not exhibit so many follicular deposits as in ordinary cases ; pain is, however, a very pronounced symptom. Severe pain of short duration precedes perforation of the drumhead frequently where the ears have previously been quite healthy, and there is no doubt that influenza lights up inflammation in an ear that had some time previously been inflamed but had reached a quiescent state. [We can all confirm this observation —*Rep.*]. Ecchymosis in the pharynx and larynx has been fairly frequently noted. Dr. Robinson has never seen ulcerations, pronounced œdema, or membranous deposits.

The cough of influenza has various underlying causes, but apart from congestion and inflammation of the throat, intense gastric catarrh will cause it, and it is then allayed by appropriate gastric remedies. Also a depressed state of the nerve centres permits of cough being readily induced, owing to the inflamed nerve filaments being unduly sensitive. Choreic movements and spasmodic conditions affecting the larynx are rare and late sequelæ.

Sudden inflammation of the muscles of the neck with pain, redness, and rigidity, but rapidly subsiding within twenty-four hours, was observed in one case. The author prescribes the following tablet—

Caffein citrat .....gr. ½
Phenacetin .....gr. i.
Ammon. salicylat.....gr. iii.

One every two or three hours. Alkalies are also administered along with this. Other appropriate local treatment by sprays, gargles, poultices, &c., is also of use. Gargling with carbolized alkaline solutions is regarded as an excellent and reliable prophylactic. [I rely considerably on this prophylactic, and frequently used it during the late epidemic in Bristol.—*Rep.*] *B. J. Baron.*

LARYNX.

Moskowitz (Budapesth).—*Sclerosis of the Air Passages.* " Pesther Med. Chir. Presse," 1892, No. 6.

A PATIENT, fifty-two years old, had rhinoscleroma, which spread to the larynx and trachea, for six years. She wore a tracheal canula. She came with strong attacks of suffocation, and died two days later. The *post-mortem* examination showed sclerosis of the nose, pharynx, larynx, and trachea. *Michael.*

Frühstück.—*Prophylaxis of Tuberculosis of the Lungs and Larynx.* Dissertation. Göttingen: 1891.

REVIEW. *Michael.*

Rice.—*The Troublesome Symptoms caused by Enlargements of the Epiglottis, and the Advisability of Reducing the Size of this Cartilage by Operative Measures.* " New York Med. Journ.," April 9, 1892.

THE author believes that the epiglottis becomes enlarged and congested when there is no corresponding congestion of the larynx, and when there

is no hypertrophy of the lingual tonsil. Such an abnormal epiglottis causes troublesome symptoms either by touching the tongue or the sides of the pharynx, and by becoming periodically inflamed and swollen. He attributes the abnormal shape of the cartilage, which we often see, to such contact.

Enlargement of the lingual tonsil is said to be the most frequent cause of epiglottic trouble, but congenital formation must be taken into account. Normally, the margin of the cartilage escapes the posterior wall of the larynx by the distance of one-fourth of an inch ; if it be elongated it touches it. A broad epiglottis, on the other hand, is very apt to come in contact with the sides of the pharynx if there is any lymphatic enlargement. If there be a sharp anterior curvature of the superior margin, then it is subjected to friction with the base of the tongue. The pendulous epiglottis is due to the increased weight of its margin, caused by disease, *e.g.*, tubercle, fibroma, etc., and an article by Sir Duncan Gibb is quoted as showing that natives of hot climates are liable to this from relaxation.

An unusually high position of the cartilage exposes it during deglutition, and impurities in the atmosphere affect it unduly ; therefore, alcohol and tobacco are especially liable to excite congestion. Dyspeptic troubles and pulmonary or cardiac disease keep the epiglottis worried.

As regards the morbid histology of the enlargement, it is a cartilaginous hypertrophy. The symptoms of this hypertrophy and the accompanying congestion are tickling and feeling of fulness in the larynx, spasmodic cough, vomiting, partial loss of voice, " empty swallowing," and fatigue of the voice.

