

gitis still present, but the dysphonia and some of the vagaries of the functional type are superadded. I may say that two of our best authorities, who have left the meeting, regarded the case as one of typical functional aphonia, but Dr. Douglas Grant's lucid observations upon it so completely embody my own views that I need only refer to what he has said for a just expression of them.

Abstracts.

PHARYNX.

Stout, P. Samuel.—**Papilloma of the Uvula.**—"Laryngoscope," 1915, p. 88.

Female, aged fourteen (coloured), noticed five months ago that something went down her throat when she swallowed and came up again when she hawked, coughed, or gagged. It did not seem to interfere much with talking or eating, but of late when she coughed it up it would fly out and strike her front teeth, and at times even came out between her teeth. Examination showed a mass hanging to the end of a very long uvula. The mass was as large as an almond. It was removed under local anæsthesia, and had not recurred at the end of one year.

J. S. Fraser.

Goldstein, Max A.—**Angioma of the Uvula.**—"Laryngoscope," 1915, p. 90.

Female, aged twenty-five, about eight years ago felt a roughness of the throat near the base of the tongue. Later there was difficulty in nasal respiration. Three years ago deglutition became impaired. Examination showed a tumour of the uvula of sufficient size to impair speech and to cause frequent regurgitation of fluid through the nose, and to excite a more or less constant short cough. The uvula was enlarged, tortuous, and mottled blue-red. The most pronounced varicosities were at the tip, but they also extended into the soft palate. On palpation the tumour was indurated and nodular. It was successfully removed under local anæsthesia.

Operation.—A widely curved uterine hæmostat, the distal end of which was shaped something like a pot-hook, was clamped well above the upper tortuous vessels. A large aneurysm needle, threaded with strong silk, was passed from behind through the palate and two ligatures firmly tied on either side, the outer curve of the clamp forceps preventing the slipping of the ligatures. With a bistoury curved on the flat the tumour was removed, using the lower curved edge of the clamp as a guide. The clamp was left in position for several hours, and the sutures were only removed on the third day. There was absolutely no deformity of the soft palate after the operation, and no recurrence after five years. Speech was perfectly normal.

J. S. Fraser.

NOSE.

Gundelach, C. Armin.—**Posterior Nasal Operation by means of the Naso-Pharyngoscope.** "Laryngoscope," 1915, p. 83.

Examination of the posterior region of the nose with the pharyngoscope gives us a comprehensive idea of our intranasal surgical technique.

Gundelach has examined the results of operations on the posterior ethmoidal and sphenoidal sinuses. In the latter he can make out the marking of the Vidian nerve on the floor of the sinus. The marking of the second division of the fifth is often quite plain, appearing as a welt on the lower half of the outer wall. The optic canal, when it presents in the sinus, appears in the upper outer angle. The writer remarks that considerable practice is necessary in order to get a correct interpretation of the anatomical markings. In one case, in which the patient's vision was rapidly failing, Gundelach saw an inflammation in the sphenoidal sinus localised to the optic canal. The condition rapidly improved, but a subsequent coryza reinfected the same area and the acuity of vision again decreased. The writer has also observed polypoid degeneration of the sphenoidal mucous membrane at the time of operation.

J. S. Fraser.

Williams, A. W.—Granulosis Rubra Nasi. "Proceedings of the Royal Society of Medicine, Dermatological Section," November, 1915, p. 20.

The case was that of a girl, aged thirteen, who had suffered from a condition of granulosis nasi since early childhood. Her nose was red and the skin wet with sweat. There were hyperidrosis and lumpy swellings in the arm-pits. The hands and feet were cold and moist.

The localised hyperidrosis of the cartilaginous part of the nose was very marked until about two months ago. A few deep-seated papules gave the appearance of something between a hydrocystoma and lupus.

The author is of opinion that recovery usually takes place at about the age of puberty.

Archer Ryland.

ŒSOPHAGUS.

Friedberg, Stanton A.—Œsophagoscopy. "Annals of Otology," etc., March, 1914.

