Abstracts.

PHARYNX.

Rolleston, J. D.—Local Treatment of Vincent's Angina with Salvarsan. "Proc. Roy. Soc. Med.," November, 1913, Clin. Sect., p. 1.

Patient, aged twenty; admitted August 2, 1913. Fauces slightly infected, dirty deposit on right tonsil, numerous Vincent's organisms in smears. Throat culture negative for diphtheria. August 3: Well-marked ulceration of right tonsil. Various local measures tried. Applications of methylene-blue powder, syringing with potassium chlorate and lavender, painting with tincture of iodine, but the ulceration spread on to the palate and uvula, which became œdematous and covered with a dirty slough. Submaxillary adenitis appeared, there was sore throat, difficulty in swallowing and pain in both ears.

On August 17 all other treatment was omitted and a throat-swab moistened with glycerine was dipped in salvarsan powder and rubbed all over the affected area. August 18: Slough clearing off palate and uvula, sore throat and earache less, still numerous Vincent's organisms in smear. Second application of salvarsan. August 19: Third application. August 21: No Vincent's organisms in smear. August 25: Still an opaque area on upper part of uvula and soft palate. Fourth application. In twelve days' time throat quite normal. A short account follows of the use of salvarsan in Vincent's angina. It is preferable to use it locally as it gives better results than when injected intravenously.

Raymond Verel.

Leslie, F. A.—Tonsil Enucleation with the Wire without Preliminary Dissection. "The American Medical Compend.," December, 1912.

The author pleads for as little dissection as possible in the performance of tonsillectomy, and has been successful in removing the tonsils with the snare alone in 50 per cent. of the cases attempted. The operation, which may be done equally well under local or general anæsthesia, is performed with any good snare and tonsil forceps. For operative purposes the tonsils may be divided into ball-valved, partly protruding and deeply embedded tonsils. The first variety can be easily removed with snare alone; the two latter often require some preliminary dissection, but only enough to give the wire a place to start. In the case of embedded tonsils the gland must be everted before the wire is placed in position between the pillars. To insure proper eversion a good forceps is essential, and the tonsil must be seized in its middle with a *deep* and *narrow* bite. Traction is then made in that direction which produces most eversion; this is generally forwards. The advantages claimed are an absence of hæmorrhage during removal, less hæmorrhage after removal, more expedition in operating, and a shorter period of healing with less subsequent scar-contraction. *J. B. Horgan.*

Kuhn, Franz (Berlin).—The Major Surgery of the Mouth (Tongue and Tonsil) without Division of the Jaw or Tracheotomy. "Zeitschr. f. Laryngol.," Bd. vi, Heft 2.

Kuhn reminds us of the unfavourable character of the statistics concerning operations for cancer of the tongue, and calls attention to the importance of an early diagnosis.

In cases of cancer of the back of the tongue and tonsil, Kuhn first uses Kocher's incision and clears out the glands and ligatures the vessels. For the second part of the operation Kuhn uses the thermo-cautery through the mouth. If possible, the second stage is carried out immediately after the first. The necessity for tracheotomy or laryngotomy is obviated by the use of the writer's peroral intubation apparatus.

In cases of cancer of the anterior part of the tongue Kuhn makes a crucial incision after Küttner's method and so clears out the submental glands. The article is illustrated by three anatomical plates.

J. S. Fraser.

NOSE.

De Roaldes, A. W., and Lynch, C.—The Preparation and Use of Thrombokinase. "New Orleans Med. and Surg. Journ.," September, 1912.

Thrombokinase is prepared by extracting the tissues (sheep's lungs) in sterile water. A precipitate is thrown down by treating with acetic acid; this is neutralised and twice evaporated to dryness after treatment successively with water and a solution of thymol in alcohol.

All experiments showed thrombokinase to be more active than any other agent in producing clotting. Three cases are given in which it was used:

Case 1.—A submucous resection in a patient suffering from hæmophilia.

Case 2.—A turbinectomy in a similar patient.

