Newly Formed Tympanic Membrane after the Radical Operation; Keloid slowly Developed and subsequently Atrophied.—Dr. Viollet.—Two cases are published, one of my own and the other by Dr. Davis.[1] The curious condition arising in these two cases of radical mastoid operation is the formation of a new membrane; in Dr. Davis's case it was observed in a girl, aged fifteen, two years afterwards; in mine it was completely formed in four months. In both patients the Eustachian tube had been curetted. Dr. Davis had, it is true, curetted the tympanic ring, but in my case the membrana tympani has been absent for the twenty years. One other point in my patient is deserving of notice: at the expiration of four months I observed a hard keloid, which disappeared seven months subsequently. It is remarkable to note what power Nature possesses in re-constructing her organs, and that, in my case, after a lapse of twenty years. Prof. Retterer has shown by numerous experiments on animals that by irritation of the cutis, such as our bistoury induces, the tissues proliferate, forming keloids.

C. A. Weill, following the communications by MM. Kœnig and Collinet, showed a patient with chronic maxillary antritis who had worn a rubber-covered meatal cannula for the past fortnight, patterns of which were exhibited. These tubes are self-retaining, being constructed on the principle of Pezzer's catheter for the bladder. The author also exhibited the metal cannula already described for the same purpose, but perfected by the addition of a movable spur, which can be projected in the sinus at will to insure its retention. The patient shown is already much improved by the daily lavages: the alveolar fistula appears closed.

G. Veillard.
H. Clayton Fox (trans.).

NOTICE.

THE SEMON LECTURESHIP.

The inaugural lectures will be delivered by P. McBride, M.D., at 5 p.m. on January 22 and 24, 1913, at University College, London.

Subject: "Sir Felix Semon: His Work, and its Influence on Laryngology."

Any Laryngological *confrères* who are able to be present will be welcomed.

Abstracts.

LARYNX AND TRACHEA.

Ryerson, G. Sterling.—Angioma of the Larynx Cured by Radium. "The Canadian Medical Association Journal," February, 1912.

The author reports a case of angioma involving both arytænoids, left ventricular band and vocal cord, which he treated by radium and obtained a complete cure. The treatment extended over two years, at intervals of three months, and consisted in the introduction of a disc containing 10 mg. of radium, activity 500,000, into the larynx, where it was retained for three minutes at a time. *Rogers-Birkett.*

[1] Otological Section, Royal Society of Medicine, London, March 5, 1910.

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Martuscelli, Dr. G. (Naples).—Changes in the Laryngeal Nerves and Plexiform Ganglion following Compression of the Recurrent. "Archiv. Ital. di Laryngologia," January, 1912, p. 1.

The author refers to another paper published in the same journal in January, 1911, which was a preliminary note of the result of certain experiments to elucidate the causes of anæsthesia of the laryngeal vestibule. These investigations form a corollary, he says, "to the new clinical aquisitions of Prof. Massei," who, in 1903 at the sixth Congress of the Italian Laryngological Society, called attention to the occurrence of anæsthesia of the vestibule in paralysis of the recurrent. The experiments were carried out on dogs, under chloroform, and consisted in attaching pieces of laminaria to the recurrent by means of loosely-tied catgut ligatures, the object being to imitate as nearly as possible the gradually increasing pressure of an aneurysm or solid tumour. The rationale was as follows: If the anæsthesia of the larynx is due to the recurrent being a mixed nerve pressure on it at a point remote from the larynx so as to exclude the sympathetic, the anæsthesia of the vestibule will be due to a degeneration of the fibres ascending to the ganglion and descending to the superior laryngeal. If, on the other hand, the recurrent is not a mixed nerve one should not obtain in this manner any change in the susceptibility of the vestibule. The laminaria remained in position for from one to four months, when the dogs were killed. The results demonstrated that the degeneration proceeded in the manner just mentioned, showing recurrent to be a mixed nerve. A full account of the histological changes in the various structures is given with four reproductions of micro-photographs.

James Donelan.