As regards treatment, no astringent is of any value ; cocaine and oily solutions are temporarily helpful, but do not cure. Removal of part of the epiglottis by the cautery is risky from the amount of imflammatory œdema induced, and the author uses a pair of long-handled scissors to snip off the redundant margin. Bleeding is free, but can be checked by the application of nitrate of silver. Inflammation following the operation is not severe. *B. J. Baron.*

Roaldes.—*A Case of Atresia Laryngis from Catarrhal Laryngitis, with Presentation of the Patient, followed by Intubation.* "New Orleans Med. and Surg. Journ.," Feb. 1892.

THE cause assigned for the marked atresia that existed in this case, and which was just such as one sees so frequently after syphilitic ulceration, was a cold caught by getting thoroughly wet. Canulas were introduced and Whistler's instrument, but the opening into the larynx refused to remain dilated. Tracheotomy had to be performed, and since then Schrötter's tubes have gradually dilated the opening until a No. 4 can be introduced, and lastly O'Dwyer's tubes have been used with success. The author relies on the facts that all history of syphilis is absent, and that there is no evidence of tubercular mischief, for making the diagnosis of a mere catarrhal laryngitis *a frigore*, and such ulceration following it as to lead to such serious results. He quotes a similar case in Schrötter's practice published by Zuffinger.

As regards treatment the author mentions three methods :—

1. The endo-laryngeal method alone by Mackenzie's dilator, Whistler's cutting dilator, Navratil's and Moure's instruments, and Schrötter's tubes, all of which can only be kept *in situ* a short time. Of those that are destined to remain in the larynx for long periods, O'Dwyer's intubation tubes are regarded as best.

2. Tracheotomy followed by dilatation by Schrötter's method.

3. Laryngotomy.

This ought to be limited to cases of chronic stenosis due to obstructive neoplasm, or for the extraction of foreign bodies. *B. J. Baron.*

Schmiegelow (Copenhagen).—*Intubation of the Larynx in Acute and Chronic Stenosis.* "Monats. für Ohrenheilk.," 1892, Nos. 1, 2, 3, 4, 5.

(A.) OF four cases of acute diphtheritic stenosis, in which intubation was performed, three died. (B.) Chronic stenosis:—(1) A patient, seven years old, had a stenosed trachea from a tracheal canula. Treatment by intubation. The extensively communicated case is not yet cured. [Some months later sudden death from asphyxia.] (2) A child, six years old. had had tracheotomy performed for diphtheria three months previously. Intubation. Cured after having intubation kept up for a whole year. (3) A patient, thirty-three years old, wore a tracheal canula for fifteen years because of diffuse stenosis and hypertrophy of the mucous membrane. Intubation; death some days later from asphyxia. (4) A patient, four years old, had had tracheotomy performed eight days before. The canula could not be removed. Intubation during a month; cure. (5) A patient, two and a half years old, had had tracheotomy performed because of diphtheria seven months previously. Granulation stenosis; intubation; death from asphyxia. Cases 6, 7, and 8 not yet cured. [The results are so unfavourable that we cannot agree with the author in the recommendation of the method.] *Michael.*

Brown, Dillon (New York).—*A Case of Stenosis of the Larynx, in which the Intubation Tube was retained nine months; recovery with a good voice.* "Arch. of Pediatrics," June, 1892.

A LITTLE girl, aged three and a quarter, had intubation done seven days after the first appearance of laryngeal symptoms. Twelve days after marked dyspnœa was present, during the course of an attack of diphtheria. Dyspnœa was immediately relieved, and a piece of pseudo-membrane was coughed up. At the end of seven and a half days the tube was removed, but had to be returned within fifteen minutes on account of return of dyspnœa. Four different attempts were made to remove the tube, but it had to be returned each time, after intervals ranging from four hours to thirteen days. It being impossible to insert a full-sized O'Dwyer's tube, and the smaller one not relieving dyspnœa, tracheotomy was performed. There was marked stenosis of the trachea, not extending along its whole length. At the time of operation only the inner tube of the canula could be pushed into the trachea, where it fitted very tightly, but next day the parts being stretched a regular tube could be inserted. A month after the tracheotomy tube was removed, and after dilating from below with sounds, a three-year old O'Dwyer tube was

inserted. An attack of pneumonia subsequently followed. The tube was removed every month or two, but always had to be reinserted within an hour. Digital exploration proved the larynx to be occupied with granulation tissue overlapping the edge of the tube. A larger tube was inserted to press upon the granulations, and subsequently this could be finally removed, and there has been no return of dyspnœa, and the patient is now perfectly well, and has a good though at times rather harsh voice. *R. Norris Wolfenden.*