Case 3.—Removal of a large papilloma from the nose.

In these cases the application of thrombokinase rapidly arrested hæmorrhage when all other measures had proved unsuccessful.

Knowles Renshaw.

Citelli (Catania).—Large Primary Osteoma of the Frontal Sinus. "Annales des Mal. de l'Oreille, du larynx, du nez, et du Pharynx," vol. xxxix, No. 5.

November 1, 1911: A youth, aged fifteen, consulted the author with the following history: Ten months previously he noticed a swelling at the supero-internal angle of the right orbit, accompanied by lachrymation and suffusion of the conjunctiva. Several surgeons had been consulted, one of whom diagnosed a bony growth of the frontal sinus, perhaps in relation with the dura mater. On examination, a hard swelling, the shape and size of a nut, presented itself above the inner canthus of the right eye. The overlying tissues were normal and mobile. Vision unimpaired. Nothing pathological in the nasal fossa. The patient only complained of occasional slight pain and feeling of heaviness in the head. In view of the radiograph and physical signs, osteoma was diagnosed November 16. The author operated and found an osteoma almost completely filling the frontal sinus. The anterior and most of the inferior wall had been destroyed. As the neoplasm completely filled the sinus it could not be seized for detachment, and its density precluded its division into fragments. Removal was effected by introducing a scalpel between the growth and the posterior wall of the sinus and carefully levering it out. The cranial wall was found wanting over an area of a square centimetre, but the dura was intact. The tumour originated on the postero-

median part of the sinus floor over some ethmoidal cells which jutted into the sinus, hence the ease with which its point of insertion was fractured. *H. Clayton Fox.*

Eckstein (Kattowitz).—Osteomyelitis of the Frontal Bone and Thrombosis of the Longitudinal Sinus. "Zeitschr. f. Laryngol.," Bd. v, Heft 2.

After a *resumé* of the literature of osteomyelitis following frontal sinus suppuration, Eckstein records a case of acute bilateral frontal sinusitis with suppuration in the left maxillary antrum. Male, aged fifteen, admitted August 1, 1911, with a history of pain for ten days in left frontal region. On admission, temperature 39° C.; great tenderness in left supra-orbital region; eyelids on left side swollen and conjunctivæ chemotic; protrusion of left eyeball; both middle turbinals swollen; pus from both frontal sinuses. Pus washed out of left antrum. Permission only obtained for removal of anterior end of middle turbinal and incision of subperiosteal abscess; foul pus evacuated and bare bone revealed August 2: Right eye swollen; heart irregular; dulness at left base. August 4: High fever and somnolence; right eye proptosed. August 5: Permission obtained for further operation. Kuhn's intubation narcosis; second subperiosteal abscess at outer part of left orbit. Advanced osteomyelitis of frontal bone on left side; left sinus only the size of a cherry—it contained swollen blueish-red mucosa and stinking pus. Frontal process removed and left ethmoid and sphenoid cleared out. Typical Killian operation on right side—no osteomyelitis here. Death the same evening.

Autopsy (head only examined).—Purulent thrombosis of superior longitudinal sinus; extra-dural abscess on left side over frontal lobes; no meningitis. (Unfortunately the bacteriology is not stated.—*Abs.*) Of the fourteen cases of thrombo-phlebitis of superior longitudinal sinus collected by Eckstein, six had also osteomyelitis. *J. S. Fraser.*

LARYNX.

Scripture, E. W.—Speech without a Larynx. "Journ. Amer. Med. Assoc.," May 24, 1913.

In the case reported, that of a man who had had his larynx removed with subsequent complete closure of the passage from the mouth to the trachea, speech was entirely absent. By employing some of the finer principles of phonetics and by teaching the patient to close his lips and compress the air in his mouth and pharynx by tension on the cheeks and in the back of the throat, the author succeeded in developing a speech that could be distinctly heard through two large rooms.

Birkett (Rogers).

