duced. Mr. Walsham, he remembered, used ordinary rubber drainage-tubes passed through the nose after septum operations. The tubes were perforated. The perforating was an advantage.

Sir WILLIAM MILLIGAN agreed that they were excellent tubes, but it raised the question whether tubes were desirable at all.

Mr. W. STUART-LOW thought this question would make an excellent subject for a set discussion.

Dr. MCKENZIE replied that the tubes were not intended for drainage; they were for the patient to breathe through during the time the packing was in the nose. Pressure of the swelling caused rubber tubes to close. He thought anyone who had once tried his tubes for twenty-four hours after the operation would continue to use them.

New Growth of Tonsil and Faucial Pillars.—H. Clayton Fox,—The exhibitor thought the growth was an epithelioma; the pathologist, on the contrary, pronounced it to be an infective papilloma.

Mr. STUART-LOW thought it was epithelioma. There was induration, and on palpation it was very firm. In a similar case radium administration had done good.

Dr. VINRACE asked whether the Wassermann test had been applied, and why there was no glandular enlargement? The faucial pillar was eroded and infiltrated and had an angry appearance, and it was as likely to be syphilis as malignant disease.

Dr. LEATHEM said he had examined the specimen and regarded it as infective papilloma. The most doubtful part of the specimen showed one or two epithelial masses resembling cell-nests, but on the whole he thought it was papilloma.

Dr. DUNDAS GRANT regarded it as epithelioma; it was diffuse and ulcerated, and there were cell-nests. If so, it was a most instructive case, showing how latent a malignant process might be.

Mr. CLAYTON FOX, in reply, said that Escat, in his work on diseases of the throat, mentioned the fact that cervical abscesses had been observed as the earliest manifestation of latent epithelioma of the pharynx. He believed that in this case the epitheliomatous growth had started in the supra-tonsillar fossa or in a palatine recess of the same. Wassermann's reaction had not been tested. He wondered whether the early overrunning of the area involved, together with the subsequent cicatrisation, might not have had some influence in blocking the lymphatics, and thus accounting for the absence of glandular enlargement met with in this case.

Abstracts.

PHARYNX.

Conroe, Julina (York, Pa.).—The Use and Abuse of the Tonsils. "Journ. Amer. Med. Assoc.," October 17, 1914.

From a review of the literature and personal investigation the author attributes to the tonsil the following functions:

(1) Protective. The tonsils are generators of lymphocytes and leucocytes, which are undoubtedly present in large numbers, where they may even be stored up for ready action when called on, and that, in addition

https://doi.org/10.1017/S1755146300014979 Published online by Cambridge University Press

to their specific bactericidal action, a constant stream of lymph from the depth to the surface exists, which alone would protect by counteracting an invasion of micro-organisms and by clearing the surface of these undesirable settlers.

(2) Defensive against absorption, by antagonising the entrance to their interior of infectious germs.

(3) Internal secretion endowing the tonsils with a physiological and biological function.

(4) Lubricant.

(5) Voice. The tonsils possess important mechanical, acoustic, and phonetic functions.

(6) Immunity. By a process of continual auto-vaccination the tonsils protect the body against chance infection.

In conclusion, Dr. Conroe enters an energetic protest against the "indiscriminate removal of the normal tonsil, but on the other hand, believes in the propriety of tonsillectomy":

(1) When these organs greatly interfere with respiration and thus lead to insufficient oxygenation of the blood; (2) when they are actually diseased beyond repair; or (3) when there is no reasonable doubt as to their being directly or indirectly an etiologic factor in the production of disease. *Birkett (Rogers).*

NOSE.

Clegg, W., and Black, H.—A Case of X-ray Diagnosis of a Chronic Cerebral Abscess secondary to Frontal Sinus Suppuration. "Lancet," January 16, 1915, p. 124.

A soldier, with a fistulous opening in the right frontal region with persistent discharge. A radical operation showed polypoid degeneration in the sinus. Discharge persisted, and subsequent operation showed caries and necrosis in the posterior sinus wall. Radiography some months later showed, after injection of bismuth, that the latter collected in the frontal lobe of the cerebrum. The abscess thus located was operated upon with excellent result. *Macleod Yearsley.*

LARYNX.