The author believes that foreign bodies in the upper end of the œsophagus are apt to be missed because the cricoid keeps the end of the tube pressed against the posterior wall. The tube therefore passes behind the foreign body. (This is not the experience of the abstractor, who has found that the difficulty is exactly the reverse, and that it is necessary to be careful not to let the tube pass in front of the foreign body.) Friedberg notes that in children with a foreign body in the gullet the cheeks and lips are distended on account of the accumulation of saliva in the mouth, owing to the child's unwillingness to swallow. The author gives an account of numerous cases, the second of which had a fatal result due to previous blind efforts at removal of the foreign body before Friedberg saw the case. In another case the foreign body was not observed at the first examination on account of œdema. At a subsequent examination the foreign body was found embedded in the right pyriform fossa. Case 10 was that of a child who had swallowed an ivory button which was not revealed by a skiagraph, as it was made of vegetable ivory. In Case 14, a boy, aged three, a nickel and two pennies were removed from the œsophagus at the same time, as they were all stuck together.

J. S. Fraser.

EAR.

Coates, E. M.—The Vaccine Treatment of Suppurative Otitis Media. "Annals of Otology," etc., xxiv, p. 785.

The author's deductions are admittedly optimistic—"a certain allowance," he says, must be made "for the rose-coloured spectacles" he "may be presumed to be looking through."

His cases are considered under two headings: *Acute* and *Chronic*. He warns the reader not to give vaccines too much credit in the former, since many cases get well without them. But he prefers to use them than to follow Heath's advice. In the chronic cases vaccines are most valuable as an adjunct to the mastoid operation. In 46 cases, 39 dry ears were obtained by the use of commercial mixed vaccines, with an average of 5 doses.

Macleod Yearsley.

McBean, Geo. M.—Theories Concerning Paracusis Willisii. "Annals of Otology," etc., xxiv, p. 874.

The author thinks that, from the variety of opinion, there is room for at least one more theory. He reviews the literature on the subject and remarks that Heath's theory is unsupported by tuning-fork tests and unlikely to find many who will agree either with his premises or conclusions. In this review McBean appears to have overlooked the comparatively simple explanation offered by Siebenmann that, in middle-ear deafness low tones being worse heard, surrounding noises are less apparent to the deaf than to the hearing, and that the latter unconsciously raises his voice and is so better heard. The author, apologising for his temerity, advances a hypothesis of his own, built on grounds which have been widely accepted by otologists and physicists. Briefly stated, it is this: The lymph in the cochlea is in a state of perpetual movement, and low-pitched sounds have the greatest amplitude of vibration. When ankylosis of the stapes is present the low-pitched sounds are lost. Hence, since the normal relation of the tectorial membrane to the hair cells must be in a moving fluid, and these nerve terminations must therefore be in a certain state of tension, stapes ankylosis stops this motion and the relation of the tectorial membrane is no longer normal, so that the auditory nerve is less capable of responding to sounds. In the normal ear the function of the membrana secundaria is a passive one, but when the normal agent for producing motion in the cochlea fluids (stapes) is ankylosed, it assumes a more active rôle, and requires a greater stimulus to do this.

Macleod Yearsley.

Jobson, G. B.—Contra-lateral Otitic Brain Abscess.—The Ocular Symptoms of Brain Abscess and Sinus Thrombosis. "Laryngoscope," p. 7, 1915.

Jobson holds that the absence of ocular symptoms does not justify the exclusion of intracranial involvement, but nevertheless considers that they are of great value. Some ophthalmic surgeons hold that the changes in the disc are due to engorgement and that the increased intracranial pressure projects the cerebro-spinal fluid into the inter-vaginal space, with sufficient force to constrict and strangulate the nerve and vessels, and that œdema of the papilla is the result. The holders of this view, further, point to the rapid subsidence produced by decompression operation.

On the other hand, Hughlings Jackson, Gowers, and others hold that choked disc and optic neuritis are inflammatory, and that they are

produced by metabolic substances projected into the cerebro-spinal fluid of the intervaginal space. Recently these two theories have been combined.