Imhofer, R. (Prague).—Metastatic Abscesses in the Muscles of the Larynx in a Case of Pyæmia. "Zeitschr. f. Laryngol.," Bd. vi, Heft 2.

The case recorded by Imhofer is that of a child, aged fifteen days. The pyæmia was due to septic infection of the umbilical vein. The left knee-joint was the first to become swollen, but later the left hip and wrist joints and the right shoulder were also affected. At the *post-mortem*

pyæmic abscesses were found in the liver, lungs, heart, intestines, kidneys, muscles and bone-marrow. The pharyngeal and laryngeal mucosa was markedly injected. The *Staphylococcus pyogenes* was the infecting organism.

On microscopical examination Imhofer found an abscess in the substance of the thyro-arytænoideus internus muscle, and a vessel with necrotic walls was found opening into the abscess; this vessel had evidently been the seat of a septic embolus. Smaller abscesses were found in the other laryngeal muscles, and the case was evidently one of pure hæmatogenous infection of the larynx.

Similar infections have been described in smallpox, rheumatic polyarthritis and gonorrhœa, and Albrecht has attempted to produce tubercular pyæmic abscesses of the larynx by injecting tubercle bacilli into the blood of animals. He at first got negative results even when he injured the laryngeal mucosa, and only succeeded when he ligatured the carotid above and below the thyroid artery, injected the part between ligatures with tubercle bacilli and then removed the lower ligature. Imhofer points out that the abscesses in his case differed from those in phlegmonous inflammation of the larynx and solitary abscess of the submucous tissue. In his case the abscesses were situated in the muscles while the submucous tissue remained free from inflammatory œdema.

J. S. Fraser.

ŒSOPHAGUS.

Thomson, Sir StClair.—Removal through the Mouth of a Tooth-plate impacted in the Œsophagus for $2\frac{1}{2}$ years. "Lancet," January 4, 1913, p. 16.

Man, aged twenty-two, swallowed half a tooth-plate in May, 1908. Examination at a general hospital in July, 1908, and at a throat hospital in July, 1909, gave no apparent results. In August, 1909, a bougie was passed into the stomach, and, in view of this fact, œsophagotomy was refused. Later, his case was considered (at a general hospital) to be one of functional dysphagia. The tooth-plate was discovered finally at the London Throat Hospital, and it was triumphantly removed at King's College by means of Brünings' tube. The case is a most instructive one.

Macleod Yearsley.

EAR.

Storath, Emil.—The Resemblance of "Friedländer Otitis" to "Mucosus Otitis." "Arch. f. Ohrenheilk.," Bd. xciii, Heft 1 and 2.

[The full title of this paper is "The Relations of Friedländer Otitis to Capsulated Coccus Otitis, with a New Case of Otitis Media Acuta due to the Bacterium" (*sic*) "Pneumoniæ of Friedländer."]

Neumann and Ruttin have shown that when acute otitis media is due to a non-capsulated coccus the course run by the disease is typically as follows: The symptom-picture is characterised by a rapid rise in severity and a rapid decline by crisis when the tympanic membrane is opened. If a complication is to follow the symptoms do not quite disappear before it sets in, but gradually merge into those of the complication.

This contrasts markedly with the course of events when the *Strepto-*

coccus mucosus is the infecting organism. Then, after the membrane has been opened (and also when it remains intact), a gradual decline of symptoms occurs and an interval follows during which pain is absent and the only abnormal phenomena present are deafness and tinnitus. If paracentesis is performed nothing but mucus escapes and the opening made soon closes again. The whole incident may escape the patient's attention entirely. Finally, however, a complication suddenly sets in, and this is generally mastoiditis, a gravitation abscess, an extra-dural abscess, or less frequently meningitis or brain abscess.

A similar course, it has been observed, is taken by pneumococcus otitis in adults.

Storath, in the present article, shows, by an analysis of the cases reported in the literature and of a further case now for the first time recorded, that acute otitis media due to Friedländer's bacillus behaves very like mucosus otitis. There are some differences, however.

