

## Abstracts.

## NOSE.

**Palleine, Robert (Adelaide).—Nasal Obstruction: its Varieties and Effects.** "Australian Medical Gazette," May 20, 1911.

The varieties of nasal obstruction, whether due to malformation of the *alæ*, septal or turbinal deformities, are well described. The effects of nasal obstruction are shown to be very injurious. The middle turbinal forms the operculum covering the ostia of the maxillary antrum, the interior ethmoidal cells, and the opening of the infundibulum. When the ostia of the sinuses are hermetically sealed by the operculum, the air is absorbed and the sinuses become vacuous. When this is complete the atmospheric pressure gives rise to intolerable headaches of long duration; disturbance of the field of vision may also take place. The swollen turbinate fits so tightly that one sometimes finds, on the removal of the anterior end, a small polyp on the outer surface which has fitted into the infundibulum. The relief capable of being given is one of the most thankful results of surgery. Obstruction in this region of the nose leads to catarrhs, which in ordinary people are only temporary, becoming a permanent sinus suppuration. In most cases of frontal sinusitis nothing is required but the amputation of the anterior end of the middle turbinate, and the resulting ventilation and drainage effect a cure. The effects on the mouth, larynx, and ears are described. People with partial nasal obstruction nearly always snore; with total obstruction only when lying on the back. Nearly everyone who snores becomes deaf. This is due to the night-long effort of the air to get through the tympanic membrane to fill the minus pressure in the pharynx. The effects of the general health are noted, the disturbed sleep and the morning headache, etc. Asthma, paroxysmal rhinorrhœa, and pseudo-angina may be the result of nasal obstruction, and are removable by treatment. Meckel's ganglion is probably the trouble-spreading centre.

A. J. Brady.

**Preysing, Prof. (Cologne).—Spongification of the Frontal Sinus.** "Zeitsch. f. Laryngol., Rhinol., etc.," Bd. iii, Heft 4.

The author states that on illumination the frontal sinuses are absent in 20 per cent. of normal people. Oppikofer, however, examined 200 cases *post-mortem*, and found the frontal sinuses absent in only 3.5 per cent. By X-ray examination Onodi found these cavities to be wanting in 5 per cent. of individuals (1200 examined). Preysing thinks that absence of the frontal sinuses may be due to a pathological process, and not to congenital defect. The mastoid air-cells may be wanting in normal people, and they may also become filled up in cases of chronic sclerosis of the process due to disease. During this slow sclerotic process there is a stage when the cells are filled by a vascular spongy bony tissue, and Preysing maintains that this stage may be present without any otitis media, and may cause mastoid pain and tenderness; such cases are usually diagnosed as hysterical or neuralgic. The author has found that complete removal of the mastoid process cures these cases. Preysing has observed seven cases of frontal pain in which a radiograph showed that both frontal sinuses were absent, while the ethmoidal cells and maxillary *autra* were healthy; there were no signs of sinusitis and no hysterical

stigmata; the author came to the conclusion that he had to deal with cases of spongification of the frontal sinuses. Resection of the middle turbinal did good for a time, but the pain returned. In six of the seven cases Preysing did not feel justified in operating, but in the seventh he found on exploration a spongification of the frontal bone, which was blueish-red and bled freely, as in cases of mastoid spongification. The pain, which was absent for a time after this operation, returned later on. All the cases occurred in females, and Preysing is of opinion that puberty may have some connection with the condition. It is interesting to note that in one of the cases the patient also suffered from otosclerosis. *J. S. Fraser.*

**Hoffmann, R.—The Pathology of Maxillary Cysts.** "Zeitschr. f. Laryngol.," Bd. iii, Heft 5.

Dental cysts are divided into (1) follicular and (2) periodontal. The former are due to faulty development of the tooth-follicle, while the latter, the more common variety, are caused by inflammation of the root of a tooth. The wall of a follicular cyst is composed of a thick fibrous layer lined by cubical or cylindrical epithelium, and the cyst-cavity contains the more or less developed tooth which is, of course, absent from the row. The wall of a periodontal cyst is made up of a dense connective tissue, which, at the root of the tooth, passes into granulation-tissue. The root itself projects into the cyst from below. The cavity of the cyst is lined by stratified squamous epithelium, derived from the embryological epithelial cells normally found in the periodontium. As the cyst grows there is resorption of bone in the outer layer of the cyst-wall, while new bone is produced in the deep layer of the periosteum beneath the mucous membrane of the antrum. If the contents of the cyst become purulent the epithelium may disappear. In one case Hoffmann found that the cyst was lined by ciliated epithelium.

Dental cysts may rupture into the mouth, inferior meatus of the nose, into the antrum, or through the skin of the face. The author records a rare case in which a cyst burst into the middle meatus. Finally, Hoffmann states that he has a rare specimen of an inner maxillary cyst. He has nothing new to say in regard to treatment. *J. S. Fraser.*

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## MOUTH AND PHARYNX.

**Bertein, P., and Gellé, E. (Lille).—Solid Thyroid Tumours at the Base of the Tongue.** "Gazette des Hopitaux," February 21, 1911.

The authors remark that these growths were first described by Wolf in 1882, and subsequently by Chevalier, Le Dentu and Delbet, Makins, Berard, and Stirling. They originate in His's tract, and may be looked upon as aberrant goitres. Cysts occasionally arise in the same structure, but are rarer. The two following cases are recorded: (1) A woman, aged eighteen, was seized with bleeding from the mouth. A buccal examination revealed no breach of surface, but a swelling the size of a large nut was noticed in the region of the foramen cæcum. The mucosa covering it was traversed by a venous plexus. On palpation it was hard and resistant. General health good. Some slight trouble in swallowing. Cervical thyroid normal. The growth was removed by the buccal route, and recovery ensued in a fortnight. Examination after removal showed that