In cases of brain abscess there are three stages: (a) The inflammatory or febrile stage, when the affected patch is in the stage of red softening and the symptoms are those of irritation. This stage lasts from a few days to a week, and is usually preceded by stoppage of aural discharge. There is no optic neuritis and the pupils react normally. (b) The manifest or early purulent stage is due to pressure and accompanied by lowering of the mental and physical functions. Optic neuritis develops and advances rapidly. It is usually more apparent on the diseased side. Choked disc is more often seen in cerebellar abscess than optic neuritis. The pupils are sluggish. (c) The terminal or paralytic stage is one of pressure combined with great toxæmia, and is associated with coma and sometimes with convulsions. Optic neuritis may be intense, and the pupils are quite insensitive to light. If the pupils are unequal the abscess will probably be found on the side of the more widely dilated one. Pupils contracted and insensitive to light indicate that the disease is in advanced stage. Jobson states that optic neuritis requires at least ten days for its development. Its absence does not negative cerebral abscess. Its value as a symptom is that if present only on one side, or more marked on one side, that side is probably the seat of the lesion. This rule, however, is not absolute. When the abscess is situated beneath the tentorium, choked disc is more frequent and severe than when it is located in the cerebrum.

Eye changes occur in about two-thirds of the cases of otitic sinus thrombosis. If the thrombus extend to the cavernous sinus the eye-ball on the affected side will be chemosed and proptosed, the pupil dilated and fixed, and the cornea dry and hazy. The lids of the affected side become œdematous.

Jobson records the following case: Female, aged twenty-eight, chronic fœtid O.M.S. on *left* side with mastoiditis; temperature 99.4° F. Extracranial abscess in middle fossa and also a perisinus abscess; sinus opened but not thrombosed. Four days later, temperature 103° F.; chill and pain in neck. Jugular exposed and found thrombosed. Case did well till one month later, when patient complained of pain on right side of head, temperature 100° F., pulse 120. Mental condition that of irritability alternating with dulness. Choked disc present on left side, and next day eye became chemotic and proptosed, with dilated pupil. Right eye normal. The left temporo-sphenoidal lobe was explored with negative result. Two days before death there was commencing left hemiplegia, and the right pupil was dilated and fixed. A cerebral abscess on the right side was suspected, but the patient was too ill for operation. The *post-mortem* showed an *abscess of the right temporo-sphenoidal lobe* with fœtid pus. Jobson holds that the abscess was probably due to metastasis. The left cavernous sinus was normal, and the right ear was perfectly healthy.

J. S. Fraser.

MISCELLANEOUS.

Freundlich, David Bernhardt.—Co-operation of the Otologist and Rhinologist with the Dentist.—“Laryngoscope,” 1915, p. 40.

Freundlich states that according to Lermoyez, pathological conditions of the maxillary antrum are more often of dental than of nasal origin!

Bayer, of Brussels, and Gruenwald also appear to hold that antral suppuration is usually of dental origin! Ingersoll, of Cleveland, reports a case in which there was persistent neuralgia over the right antrum, though the teeth were all in good condition, and the nose was normal. The patient died of pneumonia, and autopsy showed a fairly well-developed molar tooth in the posterior wall of the right antrum, just above the floor. The crown projected into the antrum, and the roots were embedded in the antral wall. A good radiogram would have revealed the condition and so brought about a cure. As a rule antral cases of dental origin showed decayed roots, pyorrhœa, or an "abscessed" tooth, but in others the exact condition is only disclosed by the X rays. Freundlich also mentions broken roots, mal-posed wisdom teeth, or growths on the root. In cases of adenoids the teeth are the victims and not the offenders, and the modern skilled dentist sends such cases to the throat surgeon for treatment. Freundlich records the following cases: (1) Female, aged ten, who had earache at intervals. Ear normal. Freundlich's examination showed an inflammation of the pulp of the lower left first molar, though the tooth contained a large filling in good condition. The writer reluctantly extracted the tooth, with good result. Case 2: Female, aged thirty-five, had empyema of the antrum. The pulp of the first upper left molar was found to be badly decomposed. After extraction of the tooth and treatment by the rhinologist the empyema cleared up. Case 3: Female, aged twenty, had a painful sore throat which did not yield to treatment. Examination showed an erupting mal-posed wisdom-tooth, from the socket of which pus oozed. The tooth was removed, and within ten days the condition subsided. Case 4: Male, aged twenty-nine, complained of intermittent earache. A radiograph showed a well-defined area of alveolar abscess around the mesial root of the first molar.