In the Friedländer type there is an acute onset followed by a long interval with deafness and tinnitus and then a complication suddenly appears. The complication is, however, more severe than in mucosus otitis. In both types about three months, on the average, elapses between the first onset of the disease and the appearance of the complication. In more than half of the cases the membrane did not rupture or there was an early cessation of the trifling discharge. The destruction of bone was less wide-spread than in mucosus otitis.

It is remarkable that in the four cases in which the nose was examined Friedländer's bacillus was also present in that cavity.

The author notes that most observers now agree that the assumption of a capsule protects the invading organism against the tissue defences and so indues it with an additional virulence. *Dan McKenzie.*

Randall, A.—Operations for Mastoid Empyema and Caries. "Therapeutic Gazette," May, 1913.

The diagnosis between mastoid empyema and caries is of importance, as in the former condition operation is by no means always necessary, since, as a rule, acutely empyematous cavities can successfully drain by their natural channels. All the classic signs of mastoiditis may be absent if a carious affection is separated from the surface by a dense layer of bone. In such cases the line of least resistance is frequently inward. Caries of the inner table is often found, but it is doubtful whether this condition furnishes symptoms of its own. The list of signs given by many writers for extra-dural abscess are frequently quite absent.

Cases with chronic middle-ear suppuration are living over a powder magazine, but explosion is the exception; if, however, the case cannot be kept under observation, a radical attempt at cure is better than neglect. The rational surgery of this region demands evisceration of seriously diseased tissues as well as good drainage, but much can be done by the "*vis medicatrix naturæ*."

In all cases the mastoid antrum should be regarded as part of the tympanum and not as a mastoid cell. Cases of chronic otorrhœa are often due to cholesteatomata, and mastoid complications are comparatively rare. Cholesteatoma urgently requires relief, but this may be afforded conservatively; radical operation is not invariably indicated.

In a large percentage of cases when operation is required, Stacke's operation is sufficient to effect a cure. It is best done by laying the soft

tissues forward and chiselling away the upper back wall of the meatus from a point 10 mm. external to the drum-head.

Complete tympo-mastoid evisceration is indicated when there is evidence of grave mischief in the mastoid or neighbouring parts. External symptoms may not be marked, but deep-seated pain, fever, arrested discharge, high polymorphonuclear count, with, perhaps, rigors and vertiginous crises, plainly show the necessity for immediate action. Under these circumstances the operation should be prompt and thorough.

Knowles Renshaw.

Wood, J. Walker.—The After-treatment of Mastoid Operations. "Annals of Otology, etc.," xxi, p. 627.

Includes an analysis of results in 260 radical and 100 conservative operations. A long paper. Some of the author's conclusions are: (1) The sooner a chronic suppurating ear is operated upon the better is the chance of recovery. (2) That even a very chronic ear discharge can be cured. (3) Great deafness before operation is usually improved by it. (4) Slight deafness before operation is always made worse by it. (5) The quicker the healing the better the prospect of improvement in hearing. (6) Hearing depends on the adhesions and density of the scar-tissue about the round and oval windows. (7) Hearing is always worse if stapes injured at time of operation. We cannot agree that the Schwartze operation has "largely fallen into disuse since" Mr. Heath introduced as so-called conservative operation. *Macleod Yearsley.*

Amberg, Emil.—Middle-ear Suppuration and Life Insurance. "Annals of Otology, etc.," xxi, p. 769.

The relation of chronic middle-ear suppuration to life insurance is by no means a simple question. Concerning radically operated cases, the decision is not very difficult. Non-operated cases require careful discrimination. It would seem that not all people with a chronic middle-ear suppuration should be excluded from life insurance, even if they have not been operated upon. The unilateral or bilateral diminution of hearing also enters into consideration. *Macleod Yearsley.*

MISCELLANEOUS.

Borden, C. R. C. (Boston, Mass.).—Salvarsan in Lesions of the Nose and Throat. "Journ. Amer. Med. Assoc.," September 21, 1912.