Citelli (Cantania).—Chordectomy in Cases of Stenosis due to Median Position of both Vocal Cords. "Zeitschrift für Laryngologie," Bd. vi, Heft 6.

This paper is really an answer by Citelli to a publication of Iwanoff's. The latter published a case (*Zeitschr. f. Laryngol.*, Bd. vi, Heft 4) of internal chordectomy for double median position of the cords. This operation allowed Iwanoff's patient to dispense with the tracheotomy tube, and yet enabled him to retain an audible, though hoarse, voice. Citelli criticises Iwanoff's article because the latter had used, and apparently given up, Citelli's method. Citelli points out the difference between chordectomy for cancer and for median position of the cords. In the latter the mucous membrane should be preserved as far as possible, whereas in the former the object is to be well clear of the disease. It is also necessary to avoid adhesions in the latter case and, therefore, necessary to leave the mucous membrane in the region of the commissures. Citelli published his paper in 1906, after numerous experiments on dogs; but in 1886 O'Dwyer and Hope had performed internal

https://doi.org/10.1017/S1755146300014979 Published online by Cambridge University Press

chordectomy. Citelli believes that the external operation is more accurate, and further that all patients are not suited for endo-laryngeal methods. Gleitsmann was the first to perform external chordectomy for double abductor paralysis. He operated according to Citelli's method. Nicolai has carried out internal chordectomy and has used an intubation tube to prevent synechiæ. Citelli holds that intubation is not necessary after external chordectomy. *J. S. Fraser.*

ŒSOPHAGUS.

Downie, Walker (Glasgow).—Œsophagotomy for the Removal of a Tooth-Plate. "Glasgow Med. Journ.," December, 1914.

The patient, male, aged twenty-four, bought on August 25th a syphon of lemonade, and to relieve his thirst, attempted to drink direct from the syphon. The fluid entered his mouth with great force, an attack of violent coughing followed, accompanied by a sense of suffocation, and he thought his tooth-plate was forced down his throat.

At the infirmary that night an X-ray examination gave no indication of the presence of a foreign body. For ten days he had pain on swallowing. The author then, by means of a bougie, detected the tooth-plate nine inches from the incisors. Bromide was administered, and next day the plate was seen with the œsophagoscope, but could not be dislodged. Attempts were made to break it with cutting forceps without any result.

A left lateral œsophagotomy was performed, and the plate removed. A soft india-rubber stomach tube was passed through the nose, and the wound left open and gently packed with iodoform gauze. The tube was kept in position for six days and then withdrawn, and nine days after the operation the wound healed up.

The firm impaction of the tooth-plate was due to a couple of sharp points at each end, which penetrated the wall of the gullet.

This is the fourth case of œsophagotomy performed by the author for the removal of a dental plate fixed by hooklets, or firmly impacted in the gullet, and each patient has recovered completely with no subsequent œsophageal discomfort. The author emphasises the point that as little injury as possible must be caused to the gullet, both before and during the operation. The wound must be shaped so as to prevent the retention of any discharge, and it is important to treat the wound as an open one.

Andrew Wylie.

EAR.

Beck, Oscar.—Bone Conduction in Syphilis.[1] "Annals of Otology, etc.," vol. xxii, p. 1099.

Beck contends that the regular occurrence of shortened bone conduction in syphilis and its practical value in diagnosis has not received proper recognition. He had made a careful study of bone conduction in syphilitics who complained of no ear symptoms, and in whom otoscopic examination revealed normal conditions. In an overwhelming majority of cases he found differences between normal hearing syphilitics and normal hearing non-syphilitics. He tabulates fifty-six cases. In only a small percentage is shortened bone conduction not found, and he believes the symptoms to be due to increased intracranial pressure.

Macleod Yearsley.

[1] See also JOURN. OF LARYNGOL., RHINOL., AND OTOL., vol. xxix, p. 388.

https://doi.org/10.1017/S1755146300014979 Published online by Cambridge University Press