examination was now discontinued owing to cessation of breathing and great cyanosis. Immediate tracheotomy was performed care being taken to avoid unnecessary bleeding, a point of considerable subsequent help. As soon as the trachea was opened, and under local anæsthesia using only the smallest tube, a brass thumb-tack was found lying across the right bronchus which was too large to come away through the tubes, so tube, foreign body and forceps were removed together. A rapid and uneventful recovery ensued. *Perry Goldsmith.*

## NOSE AND NASO-PHARYNX.

**Wilson, H. W.—A Case of Rhinitis Caseosa.** "Lancet," January 27, 1912, p. 226.

Girl, aged eleven. Left naris normal. Right side: muco-pus, yellowish-white "membrane" in middle turbinate region, removable with forceps; underlying mucous membrane appeared healthy. A week's douching with alkaline lotion cleared the nose completely. Microscopically the mass consisted of long, fine needles, mixed with structureless material, with numerous microbes, pus cells and a few crystals. Bacteriologically short-chained streptococcus and *Staphylococcus pyogenes aureus.*

*Macleod Yearsley.*

**Tratman, Frank.—A Naso-pharyngeal Fibroma.** "Australasian Medical Gazette," June 29, 1912.

The patient was a boy, aged sixteen. After preliminary high tracheotomy, and application of phagones larynx, the tumour was removed. The pedicle, one inch in diameter, sprang from the base of the skull near the root of the vomer. The pedicle was easily broken through with the finger, and the area of origin scraped with a curette. Microscopic examination showed it to be a pure fibroma with some mucoid degeneration of stellate connective-tissue cells.

[Such an easily separated attachment suggests a pedunculated polypus of the naso-pharynx rather than a fibroma.—Ref.]

*A. J. Brady.*

**Kanellis, Smyrne.—Naso-pharyngeal Fibroma.** "Archiv. Internat. Laryng., Otol., Rhinol.," November–December, 1911.

From three cases of the above condition which the author carefully describes, he draws the following conclusion: That the classic opinion that these growths take their origin exclusively from the fibrous tissue of the basilar apophysis is untenable. In the first case the pedicle was inserted into the superior and internal angle of the choana and a large part of the septum. In the second and third cases the site was slightly higher up and involved the sphenoid. Kanellis considers that rhinologists would be well advised to remove these growths *per vias naturales* even when the size would appear to indicate a bloody preliminary operation such as that of Olier. In cases where this is impossible, owing to the extreme size of the growth as in the third case, sufficient access can be obtained by Moure's incision with excision of the ascending process of the superior maxilla and nasal bone. *J. D. Lithgow.*

**Jacques (Nancy).—The Insertion and Site of Naso-pharyngeal Fibromata.** "Archiv. Internat. de Laryng., Otol., Rhinol.," November–December, 1911.

This important paper, after dealing with the literature of naso-pharyngeal fibromata, gives the opinion of the author as to their insertion and site; his views are in accordance with those of many rhinologists. Jacques considers that they are inserted ordinarily by means of a thick bundle of leather-like tissue of parallel fibres into the most recessed part of the roof of the nose posteriorly. The most common point seems to be the anterior aspect of the sphenoid and more particularly the recessus spheno-ethmoidalis, whence they may spread towards the arch of the choana, the base of the vomer and pterygoid, the fossa of Rosenmüller (Moure), the ethmoid, the sphenoidal sinus and even the maxillary antrum. These diverticular expansions of the tumour are the rule; the most important and constant of all occupying the cavity of the sphenoid. In matter of frequency the ethmoidal cells are next invaded, the antrum of Highmore following; the anterior ethmoidal cells are less often affected and the frontal seldom at all. The extra-nasal prolongations may gain the cranial cavity through the nasal roof, the orbit through the lamina papyraceæ, and even, as in the case of another, the zygomatic fossa and temporal region through the distended spheno-palatine fossa. Secondary adhesions may occur wherever the tumour comes in contact with a resistant wall; above all, at the posterior edge of the vomer, these fibromata have a remarkable predilection for the left side. Before the tumour appears in the naso-pharynx the sphenoidal sinus has already been invaded some time. *J. D. Lithgow.*

**Turner, A. Logan.—The Spread of Bacterial Infections from the Nasal and Naso-pharyngeal Cavities by way of Lymphatic Channels.** "Annals of Otol., Rhinol,, and Laryngol.," vol. xx, p. 751.