J. S. Fraser.

Edwards, J. G.—A Calculus in Submaxillary Gland. "The Medical Journal of Australia," January 1, 1916.

The patient was a man, aged forty-one. He had a swelling under the ramus of the jaw about the size of a hen's egg. The swelling was very tender, and the patient had suffered a great deal of pain. Pus was seen exuding from the papilla of Wharton's duct. The anterior end of the duct was slit up to provide a free escape for pus. A probe introduced along the duct felt a gritty substance which was very elusive. At times it could not be felt at all. A skiagram very clearly showed the presence of a calculus. A. J. Brady removed the submaxillary gland by an external incision. The gland tissue was very hard and scirrous like. An abscess cavity in the centre contained a spherical smooth calculus like a pearl from a lady's ring. The floor of the mouth was not opened, the duct was slit up on a director, and the larger rough calculus situated where the duct joined the gland was removed. Skiagram very useful to confirm diagnosis. Recovery complete.

A. J. Brady.

Grey, E. G. (Boston).—Studies on the Localisation of Cerebellar Tumours: II. The Pointing Reaction and the Caloric Test. "Amer. Journ. Med. Sci.," May, 1916.

This paper is based on an analysis of thirty-one cases of cerebellar or extra-cerebellar tumours which were examined by means of the pointing and caloric tests. The diagnosis and localisation of the lesions were confirmed in all of the cases either at operation or on *post-mortem* examination. It was found that in most of the patients having cerebello-pontine

new growths and in certain of those with tumours of one or other hemisphere the reactions were sufficiently characteristic to be of supplementary value in localising the disease. In other cases with intra- or extra-cerebellar tumour, on the contrary, the results were often ambiguous and afforded no assistance in establishing a diagnosis. In many instances, indeed, the conclusions drawn from these results were actually at variance with the other physical findings, and had much reliance been placed on them would have led to error. Several factors are probably responsible for the occurrence of atypical reaction in patients with cerebellar tumours. In the author's opinion the two most important are, first, the greatly increased intracranial pressure due to internal hydrocephalus, and, second, the diffuse nature of many of the tumours.

Thomas Guthrie.

Randall, B. A., and Jones, I. H. (Philadelphia).—The Ear-tests of Bárány in Locating Cerebellar and other Encephalic Lesions.
"Amer. Journ. Med. Sci.," April, 1916.

This paper is the outcome of work done in the Department of Neuro-otology, recently created in the University of Pennsylvania. In the past eighteen months 125 pathological cases have been investigated in the Department, and of these 18 have been submitted to operation and 4 have been examined *post-mortem*. These sections, *ante-mortem* and *post-mortem*, have shown the deductions from the ear examinations to have been remarkably accurate. Most stress is laid in this paper on the pointing reactions, which have far surpassed the nystagmic in value and importance.

The writers have come to the conclusion that all pointing reactions are primarily cerebral, and not, as generally stated, cerebellar. Yet they are achieved through the synergising action of the cerebellum. With the cerebral mandate is associated the cerebellar influence, muscle sense, arthrodial sense, tactile, auditory, and visual impressions, and memory. The pointing reactions are, in fact, dependent on so many things that a complicated arc must be assumed to explain them. The writers postulate and give proofs of a "subjective circuit" through the cerebellum to the higher centres. They also claim that each semicircular canal has an entirely separate tract of its own, and this they have proved in the case of the horizontal and superior canals in a series of 28 cases.

In conclusion, they affirm that by means of these ear tests "we can usually distinguish lesions of the labyrinth from those of the cerebellum; we can always tell when the eighth nerve is diseased; we can say positively whether or not the posterior longitudinal bundle is affected; and we can detect a lesion of the cerebellum, but cannot always locate it."

Thomas Guthrie.

OBITUARY.

SIR VICTOR HORSLEY, C.B., F.R.C.S., F.R.S.

THE premature death of Sir Victor Horsley is the greatest loss medical science has so far sustained in this horrible war. Though not slain in battle he fell like a soldier on the post of honour he had selected. With that utter disregard of himself which he had shown throughout life he had no sooner heard of the insanitary conditions prevailing in