Grünwald (München).—*Primary Inflammations of the Crico-Arytenoid Joint.* "Berliner Klin. Woch., 1892, No. 20.

THE author has observed five cases in which he believes there was primary inflammation of the crico-arytenoid joint. They had all the following symptoms :—(1) Disagreeable feeling in swallowing on both sides of the neck, sometimes felt in the tonsils or in the hyoid bone ; (2) this feeling was increased by pressure in the region of the joint ; (3) the feeling was increased in the dorsal position ; (4) crepitation of the painful point ; (5) pain on pressure on the same part, and also by rotation of the arytenoid cartilage to the inside ; (6) hyperæsthesia of the region of the joint when touched with a probe. *Michael.*

Krause (Berlin).—*Centripetal Conduct of the Nervus Laryngeus Inferior and the Pathological Median Position of the Vocal Band.* "Berliner Klin. Woch.," 1892, No. 20.

NINE experiments made by the author gave the following results. The view of Burkart, that the nervus laryngeus inferior has not only centrifugal but also centripetal functions, must be allowed, and that centripetal irritation of the nerve produces not only expiration position of the diaphragm and arrest of the respiration, but also constriction of the larynx, adduction of the vocal bands, and persistence of the vocal bands in the position of adduction ; also by electrization of the nerve its sensibility is proved. The laryngeus inferior, therefore, is a mixed nerve. As such it can produce reflex symptoms, as tremor, spasm, and contractions. Concerning the posticus the author agrees with Hermann von Meyer and Jelenffy that it is not only a muscle of respiration, but also the regulating antagonist of the crico-arytenoid muscle (anticus) in its phonatory functions. So we understand that the muscle also is touched by every irritation of the whole larynx, and answers by reflex contraction of the vocal band. The atrophy sometimes found is produced by the persistent effect of mechanical irritation on the nerve by which the less resistant muscle becomes atrophic. *Michael.*

Meyes (Amsterdam). — *Case of Laryngeal Chorea Cured.* "Monats. für Ohrenheilk.," May, 1892.

A PATIENT, fifty-two years old, had a dry, irritating cough for four years. Cured with antipyrin. *Michael.*

Bowen.—*A Fatal Case of Laryngismus Stridulus in an Infant Six Days Old.* "Med. News," April 16, 1892.

THIS was a healthy child with no sign of rickets, with no pharyngeal or

laryngeal abnormality, and whose parents were healthy, strong people. The author thinks that we ought to administer chloroform in severe cases rather than wait for more slowly acting drugs to exert their effects. He has not been able to find records of any similar case in so young an infant, which was fatal. *B. J. Baron.*

Lichtwitz (Bordeaux).—*Operation for Multiple Papillomata of the Larynx in a Child; Intubation.* "Deutsche Med. Woch.," 1892, No. 20.

THE report of the meetings of the Société de Laryngologie, Rhinologie, et d'Otologie of Paris in this Journal. *Michael.*

Schäfer (Heidelberg). —*Diffuse Pachydermia of the Larynx.* Verein der Pfälzischen Aerzte, 1891, No. 7.

DESCRIPTION of five cases of pachydermia observed in Jurasz's clinic. The cases were improved by removal of the diseased parts. *Michael.*

Giles, Anstey (Adelaide).—*A Case of Partial Laryngectomy.* "Australasian Med. Gaz.," Feb., 1892.

