ABSTRACTS

THE EAR.

Development of Auricle on Second Branchial Cleft. SPENCER MORT. (*Lancet*, 1924, Vol. ii. p. 322.)

The writer describes the case of a schoolboy with a displaced and malformed left auricle, associated with facial hemiatrophy and paresis of muscles supplied by the left facial nerve. A dimple above the auricle marked an efficient, active internal ear.

MACLEOD YEARSLEY.

Hearing in the Presence of a Noise. F. W. KRANZ. (*Annals of Otology, Rhinology, and Laryngology*, March 1924.)

A number of tests in patients with middle-ear deafness, who found themselves able to hear conversation better in a noise, were carried out by F. W. Kranz. The tests were made by talking to the subject in a monotone, repeating over and over again some phrase, and using either (1) a telephone receiver which was emitting a loud tone of 120 cycles per second, and alternately placing it near to his ear and taking it away or using, (2) a specially designed bone conductor type of telephone receiver actuated by a 120-cycle current, and alternately placing this on his head and taking it off, there being sufficient intensity to give the subject a loud subjective sound when on his head.

In most cases the presence of the disturbance was found not to increase the subject's ability to hear or understand the phrases spoken.

The writer concludes that the ability to hear speech in a noise is due to the raising of the voice of the speaker. The deaf subject is less conscious than the normal individual of the disturbing noise, the prevailing pitch of which is usually outside the range of his maximum acuity.

G. WILKINSON.

A Simple Medication for Cases of Suppurative Otitis Media. TRÉTROP, Antwerp. (*Comptes Rendus, Fifteenth International Congress of Otology.*)

Trétrop recommends the following simple medication in all cases of otorrhœa. As the result of twenty years' employment he states that he finds it the most efficacious, rapid, reliable, and the least irritating of any of the applications he has tried.

The solution used is a freshly prepared 1/1000 bichloride of mercury in water, with the addition of an equal part of glycerin. A careful toilet of the external ear is carried out every day, or every

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

alternate day, according to the severity of the case, by swabbing out the passages with cotton-wool mops moistened with the solution. In the intervals the same solution is employed as an instillation every two hours, the head being held in the horizontal position for three minutes following the application, and this is followed by lightly packing the meatus with a wick of gauze moistened with the same, which is removed at each dressing. He considers that he has obtained resolution by these measures in a number of cases in which a mastoid operation appeared to be inevitable. An inflamed condition of the skin of the meatus is a contra-indication to this treatment.

G. WILKINSON.

Latent Mastoiditis in the Course of Acute Otitis Media. P. BERTEIN. (*Presse Médicale:* 25th October 1924.)

The writer gives an account of three cases having the following features in common: an acute otitis media, suppurating freely and apparently draining well; the patient seeming fairly well day after day, but with a slightly raised temperature, poor appetite, and sleeping indifferently; *no trace of mastoid tenderness* at any time after the first three or four days. In each case, quite suddenly, signs of generalised infection declared themselves during the second or third week, the onset being marked by a sudden rise of temperature. The special signs of this general infection were found in the first case in the heart (syncope) and, later, in one lung; in the second case an acute arthritis of the right knee occurred with effusion, and, in the third, an irregular swinging temperature with slight rigors. In the last case radiograms of the mastoid processes were found helpful in diagnosis.

All three cases recovered completely after a simple mastoid operation. The cells of the cortex in each case contained pus and, in all, the lateral sinus was exposed; it appeared healthy, and was not interfered with. The author infers that in no case was there any thrombo-phlebitis of the lateral sinus, the infection having become generalised by way of the lymphatics and small venous radicles of the mastoid process.

F. J. CLEMINSON.

Parotid Fistula as a late Complication of Mastoid Operations; Modes of Treatment and Cause of Origin. JOHANNES BERTOG, Hamburg. (*Archiv. für Ohren-, Nasen-, und Kehlkopfheilkunde.* Bd. iii., Heft 3-4.)

During the past year the writer has had the unusual experience of observing four cases of parotid fistula in connection with mastoid operations, two of which were radical, and the other two simple cortical mastoidectomies. After normal healing had taken place, at intervals of four to nine months after the operations, fistulæ developed in the

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

lower angles of the wounds, too minute to admit the finest probe, yet permitting of free escape of saliva the moment the patient commenced to chew.

The most satisfactory way of dealing with the condition is excision (under local anæsthesia) of the track, destruction of the adjacent lobules of the parotid with the thermo-cautery, and suture of the wound in layers.