Graeffner, Dr. (Berlin).—Rotation of the Larynx due to Aortic Aneurysm. "Zeitschr. f. Laryngol.," Bd. iv, Heft 3.

The patient was a male, aged fifty-four, who had complained for two years of breathlessness and sternal pain. The classical signs of aortic aneurysm were present. The larynx was rotated to the left through a right angle so that the outer surface of the right ala of the thyroid faced forwards. On laryngoscopic examination the right cord occupied the frontal plane, but was motionless; its free border was slightly excavated; the left cord was freely movable. *Post-mortem* the larynx returned to its normal position, thus showing that the dislocation was due to the aneurysm alone. There was a diffuse dilatation of the aortic arch and the right vagus was markedly compressed. The Wassermann reaction was positive from blood obtained *post-mortem* although lues had been denied during life.

J. S. Fraser.

Todd, Frank C.—Removal of Foreign Body from the Right Bronchus. "Journ. Amer. Med. Assoc.," March, 1912.

Dr. Todd was asked to see a patient, aged three and a half, suspected of having swallowed a foreign body ten days previously. An X-ray picture showed nothing, but as the trachea alone was exposed the negative finding was of no value. On attempting anæsthesia with first chloroform and again with ether, very great cyanosis took place and was relieved when the patient was placed in a sitting position and recurred when lying down. A bronchoscope was at once passed without anæsthesia and the dyspnœa was found to be due to an œdema of the larynx. The instrument was then passed through the larynx into the trachea. The

examination was now discontinued owing to cessation of breathing and great cyanosis. Immediate tracheotomy was performed care being taken to avoid unnecessary bleeding, a point of considerable subsequent help. As soon as the trachea was opened, and under local anæsthesia using only the smallest tube, a brass thumb-tack was found lying across the right bronchus which was too large to come away through the tubes, so tube, foreign body and forceps were removed together. A rapid and uneventful recovery ensued. *Perry Goldsmith.*

NOSE AND NASO-PHARYNX.

Wilson, H. W.—A Case of Rhinitis Caseosa. "Lancet," January 27, 1912, p. 226.

Girl, aged eleven. Left naris normal. Right side: muco-pus, yellowish-white "membrane" in middle turbinate region, removable with forceps; underlying mucous membrane appeared healthy. A week's douching with alkaline lotion cleared the nose completely. Microscopically the mass consisted of long, fine needles, mixed with structureless material, with numerous microbes, pus cells and a few crystals. Bacteriologically short-chained streptococcus and *Staphylococcus pyogenes aureus.*

Macleod Yearsley.

Tratman, Frank.—A Naso-pharyngeal Fibroma. "Australasian Medical Gazette," June 29, 1912.

The patient was a boy, aged sixteen. After preliminary high tracheotomy, and application of phagones larynx, the tumour was removed. The pedicle, one inch in diameter, sprang from the base of the skull near the root of the vomer. The pedicle was easily broken through with the finger, and the area of origin scraped with a curette. Microscopic examination showed it to be a pure fibroma with some mucoid degeneration of stellate connective-tissue cells.

[Such an easily separated attachment suggests a pedunculated polypus of the naso-pharynx rather than a fibroma.—Ref.]

A. J. Brady.

Kanellis, Smyrne.—Naso-pharyngeal Fibroma. "Archiv. Internat. Laryng., Otol., Rhinol.," November–December, 1911.

From three cases of the above condition which the author carefully describes, he draws the following conclusion: That the classic opinion that these growths take their origin exclusively from the fibrous tissue of the basilar apophysis is untenable. In the first case the pedicle was inserted into the superior and internal angle of the choana and a large part of the septum. In the second and third cases the site was slightly higher up and involved the sphenoid. Kanellis considers that rhinologists would be well advised to remove these growths *per vias naturales* even when the size would appear to indicate a bloody preliminary operation such as that of Olier. In cases where this is impossible, owing to the extreme size of the growth as in the third case, sufficient access can be obtained by Moure's incision with excision of the ascending process of the superior maxilla and nasal bone. *J. D. Lithgow.*