The Boston City Hospital has had the most rapid and satisfactory results with the use of salvarsan in all syphilitic lesions of the nose and throat, with the exception of the larynx, which does not react so favourably to treatment. Any acute inflammation, other than luetic, of the eye, heart, kidneys or nervous system, contra-indicates its use.

Salvarsan is injected intra-venously, 0·9 to 0·6 gr. constituting a dose, followed by mercury and iodide in the ordinary doses. Sometimes 0·9 gr. is given in one dose, to be repeated in three months, but is not followed by a course of iodide.

Untoward symptoms were two deaths, some very sore arms, arsenic poisoning, panophthalmitis, and two cases of tinnitus with fulness in one ear and some decreased hearing, which cleared up after a few weeks.

Birkett (Rogers).

Schlesinger, Ernst (Prof. Gerber's Clinic).—Results obtained with Neo-salvarsan in Cases of Luetic Affections of the Upper Air-Passages. "Zeitschr. f. Laryngol.," Bd. vi, Heft 3.

The writer states that in the early stages of syphilis they give mercurial injections in addition to injections of neosalvarsan, while in the later stages they combine the neo-salvarsan treatment with mercury or iodine.

Schlesinger calls attention to the greater solubility and ease of administration of neo-salvarsan over the older remedy. Details are given of nineteen cases of syphilis and six cases of non-specific affections due to spirochætæ other than the *Spirochæta pallida*.

Schlesinger considers that the ideal to be aimed at is a total dose of 2·4 to 3 grm. of neo-salvarsan spread over four injections, beginning with an injection of ·5 or ·6 of a gramme. The method used was that described by Dreyfuss in the *Münch. med. Wochenschr.*, 1913, Nr. 12. In no case did the patient collapse after the injection, but in six cases the reaction was severe, in three slight, and in nine the reaction was altogether absent. If a single dose is to be given Schlesinger recommends ·8 for men and ·6 for women. Great differences are noted in the effects of the injection as regards the rate of disappearance of signs of the disease and of the spirochætæ; for this the paper must be read in the original.

J. S. Fraser.

BRITISH MEDICAL ASSOCIATION.

Eighty-second Annual Meeting, Aberdeen.

July 28, 29, 30 *and* 31, 1914.

Section of Laryngology, Rhinology, and Otology.

President: Harry Lambert Lack, M.D., F.R.C.S., London. Vice-Presidents: James Mackenzie Booth, M.D., C.M., Aberdeen; John Smith Fraser, M.B., F.R.C.S.E., Edinburgh; Albert Alexander Gray, M.D., F.F.P.S., Glasgow; Thos. Hillhouse Livingstone, M.D., F.R.C.S.E., Newcastle-on-Tyne.

The following subjects have been selected for special discussion:

Wednesday, July 29, 10 a.m. — Discussion: "The Treatment of Inoperable Growths of the Nose and Throat." (*a*) Diathermy, Mr. W. D. Harmer, London. (*b*) Radium, Dr. William Hill, London. (*c*) X Rays, Dr. John Macintyre, Glasgow.

Thursday, July 30, 10 a.m. — Discussion: "Otosclerosis." (*a*) Ætiology and Pathology, Dr. A. A. Gray, Glasgow. (*b*) Clinical Aspects, Mr. J. S. Fraser, Edinburgh. (*c*) Treatment: (1) Various Methods, Mr. G. J. Jenkins, London. (2) Auditory Re-education, Mr. F. F. Muecke, London.

Friday, July 31, 10 a.m.—Papers. *The following is also promised:* "Demonstrations of the Pathology of Labyrinthitis," Mr. J. S. Fraser, Edinburgh.

The Hon. Secretaries are: Oliver St. John Gogarty, M.D., 15, Ely Place, Dublin; John Francis O'Malley, F.R.C.S., 16, Weymouth Street, London, W.; Henry Peterkin, M.B., 17, Bon Accord Crescent, Aberdeen.