An exhaustive paper of great value. Commencing with a brief review of the bacteriology of the healthy nasal and post nasal cavities. and of the common catarrhal conditions of the upper respiratory passages, Turner summarises recent work. Evidence shows that the accessory sinuses are free from bacteria during life. Interesting results of his own work (in conjunction with Esmond Reynolds) are given as to the bacteriology of accessory sinusites. The chief organisms found are the pyogenic cocci, pneumococci, *M. catarrhalis*, *B. influenzæ*, meningococci, and *B. tuberculosis*. The passage of infections (*a*) from the nasal and naso-pharyngeal cavities to the cerebro-spinal meninges and (*b*) to the cervical lymphatic glands is discussed. The former are summarised as (1) suppurative meningitis (pyogenic organisms); (2) influenzal meningitis (Pfeiffer's baccillus and allies); (3) pneumococcal meningitis (pneumococcus); (4) epidemic cerebro-spinal meningitis (meningococcus); (5) acute poliomyelitis; (6) tuberculous meningitis (*Bacillus tuberculosis*). These are discussed in detail, the evidence as to the lymphatic route of infection being carefully analysed. Turner considers that the part assigned to lymphatic vessels in these cases is largely speculative and that definite pathological proof is still wanting. He then considers tuberculous infection of the cervical lymphatic glands and lungs from the nasal and naso-pharyngeal mucous membrane in detail and concludes that further investigation and observation are still necessary. There is experimental evidence that tuberculous disease of the cervical lymphatic glands may be derived from the nasal and naso-

pharyngeal mucosa, but none in support of direct extension from cervical glands to the apex of the lung. *Macleod Yearsley.*

**Rhese.—Mucocele of the Sphenoidal Sinus with Remarks on the Ætiology of the Mucocele.** "Zeitschr. f. Ohrenheilk.," vol. lxiv, Part II.

Three cases of mucocele of the sphenoidal sinus are described in two of which a large defect in the roof of the sinus was present through which the pulsating dura mater was clearly seen. The condition may arise from cyst formation in the mucous membrane of the sinus but more usually from closure of the ostium, or a mucocele of the posterior ethmoidal cells may extend into the sphenoidal sinus. The occlusion of the ostium of a nasal accessory sinus may come about from trauma, periostitis, tumour formation, septal deviation, use of cautery, cicatrices, and inflammatory swelling. Following on the closure of the ostium special causes lead to an increase of secretion such as inflammatory swelling leading to compression of the veins about the narrow ostium and increased activity of the glands. The mucocele is to be regarded as a purely mechanical result of such changes. In the case of the sphenoidal sinus inflammatory changes in the posterior ethmoidal cells and in the recesses spheno-ethmoidalis, and unfavourable position and size of its ostium are the chief predisposing causes. *Lindley Sewell.*

**Konietzko, P. (Bremen).—Exfoliation of a Bony Sequestrum from the Region of the Sphenoidal Sinus and the Basilar Process with Exposure of the Dura.** "Archiv. f. Ohrenheilk.," Bd. lxxxiii, Heft 3 and 4, p. 282.

The patient was a male, aged thirty-three, who had lost a leg from what was supposed to be tuberculosis of the knee-joint. Three months after the amputation was performed he began to suffer from nasal obstruction and the discharge of fœtid pus, with continuous headache radiating from the occiput to the temples. After resection of the nasal septum, the right antrum and posterior ethmoidal cells, which were suppurating, were opened up, and the symptoms underwent some mitigation. Four days later a bony sequestrum was spontaneously detached from the region of the sphenoidal sinus and the basi-occiput. The sequestrum measured 3 by $2\frac{1}{2}$ by 1 cm., and consisted of the border of the left and part of the border of the right choanæ, together with the site of attachment of the vomer, the floor of the sphenoidal sinus and a portion of the basilar process. The author suspected that the dura must have been exposed. Eighteen months later the patient returned with a recent perforation through the soft palate, and then for the first time suspicions of syphilis arose. Under anti-syphilitic treatment the lesion began to cicatrise, but ascites from cirrhosis of the liver set in and two months later the patient died with symptoms of meningitis.

*Post-mortem:* Purulent basal meningitis. The dura showed in the centre of the dorsum sellæ a fistula the size of a lentil through which a probe could be passed into the nasal cavities. The dura around the opening was necrotic, and further examination showed that it had been laid bare by the exfoliation of the sequestrum. The delayed appearance of the meningitis until two years after the detachment of the sequestrum was obviously due to the fact that the dura had remained intact until the syphilitic ulceration had effected its penetration.

*Dan McKenzie.*