas Harmer, 9, Park Crescent, London, W. 1.

Authors of Original Communications on Oto-laryngology in other Journals are invited to send a copy, or two reprints, to the Journal of Laryngology. *If they are willing, at the same time, to submit their own abstract (in English, French, Italian or German) it will be welcomed.*

EAR.

Influenzal Mastoiditis.—Jacques and **Daure.** "Rev. de Laryngol., d'Otol., et de Rhinol.," August 31, 1919.

A large proportion of cases have been notable for the formation of remote abscesses in fascial planes of the neck—not as in Bezold's type, but far back towards the ligamentum nuchæ. Such septic foci may be multiple, appearing at intervals one after the other.

The signs and symptoms referable to the ear itself may be trivial. But the remote sequelæ above referred to may be serious and protracted.

H. Lawson Whale.

Presentation of Mastoid Cases, with Remarks and Lantern Slide Demonstration.—Major Christian Holmes. "Annals of Otology," &c., xxviii, p. 1.

These cases occurred at the Base Hospital, Camp Sherman, Ohio, and numbered fifty. The author considers that to keep down mortality from pachymeningitis, serous meningitis, leptomeningitis, sinus thrombosis, and brain abscess, every discharging ear must be looked upon as one that may lead to fatal complications, and every symptom watched for prompt interference if necessary. *Macleod Yearsley.*

Spontaneous Hæmorrhage from the Lateral Sinus occurring six days after Simple Mastoid Operation.—F. T. Hill. "Annals of Otology," xxviii, p. 29.

Patient was a man, aged twenty-one. The case appears to support generally accepted opinion that thrombosis of the lateral sinus is due to necrosis of intima of vessel wall. This may be manifested by hæmorrhage from the sinus. Therefore, it would seem decidedly indicated in a case showing this sign to operate immediately rather than wait for the classical two chills and septic rise of temperature. *Macleod Yearsley.*

Toxic Delirium following Mastoidectomy.—J. A. Robinson. "Annals of Otology," xxviii, p. 86.

Patient was a woman aged fifty, who had been in urgent need of operation for two weeks. Temperature after operation varied from 99° to 103° F. on the twelfth day. Facial paralysis developed on the morning of the operation. Delirium began two days after operation and lasted several months. The author considers the condition to have been due to absorption of toxic products from the mastoid.

Macleod Yearsley.

Gas-embolism of the Lateral Sinus after a Mastoid Operation.—Baraud (Lausanne). "Rev. de Laryngol., d'Otol., et de Rhinol.," August 31, 1919.

We no longer regard pulsations of the lateral sinus as indicative of thrombosis. Either a healthy or a thrombosed sinus may behave in either fashion—pulsate or not pulsate.

The pulsation of the sinus—healthy or otherwise—is not communicated cerebral pulsation; it is not synchronous with either pulse or respiration. It is due to the resultant of two forces of negative aspiration, one being the negative pressure in the right auricle, and the other the negative pressure of the thorax on inspiration, and the point which the reporter seeks to emphasise is that these two forces are both obviously more potent if the lateral sinus be closed off above. Hence the old idea that pulsation signified thrombosis, and was communicated from the underlying brain.

In the particular case, described in lengthy detail, the sinus bled fourteen days after the mastoid operation; the sinus had been deliberately exposed in the course of evacuating an extradural abscess. At the moment when the bleeding occurred the wound was being dressed, with the patient in the sitting position.

The reporter had instinctively closed the bleeding point with his finger. But the patient took a deep breath, and fell to the floor. The reporter's finger naturally slipped from the sinus, but the latter ceased to bleed. Almost immediately bleeding recommenced, and the sudden stertor, cyanosis, dyspnœa and audible pulmonary gurgling, which had a moment before ceased. The patient recovered, and the reporter emphasises the probability that his fall from the sitting position (by allowing blood to regurgitate up along the jugular and expel much of the air), was instrumental in saving his life. *H. Lawson Whale.*

ŒSOPHAGUS.

Œsophageal Strictures in Children due to Lye Burns.—George F. Keiper. "The Laryngoscope," September, 1919, p. 548.