The anatomical relationship of the parotid to the cartilaginous meatus is so intimate, that the gland capsule may readily receive injury, particularly if the lower part of the incision be prolonged unduly forwards. In none of the four cases, however, was any such injury recognised at the time of operation, nor was there any suggestion of an abnormally situated accessory lobe of the parotid gland.

WM. OLIVER LODGE.

A New Method of Draining Cerebral Abscess. Professor E. J. MOURE. (*Revue de Laryngologie*, 24th February 1924.)

After reviewing the various methods adopted by different surgeons to secure drainage of cerebral abscess, and the difficulties encountered, the writer proceeds to describe an instrument which has given complete satisfaction in an advanced case of recurrent cerebral abscess.

The instrument consists of a metal "bivalve" held apart by a light spring (resembling a long Thudichum's nasal speculum), which on insertion into the abscess cavity maintains a permanent opening and prevents pocketing while resolution takes place.

J. B. CAVENAGH.

Serous Cystic Cerebellar Meningitis. P. CALICETI. (*Arch. Ital. di Otol.*, April 1924, Vol. xxxv., p. 115.)

The author reports the case of a woman of 28 who developed an acute otitis media on the left side following a cold, which went on to a mastoiditis with subperiosteal abscess. As the patient was in the later months of pregnancy, operation was postponed till after labour. Two weeks after labour the mastoid was opened up and was found to have extensive osteitis, but no lesion of the dura mater. A week later, the patient developed a left-sided headache in the occipital and parietal regions accompanied by weakness, vertigo, vomiting, inability to stand, and tendency to fall to the right. There was no mental dullness. The condition became gradually more marked during the next month. The temperature was normal most of the time with an occasional rise to 37.8°. Hearing was good on both sides. Spontaneous nystagmus was present and more marked on the affected side. Labyrinth and sinus disease could be excluded,

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

and the lesion, whether due to abscess or circumscribed meningitis, appeared to be in the cerebellum on the left side.

The mastoid wound was reopened and an area of tense and infiltrated dura mater was found behind the sinus. This was incised, and about 50 c.c. of serous fluid escaped. Adhesions were seen between arachnoid, pia and dura mater. Following the intervention, the symptoms gradually disappeared, and the patient remained perfectly well when seen six months later. J. K. MILNE DICKIE.

Abscess of the Brain which pointed externally. HORSLEY DRUMMOND, M.D. (*Brit. Med. Journ.*, 7th June 1924.)

A case of acute earache, followed by discharge which shortly ceased, had in the early stage some mastoid tenderness; this also disappeared. Headache, however, increased in intensity, and the pulse was occasionally slow, while the patient sometimes used the wrong word. He was emotional and excited at times, especially at night when the headache was severe. After two weeks' observation, during which time all the symptoms improved, he was allowed to leave hospital, but in a few days returned looking very ill with severe headache and neuralgic pains. He had vomited several times. A week later a tender swelling appeared over the zygoma.

This was incised and pus was found deep down in the temporal fossa. Slight improvement followed but was not maintained, and it was decided to trephine over the temporo-sphenoidal lobe. During the operation artificial respiration had to be resorted to, and the patient died after an abscess containing 5 oz. had been evacuated. On post-mortem a connection was demonstrated between the abscess cavity in the brain and that in the temporal fossa, the great wing of the sphenoid being perforated by a small hole admitting the point of a probe. T. RITCHIE RODGER.

Spontaneous Discharge of Cerebro-Spinal Fluid from the Ear. D. VAN CANEGHEM, Bruges. (*Bulletin d'Oto-Rhino-Laryngologie*, Paris, March 1924.)

A woman of 72, while out walking, heard a rustling in the right ear, which she imagined was due to the noise of wind in the trees. But on the following day the same noise persisted, and she found her pillow soaked with a clear watery discharge from the ear. The liquid came from the ear in drops at varying speed, and analysis showed it to be cerebro-spinal fluid. There had been ear trouble on the same side, twenty years previously. The discharge continued for seventeen months, with no apparent interference with health. The mentality was good, and the nervous system seemed intact; there was neither headache nor vertigo. The tympanic membrane showed a small

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

central perforation; from this, the fluid exuded at rates varying from 300 c.c. per diem to 90 c.c.; on bending the head, the rate rose to 50 drops in three minutes, or 1.2 litres per diem. The end came suddenly, from meningitis, without preceding symptoms. At the autopsy there was found a long tear in the dura mater on the posterior surface of the petrous bone, below the internal auditory meatus; a portion of the bone between this and the carotid canal was rarefied, and presented a channel for the flow of cerebro-spinal fluid into the middle ear. The author discusses at length the reasons for assigning this course for the fluid, but cannot suggest any antecedent cause for the rarefaction. E. WATSON-WILLIAMS.

