NOSE AND ACCESSORY SINUSES.

Bruehl, G. (Berlin).—*An Anatomical Method of demonstrating the Accessory Cavities of the Nose.* "Arch. of Otol.," vol. xxxii., No. 2.

The skull is decalcified in a 10 per cent. nitric acid solution, and is then hardened in alcohol, then dehydrated, and finally subjected to a mixture of equal parts of absolute alcohol and ether. If this is done thoroughly, the specimen is rendered transparent by being placed in carbol-xylol for a day. The specimen is then removed from the liquid, an opening is cut in the septum of the frontal sinus, and the canal is closed with cotton; Wood's metal is then poured in, and apparently it finds its way into the sphenoidal and ethmoidal sinuses, and is allowed to harden. *Dundas Grant.*

Bruehl, G. (Berlin).—*On the Duplicity of the Accessory Sinuses of the Nose.* "Arch. of Otol.," vol. xxxii., No. 2.

The observations were based on the study of seventy specimens from his own collection and 130 belonging to Dr. Arthur Hartmann. He frequently found in the frontal and in the sphenoidal sinuses, but rarely in the maxillary antrum, two cavities instead of one. In some cases it was due to ethmoidal cells extending into the frontal bone, the sphenoid, and the superior maxillary. Duplication of the accessory sinuses resulting from the division of the rudimentary condition is extremely rare. Among conditions producing a simulated duplicity we have to note dentigerous cysts invading the maxillary antrum, and inflammatory membranes subdividing it. *Dundas Grant.*

Muck (Rostock).—*The Occurrence of Rhodan in the Nasal Secretion, and its Absence in Ozæna.* "Arch. of Otol.," vol. xxxii., No. 2.

Rhodan (in the form of sulphocyanide of potassium or sodium) being a normal constituent of the secretion from the serous glands of the nose, its presence or absence may enable us to distinguish between the nasal and cerebro-spinal origin of the secretion in rhinorrhœa, as cerebro-spinal fluid does not contain rhodan. This is absent also in genuine ozæna—at all events, when this has reached such a stage that the glandular cells have atrophied. *Dundas Grant.*

LARYNX, Etc.

Cuno (Frankfurt).—*Fixed Tubes and Bolt Cannulæ for Cases of Difficulty in "Décanulement."* "Münch. Med. Woch.," May 5, 1903.

In view of the liability of intubation-tubes to be coughed out, the author recommends the following method of fixing them: A tube is introduced into the larynx in the ordinary way, and scratches are made on it through the tracheal fistula to mark the portion of it which is opposite this opening; it is then extracted, and at the marked level two holes are bored through the front-wall of the tube; a thread is passed through these two holes (a procedure facilitated by the use of a loop of fine wire), and a string is then, by means of Bellocq's sound, passed through the fistula, up through the larynx, to the back of the throat, where it is caught and brought out through the mouth; this string is attached to the fixation threads of the intubation-tube. The larynx is then intubated with this tube, and the fixation threads are drawn down

by the string which had been previously introduced through the fistula. When the tube is in place, the fixation threads are pulled out through the fistula; a short piece of indiarubber drainage-tube is passed over them, so as to keep the fistula from closing, and the strings are tied over a small pad of folded gauze. To prevent the silk thread (which is, as usual, attached to the upper end of the intubation-tube) from being bitten through, it may be brought through the nose by means of Bellocq's sound. [The author describes this excellent proceeding as being quite new, but it is very similar to one recommended by Killian, the apparatus for which is described, we believe, in a catalogue issued by Fischer of Freiburg.—D. G.] Dr. Cuno states that the tube may remain, without damage to the tissues—such as pressure ulcer—for even as long as fourteen days. In cases where intubation, as above described, fails, especially in the so-called "valvular stenosis," with inward pressure of the upper margin of the tracheal fistula, he recommends a "bolt cannula." This is introduced through the fistula with its point upwards. It has a large slit through which the patient can breathe, and it can be fixed at different depths by means of a collar similar to that of a tracheotomy-tube. He finds that when this is first introduced there is usually a gradual increased flow of saliva, but at the end of about twenty-four hours the children get quite accustomed to it. [Any contribution towards the treatment of these most difficult cases is gladly welcomed by those whose experience has been at all considerable.—D. G.] *Dundas Grant.*

EAR.

Breyre, C.—*A Case of Otitic Pyæmia; Recovery.* "La Presse Oto-Laryngologique Belge," March, 1902.

Mastoiditis supervened in the case of a child, aged seven, with old-standing suppuration of the right middle ear. A fortnight later the usual mastoid operation was performed. The lateral sinus was then found to be very superficial, and only separated from the antrum, which was packed with granulations, by a thin layer of inflamed bone. The sinus itself appeared healthy. The next day the patient had a rigor, followed by oscillations of temperature and abundant and fœtid suppuration. This condition continued for nine days. The field of operation was then further explored, and the parts again carefully curetted. After this there was very little discharge and only slight smell, but the tissues remained inactive. Meanwhile, though there was nothing in the state of the wound to account for it, the general condition of the patient gradually became very critical. There was hectic fever, a small and rapid pulse, and total anorexia; also repeated rigors followed by profuse sweats. The spleen was very large. There was no headache or any other cerebral symptom.

Six days after the second operation dulness with deficient respiratory murmur was detected at the base of the right lung. Then followed a troublesome cough with expectoration, at first scanty, but afterwards daily more and more abundant, and eventually very profuse and altogether purulent. The breath became intolerably offensive. At length, a fortnight from the onset of the pulmonary signs, the temperature fell to normal. From this date all the symptoms gradually abated, the wound took on a healthy action, and the patient slowly recovered.

Chichele Nourse.