Keiper's paper refers to strictures of the œsophagus which the general practitioner or surgeon is unable to dilate with the ordinary instruments after "blind" attempts. The case is referred to the laryngologist as a last resort before gastrostomy is done to relieve the patient of water hunger. The ætiology of strictures of this sort lies primarily in gross carelessness. Too often concentrated lye in solution is left within easy reach of small children after the kitchen sink has been cleaned. The inquisitive child investigates the contents of the vessel and very often drinks it. The usual distressing results follow and sooner or later there is difficulty in swallowing food or drink. A thimbleful of lye is sufficient to cause stricture. These lyes are corrosive poisons, and a druggist must affix the poison label with the skull and cross-bones as well as information as to the antidote. The grocer next door sells them without these precautions and with impunity. Keiper has also had two cases of poisoning due to hydrochloric acid, which is used to burn warts off the legs of horses and cattle. In neither instance was there a stricture of the œsophagus, but the mucosa of the stomach was in large measure destroyed. Haste in dilating strictures of the œsophagus after the ingestion of the corrosive fluid is to be deprecated for fear of perforation. The stricture may take several weeks to form. No attempt

should ever be made at bouginage until two sets (lateral and antero-posterior stereoscopic) of X-ray plates have been made to locate accurately the site, extent and character of the stricture. No bougie should ever be passed except under direct inspection through the œsophagoscope. As large an œsophagoscope as possible should be passed in order to render as easy as possible the location of the ofttimes very narrow opening. Keiper believes frequent general anæsthesia to be highly dangerous. We may need to make as many as sixty dilatations before we can dismiss the patient as cured. The child is therefore pinned in a sheet or blanket and laid flat on the operating table while the assistant holds its head over the end of the table. A nurse holds the body of the child in position on the table. Tickling the fauces with a fine probe introduced between the teeth quickly causes the mouth to open. When the child once realises what is demanded of him it is surprising how docile he becomes. These strictures are often multiple and tortuous. For dilating the former the two-prong dilator of Jackson is valuable. For tortuous and tight strictures Keiper likes the Guisez instrument, in different sizes. Keiper reports the following case, pronounced impermeable by the general practitioner and surgeon: Male, aged three; regurgitates his food and is losing flesh. Four months before he swallowed a thimbleful of lye solution. Steps were taken to neutralise the poison. Without any anæsthesia, local or general, a fairly large œsophagoscope was passed down to the stricture. Keiper located the entrance into the stricture and was able to pass the smallest sized Jackson-Guisez instrument right into the stomach. At frequent intervals larger and larger sizes were introduced, until at the end of six months, and after thirty such *séances*, Keiper was able to pass the largest size. Infrequent dilatations were made for three months longer. Many of these cases need subsequent help at long intervals. *J. S. Fraser.*

MISCELLANEOUS.

Malignant Disease of the Pituitary Body, with Comments.—G. Maxted. "Proc. Roy. Soc. Med.," August, 1919, Section of Ophthalmology, p. 42.

The patient, a well-nourished man, aged twenty-five, was admitted to hospital in March, 1918, on account of diplopia which had persisted for about a month. This was preceded for about eleven months by occasional slight attacks of epistaxis, never severe, and also intermittent headaches. The onset of the diplopia was said to have been sudden. The patient stated that at the beginning of the attack the divergence of the right eye was extreme, and that it was now much less than at the commencement. The right pupil is semi-dilated and fixed. The epistaxis was reported to be due mainly to a chronic pharyngitis. Wassermann negative.

In May, 1918, an operation for deflected septum was undertaken. In June the patient was sent to an auxiliary hospital for five weeks, during which time he complained of almost continuous blood-stained mucus from his throat. On his return to hospital he still complained of headaches and the diplopia persisted; still, no decided pathological change in the discs was apparent. Repeated examination of nasal sinuses showed no further evidence of sinus suppuration. The anæmia, if anything, seemed to have become more severe. On August 12 it was noticed that there was some weakness of the left external rectus muscles,

as well as partial third nerve paralysis of the right eye. On lumbar puncture the fluid escaped under pressure, but was quite clear and revealed no pathological changes. Wassermann negative.

September 12 exploration of right sphenoid sinus. The cavity was found to be full of a soft, very hæmorrhagic mass resembling growth, with destruction of the posterior wall of the sinus. Microscopical examination revealed sarcomatous growth, probably tumour of pituitary body. On recovering from anæsthetic the patient noticed that he was almost blind, and by the following morning the blindness was complete, remained so for five days and them began slowly to disappear.

Skiagram showed destruction of the sella turcica with the anterior and posterior clinoid processes and lack of definition of all that area of the base of the skull. The fields of vision showed a very striking bitemporal hemianopsia, the nasal side of each field remaining nearly full. The headaches were considerably relieved by the operation; the discs became slowly and progressively more pale and atrophic. The hæmorrhagic discharge from the nose continued and the patient's anæmia became more severe.

On December 5 the nose was again explored in the sphenoidal region and soft vascular growth removed; a fresh opening was made in the sphenoidal sinus and 100 mg. of radium inserted for three hours. Five days later he became delirious, collapsed rather suddenly and died.