THE NOSE AND ACCESSORY SINUSES.

Recent Problems in Rhinology. G. E. SHAMBAUGH, M.D. (*Minnesota Medicine*, July 1924, p. 496).

The discussion upon nasal reflexes began in 1871, when Voltolini reported two cases of asthma cured by removal of nasal polypi and resulted later in a flood of contributions to the literature in which the wildest prophecies were expressed regarding the extent of the relations of the nose to other diseases. Some rhinologists seemed ready to believe that almost every ailment might be cured by treating the nose. It is easy for us to-day to agree with Bosworth's proposition that all cases of asthma are associated with pathological conditions in the nasal cavities, particularly if we are permitted to include irregularities of the septum, the ordinary turgescence of the turbinated bodies and hypersensitive spots in the mucous membrane. Such an attitude places the treatment of asthma in a most unsatisfactory state, since it inevitably leads to a great deal of uncalled-for surgery.

Recently, headache, eye symptoms, various neuralgic syndromes, and migraine have been placed in the same category, but it is quite another matter to accept the view that nasal conditions are causing the symptoms. The conscientious rhinologist must deprecate such teaching, more especially because the rhinological field has, in recent years, been flooded by men who, after a few months' attendance at clinics, have taken to operating on the nose, usually upon the ethmoid and sphenoid sinuses. In the so-called "vacuum" headaches, it is assumed that closure of the naso-frontal duct takes place and is followed by the creation of a "vacuum" and by pain resulting from negative pressure without inflammation or the accumulation of fluid in the sinus. Shambaugh has never encountered a case where this hypothesis offered the most plausible explanation. In some of these cases the skiagram demonstrated the complete absence of a frontal

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

sinus. He has also failed to find the headaches in cases of hyperplastic ethmoiditis where polypi completely closed the middle meatus. It would seem, moreover, from analogy with obstruction of the Eustachian tube that the sinus would soon fill with a serous exudate—a condition which would very quickly relieve any negative pressure.

In regard to the relief of certain types of headache by the application of cocain to the region of the spheno-palatine ganglion, Shambaugh points out that an effort has been made to associate certain chronic, rather impalpable alterations in the mucous membranes with the etiology of these neuralgias. While this is not easy to disprove, it is even more difficult to prove. Is it not more probable that the cause of the spheno-palatine neuralgia is the same as that of neuralgias occurring elsewhere, *i.e.*, some focus of infection at a distance from the nerve?

Lastly, in regard to involvement of the optic nerve from its proximity to the sphenoid and posterior ethmoid cells, the ophthalmologists assert that they are not capable of telling which cases of retrobulbar neuritis are caused by extension of sinus disease. The competent rhinologist, on the other hand, is rarely in doubt about the diagnosis of sinus disease associated with a suppurative process. We are now, however, confronted by the proposition that sinus disease may be a hyperplastic non-secreting one to which the skiagram gives no clue and for which neither anterior nor posterior rhinoscopy can give any tangible evidence. Operation must therefore be undertaken in any case. This is, to say the least, not a very satisfactory position for rhinology, for it opens the way to indiscriminate intranasal operations which are much more formidable undertakings than those proposed in the eighties for the relief of the nasal reflex neuroses. In the case of the facial, the acute processes—catarrhal or suppurative—affect the nerve. Facial paralysis is never the result of the chronic, hyperplastic, adhesive middle-ear catarrhs, nor is it often the result of chronic suppurative otitis media unless this be associated with cholesteatoma or sequestrum formation. Even when optic neuritis occurs in connection with an acute posterior sinusitis, many cases recover spontaneously as do most cases of facial paralysis which complicate the mild attacks of acute otitis media, and without any mastoid operation. Shambaugh holds that if the degree of nerve involvement or sinusitis is severe, we should operate at once. When both are mild, spontaneous recovery will probably take place in the course of a few weeks. If not, the question of operation should be again considered. If, in a case of optic nerve involvement, the rhinologist is unable to discover any obvious evidence of sphenoiditis or ethmoiditis, Shambaugh suggests that he should look elsewhere for a source of infection rather than operate on the nose. J. S. Fraser.