THE patient, a married man, aged fifty-one, had complained for three or four months of hoarseness, and a disagreeable sensation, hardly amounting to pain, whenever he swallowed. The voice had been becoming gradually more and more husky. There was cough and profuse expectoration, especially at night. There had been no hæmoptysis, although on two or three occasions the sputum had had a sanious tinge. His previous health had been good, and he had never suffered from any venereal trouble. His father died of cancer of the stomach, but no other relative had suffered from malignant disease. The pharynx was found to be healthy. On laryngeal examination the posterior part of the right vocal cord was found ulcerated, and a fungating mass infiltrated the ventricular band and the ary-epiglottic fold. The right arytenoid cartilage was much swollen. The left half of the larynx appeared fairly healthy ; the vocal cord was somewhat congested, but was otherwise normal, and moved freely. The right cord was firmly fixed. Portions of the projecting mass were removed by means of Schrötter's forceps, and on section presented the appearances of true epithelioma. There were no enlarged glands in the neck. The heart and lungs were healthy. It was decided, from the fact that the growth was limited to one side of the larynx and also from its recent origin, to remove one-half of the larynx. A high tracheotomy was first performed and a Trendelenburg's india-rubber inflating tampon canula inserted. The thyroid perichondrium and the soft parts lying over it were carefully peeled off from the cartilage by means of a raspatory. The cartilage was then divided along its centre. During the progress of the operation the rubber tampon collapsed, with the result that a quantity of mucus and blood passed into the trachea, and set up troublesome coughing. The operation had accordingly to be finished somewhat quickly. At first the patient seemed to do well, but on the second day died of septic pneumonia. The author attributes the want of success to the failure of action of the tampon-canula, and strongly advises the use of Hahn's instrument (which unfortunately he had been unable to

procure) in place of Trendelenburg's. He also strongly advises the stripping of the perichondrium, together with the soft tissues from the thyroid cartilage, as a decided advance in this operation. In cases of carcinoma affecting both sides of the larynx he recommends tracheotomy in preference to total extirpation. *W. Milligan.*

THYROID GLAND.

Hofmeister.—*Physiology of the Thyroid Gland.* "Fortschritt der Medicin, 1892, No. 3.

IN rabbits whose thyroid gland was extirpated the author found that the hypophysis cerebri had double the weight of that of other animals. In the animals without thyroid gland the development of the bones was also much diminished. *Michael.*

Podbelsky (Kasan).—*On the Existence of Colloid in the Lymph Vessels o Goître.* "Prager Med. Woch.," 1891, Nos. 19, 20.

TWENTY cases examined, in four of which colloid substance was found in the lymphoid vessels. *Michael.*

Lydston, F. (Chicago).—*Cases from Private Practice.* 1. *Acute Thyroiditis with Abscess.* "New Orleans Med. and Surg. Journ.," May, 1892.

A YOUNG man of twenty-four, with incipient pulmonary phthisis, improved very rapidly on the Shurley-Gibbes treatment, when the right thyroid lobe began to swell, and was painful on pressure. Dysphagia occurred and the temperate rose to 103½. The tumour being aspirated allowed exit of some pus. On being tapped, three ounces of pus were withdrawn; the cavity of the abscess was irrigated with peroxide of hydrogen, and pus ceased to form though the gland remained large.

This and one other case of thyroiditis with abscess led the author to conclude that it is not good practice to wait for fluctuation in such cases, the capsule and thyroid tissues being so dense as to mask this symptom. Pain is disproportionately severe in such cases, and a small punctured incision is better than a free one, the gland shrinking rapidly after evacuation of the abscess, and hæmorrhage is thereby avoided.

R. Norris Wolfenden.

Kugler (Graz).—*The Diagnosis of Accessory Goîtres.*—"Wiener Med. Woch.," Nos. 13, 14, 15.

A PATIENT, twenty-two years old, had on the right side of the neck a tumour of the size of a little apple. The tumour could be moved, but seemed to be fixed to the hyoid bone. The tumour was noticed in the patient in his eighth year, and was at that time the size of a bean, and gradually increased. It was diagnosed as accessory goître, and removed. Cure. The author then referred to the diagnostic symptoms