Post mortem.—A large growth was exposed in the region of the sella turcica with much erosion of the surrounding structures; the optic chiasma and the optic nerves were stretched over it and flattened out, resembling pieces of tape. One lobule of growth occupied the angle between the two nerves and was compressing the right nerve rather than the left. Both cavernous sinuses were distended to about three times their normal size with masses of the tumour. The growth had not penetrated their dural sheath, which was stretched smoothly over them. The anterior clinoid processes had disappeared and the lesser wings of the sphenoid were becoming eroded. The growth was very hæmorrhagic throughout and the colour almost of chocolate hue. On removal of the growth it was found that all the clinoid processes, the sella turcica and its walls were completely destroyed and no trace of the pituitary body as such was visible. There was recent hæmorrhage into the growth, which was the probable explanation of his apparently sudden collapse and death.

Pathological report: Section of growth removed at the operation shows a carcinomatous tumour of the pituitary body undergoing cystic degeneration. *Archer Ryland.*

Pituitary Tumour (Hypopituitarism).—L. V. Cargill. "Proc. Roy. Soc. Med.," August, 1919, Section of Ophthalmology, p. 41.

Patient, a male, aged twenty-two. Duration of disease not stated.

The family history is unimportant, and he has always had good health. History of present attack: Was working at a telephone switchboard last Christmas when he discovered that he could only see half the board with the left eye.

Complete temporal hemianopia left eye, the nasal field being encroached upon some 15° from vertical below. Wernicke's sign present. Right field contracted, to temporal side especially. Both optic discs pale, simple atrophy. Looks younger than his age, having the general appearance of a youth of sixteen. Very little hair on face. Weight 5 st. 2 lb. Sexual organs and pubic hair normal.

Skiagram shows enlargement of sella turcica in antero-posterior diameter; depth about average. Anterior clinoid processes undermined; posterior clinoid processes look partly effaced.

Cranial nerves (apart from optic) normal. Speech normal. Motor power, co-ordination and sensation good. Arm and abdominal reflexes good. Knee-jerks exaggerated. Left ankle clonus; none right. Plantar reflex not obtained. No sphincter trouble. Chest *nil*.

The case was thought to be one of hypopituitarism, which may possibly depend on destruction of the pituitary body by a cystic growth.

Archer Ryland.

Herpes Zoster of the Glosso-pharyngeal Nerve.—C. T. Neve. "Brit. Med. Journ.," November 15, 1919.

Two days after a long and cold motor journey, Miss M——, aged fifty-seven, complained of vomiting and malaise, of deafness in the left ear, and of pain behind the left ear and in the left side of the neck.

The temperature was 100° F., the left facial nerve was paralysed, and there was a herpetiform eruption on the left side of the soft palate. The left tympanic membrane was of normal appearance and the skin of the auricle was unaltered, though the acoumeter was heard at 2 in. only.

All the symptoms passed off within ten days.

The writer suggests that the lesion on the palate was due to a lesion of the ninth nerve ganglion, that the pain behind the ear and the vomiting resulted from involvement of the tenth nerve ganglion, and that the pains in the neck indicated lesions of the second and third cervical ganglia. The picture, therefore, was that of a posterior polio-myelitis of the ganglia of the seventh, eighth, ninth and tenth cranial nerves, and of the second and third cervical nerves, the infection being most acute in the upper ganglia. In support of this contention the views of Ramsay Hunt are quoted. Hunt did not describe any cases in which he found evidence of herpetic inflammation of the glosso-pharyngeal ganglion, though he mentions the possibility of its occurrence. He had one case of herpes auricularis in which stiffness of the neck, frequent vomiting and slow, irregular pulse indicated that the vagus might be involved.

Douglas Guthrie.

NOTES AND QUERIES.

SIR JAMES DUNDAS-GRANT, K.B.E.

Among the recipients of the recent Birthday Honours we are interested and pleased to observe the name of Dr. J. Dundas Grant, who, for notable and highly successful services in connection with the treatment of ear disease in pensioners, has received a Knighthood of the British Empire.

Readers of this Journal, which for many years he edited, will, we are sure, be pleased to unite with us in offering to Sir James Dundas-Grant our warmest congratulations upon a well-deserved honour.

SOCIÉTÉ BELGE D'OTOLOGIE, DE RHINOLOGIE ET DE LARYNGOLOGIE.

The Twenty-sixth Annual Congress of this Society will be held in Brussels on July 10–12.

The general discussions will be on (1) Diphtheria and its complications, and on (2) The operative treatment of laryngo-tracheal stenoses of diphtheritic origin. There will be a demonstration of patients, specimens and instruments.

On July 12 there will be an excursion to the Domaine de Mariemont and the rich collections of the Fondation Warocqué.

The President of the Congress is Dr. Ernest Delstanche, and the Secretary General is Dr. A. Capart fils, rue d'Egmont 5, Bruxelles.