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

Nose and Accessory Sinuses

Three Cases of Trochlear Paralysis after Operation on Frontal Sinus. J. OHM. (*Acta Oto-Laryngologica*, Vol. iii., fasc. 1-2, February 1924.)

In the case of a boy, and of two adult males, after the displacement of the trochlea during the frontal sinus operation, paralysis of the superior oblique muscle appeared. In two of the cases the disturbance in the mobility of the eye was exactly analysed by Ohm's method with double pictures. The method has been somewhat improved by bringing the readings on to a blackboard and photographing them for inclusion in the record of the patient's case. In one of the cases observations were made continuously for fourteen days.

The above method is also to be recommended for the analysis of innervation disturbances of the eyes when of labyrinthine origin.

H. V. FORSTER.

Puncture of the Sphenoidal Sinus. K. M. MENZEL, Vienna. (*Zeitschrift für Hals-, Nasen-, und Ohrenheilkunde*, Bd. viii., Heft 2, May 1924.)

The writer recommends a sharp-pointed cannula (on the lines of the one devised by Lichtwitz) shown by him in 1914. It is about 14 centimetres in length and the thin sharp end is bent down at an angle of about 120° to the length of 1½ centimetres. It is passed through the olfactory fissure after anæsthetisation with 20 per cent. cocain. The outer end is tilted up before puncture, in order to keep the point downwards away from the roof of the sinus.

JAMES DUNDAS-GRANT.

THE LARYNX

Multiple Papillomata of the Larynx. H. BALDWIN GILL. (*Medical Journal of Australia*, 22th November 1923.)

A girl, aged 6 years, had a history of eight weeks' partial aphonia and increasing dyspnœa. Under rectal anæthesia an attempt was made to examine by means of Brünings' tube. The breathing became so hampered that tracheotomy had to be performed. A large papilloma was seen in the subglottic space. Thyrotomy was performed. The growths, which were largely attached to the depths of the sacculi and the margins of the vocal cords, were removed. The points of attachment were very lightly touched with the galvano-cautery and the larynx was closed. The child has recovered with a hoarse whisper. The case is too recent to judge of the final result.

A. J. BRADY.

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

Abstracts

Laryngeal Radiotherapy through the Thyroid Cartilage. ESCAT and LAVAL, Toulouse. (*Annales des Maladies de l'Oreille*, February 1924.)

The complications and lack of success in radiotherapy following laryngo-fissure may be classified as follows:—

1. Difficulty in applying and maintaining the radium in the wound cavity.
2. Constant irritation causing hypersecretion of the laryngeal mucosa.
3. Incessant contamination of the cut sections of the cartilage.

The case is quoted of a man who presented a growth occupying the anterior three-quarters of the right cord. The growth looked benign, the cord moving freely. There were no enlarged glands. Under local anæsthesia the growth was removed and found to be epithelioma. Laryngo-fissure was proposed to the man, but he refused further operation. He returned, however, two and a half months later, when the tumour was found to have recurred and to be occupying the whole length of the right cord and extending across the glottis; the movement of the right cord was limited. The condition seemed too far advanced for thyrotomy, and radiotherapy was decided upon. Under local anæsthesia, low tracheotomy was performed, the right wing of the thyroid cartilage was exposed and fenestrated, and 12.5 mgr. of radium were inserted between the soft tissues and cartilage, and maintained for seven days. Six months later, there was no sign of recurrence.

Among other points the writers note:—

1. The simplicity of the operation under local anæsthesia.
2. The necessity for rigorous asepsis which is obtained by preserving the laryngeal mucosa intact.

GAVIN YOUNG.

Paralysis of the Left Recurrent Laryngeal Nerve in association with Mitral Stenosis. GEORGE E. PRICE, M.D., Spokane, Washington. (*Journ. Amer. Med. Assoc.*, 19th April 1924, Vol. lxxxii., No. 16.)

The author cites an instance of left recurrent laryngeal paralysis in a cardiac patient. It cleared up as the heart condition improved. He discusses the various ways in which the paralysis may be brought about in mitral stenosis with enlargement of the left auricle, which causes pressure on the nerve by squeezing it between the left pulmonary artery and aorta or aortic ligament. He states that the paralysis may occur at any time during the course of a mitral stenosis, and may come on either suddenly, during a break in cardiac compensation, or gradually. The prognosis depends on the duration and severity of the pressure, and ability of the heart to respond to treatment.

PERRY G. GOLDSMITH.

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

PERORAL ENDOSCOPY.

Malformations of the Trachea. M. BIGLER, Zürich. *Zeitschrift für Hals-, Nasen-, und Ohrenheilk.*, Vol. viii., Part 2, p. 142.)

A case is described in which the right upper bronchus came off from the trunk of the trachea. The patient suffered from asthma and the bronchoscope was used for the purpose of carrying out Ephraim's treatment (spray of adrenalin, etc.). What appeared to be the carina was seen close below the rima glottidis, but to its left and lower down was another—the real interbronchial carina—the former being the ridge between the right bronchus proper and the right upper lobe, the bronchial tube coming off directly from the trachea. This explanation was confirmed by the X-ray examination with curved metal probes passed into the air-tubes concerned. The writer explains this rare occurrence by reference to the phylogenetic and ontogenetic relations of the bronchial tree and the lungs. JAMES DUNDAS-GRANT.

Asphyxia due to Ulceration of a Gummatous Lymphatic Gland into the Trachea. A. BEUTLER, Breslau. (*Zeitschrift für Hals-, Nasen-, und Ohrenheilk.*, Sept. 1924, Vol. ix., Part 2, p. 12.)

A young woman, who six months previously had been under treatment for syphilis, suddenly experienced increasing difficulty in breathing, and was first brought to the hospital when this had lasted for three days. There was cyanosis and both inspiratory and expiratory stridor of equal loudness. The vocal cords lay widely apart. Iodide of potassium was given and it was proposed to perform direct endoscopy, but she died before this could be done. A caseating gland was found to have discharged into the trachea through a large lateral opening. It looked like a typical tuberculous gland. It was in reality gummatous, as proved by microscopical examination. The writer advocates earlier tracheotomy and endoscopy in such a case and deprecates the administration of iodides. JAMES DUNDAS-GRANT.

Spasms and Dilatations of the Œsophagus. By L. BALDENWECK. (*Archives Internat.*, November 1924.)

The author deals, in his lecture of thirty pages, with the spasmodic affections of the œsophagus. As he strongly supports the spasmodic, against the congenital origin of œsophageal diverticula and œsophagectasis, he includes these affections under the general heading.

He subdivides anatomically the spasmodic affections of the œsophagus into general, upper, and lower.

The general group is rare and of ephemeral nature. It is found in neurotic women and in alcoholics. The passage of the œsophagoscope effects a cure.

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press

The author's views on pharyngo-spasm are based on Killian's work on the musculature of the crico-pharyngeal region. He considers that spasmodic affections of this musculature are probably induced either by a lesion of the mucous membrane, such as an abrasion, or to some disturbance of the central nervous system as typified by the *globus hystericus*. Spasm in this region can simulate very closely carcinoma of the œsophagus. He urges that for this reason all cases of suspected carcinoma should be œsophagoscoped to exclude the possibility of spasm.

The pathology, symptomatology and treatment of œsophageal diverticula and œsophagectasia are described in detail.

MICHAEL VLASTO.

The Extraction of Foreign Bodies impacted in the Œsophagus by means of Gastrostomy. EMIL NIESERT. (*Münch. Med. Wochenschrift*, Nr. 13, 71 Jahr.)

This is the record of two cases in which tooth plates provided with hooks were easily and quickly removed through the stomach, followed by rapid and uneventful healing of the operation wounds.

The screen had, in each case, depicted that the plate was obliquely impacted, and that removal with the œsophagoscope would have been unsafe.

Atropine-morphine-chloroform-ether anæsthesia was employed, the stomach having previously been emptied. In each case the transition from stomach to œsophagus was devoid of any palpable muscle-ring or constriction, and not the least difficulty was experienced in inserting two fingers into the gullet and withdrawing the plate.

The author concludes that this is the method of choice in the removal of deep-lying foreign bodies with sharp hooks or edges.

JAMES B. HORGAN.

GENERAL NOTES

ROYAL SOCIETY OF MEDICINE,

1 *Wimpole Street, London, W.*1.

Section of Laryngology—President, A. Logan Turner, M.D. *Hon. Secretaries*, E. D. D. Davis, F.R.C.S., 46 Harley Street, London, W.1, and Philip Franklin, F.R.C.S., 27 Wimpole Street, London, W.1.

The next Meeting of the Section will be held on Friday, 6th February, at 5 P.M. Patients will be shown at 4 o'clock. A *précis* of cases and specimens stating the more important facts and drawing attention to the points upon which discussion is invited should be placed in the hands of the *Senior Hon. Secretary*, Mr E. D. D. Davis.

https://doi.org/10.1017/S0022215100027092 Published online by Cambridge University Press