

eight days longer, and by that time the ends of the cartilage had united. The operation had been done two months ago, and at the present time the extra fold of skin left after the operation had nearly disappeared. He was opposed to making an anterior as well as a posterior incision.

Dr. J. F. MCKERNON, of New York City, said that he had seen a very similar operation done ten years ago by Dr. George Abbott, of that city, except that three sections of the cartilage had been taken out without affecting the skin anteriorly at all. The result had been very good. Within the last three years he had seen another case also yielding a good result.

Dr. POOLEY said that he felt sure that any operation which did not involve a considerable dissection of the cartilage would not succeed, but whether one should go through the entire concha or not was a question.

(To be continued.)

## Abstracts.

### NOSE, Etc.

**Halsted, T. H.** (Syracuse, N.Y.).—*Empyema of the Right Maxillary, Ethmoidal, and Sphenoidal Sinuses, with Sudden Blindness of the Left Eye; Operation; Recovery of Sight.* "Arch. of Otol.," vol. xxx., No. 3.

A lady, aged twenty-one, who had previously suffered from an offensive purulent discharge from the right nostril, became suddenly blind in the left eye. The left pupil was widely dilated, but contracted when light was thrown into the right eye. The right eye was unaffected, and there was a temperature of 99.4° F. In the nose there was found a general deviation of the septum to the right side, which, along with the swollen inferior turbinated body, concealed the middle one. When, however, the parts were made clearer by means of cocaine, there was found to be pus coming from under the middle turbinate.

Transillumination showed the right maxillary sinus to be completely dark. The nose on the left side was almost normal. The writer made a diagnosis of empyema of the right maxillary antrum, the ethmoidal and sphenoidal sinuses. He attributed the sudden occurrence of blindness of the opposite eye to the giving way of the septum between the two sphenoidal sinuses, pus finding its way into the left one and pressing on the optic nerve. (It seems difficult to understand why it should not first have affected the right optic nerve, but presumably the bony plate intervening between the sphenoidal sinus and the left optic foramen was thinner than on the right side, or possibly dehiscant.) Dr. Halsted removed the anterior portion of the right middle turbinal, and scraped through into the posterior ethmoidal and ultimately the

sphenoidal cells, all at one operation. There was a considerable amount of bleeding, so that the immediate result was not quite recognisable; but relief was obtained, and subsequently he removed the posterior part of the middle turbinal and enlarged his opening into the sphenoidal sinus, washing it out, and thereby bringing about a remarkable degree of improvement in the vision of the left eye. He answers the possible (and not improbable) criticism of his methods, to the effect that he might have operated through the left nasal passage, which was almost abnormally wide, by stating that he objected to removal of the normal left middle turbinal, which would mean the "wounding of the ethmoid, and the probable subsequent necrosis of this normal structure." He appeals to the subsequent history of the case, which appears to have borne out the wisdom of the course he pursued.

*Dundas Grant.*

**Lewy** (Berlin).—*An Unexpected Discovery in the Nerves of the Nasal Mucous Membrane in Nasal Reflex Neurosis.* "Arch. f. Laryngologie und Rhinologie," Bd. 12, Heft 1.

In two cases of marked nasal reflex neurosis, due to hypertrophy of the inferior turbinates, the hypertrophied tissue showed on removal an extraordinary number of thickened nerve branches running under the free surface. The author would attribute the increase of reflex irritability to this increase of nerve-supply, and not to change in the nerves themselves. As this has not been described before, he would like further investigation to be carried out.

*Guild.*

**Mann** (Dresden).—*Mucocele of the Right Ethmoid.* "Münchener Medicinische Wochenschrift," No. 28, 1901.

A patient, thirty-nine years of age, who in his youth had had a head injury, acquired syphilis at nineteen. For two years he had noticed prominence of the right eye and impaired vision. There was at first a normal fundus oculi, but later a choked optic disc and diminution of acuteness of vision. On examination the author found the right eye displaced outwards and forwards, and in the inner canthus an elastic tumour the size of a cherry. The floor of the ethmoidal cells was enlarged downwards and inwards, the mucous membrane pale. The bone was broken through with a probe, and opened out with Hartmann's forceps. The contents were chocolate colour, syrupy, contained no bacteria, but much cholesterin. There was no further secretion from the cyst. The eyeball sunk back in the orbit after the operation, but it projected for a few days on blowing the nose. Vision became normal. The choked disc disappeared. In spite of the history, it seemed to be a congenital cyst. Only eight similar cases have been described.

*Guild.*

**Natier, Marcel** (Paris).—"Transactions of the Laryngological Society," Paris, May, 1901.

Mention is made of cases of false adenoids in neurotic children, giving rise to the usual symptoms of post-nasal adenoids, which were cured by suitable general treatment, accompanied by certain methodical breathing exercises. The author warns against operative treatment, either in nose or naso-pharynx, in such cases.

*Anthony McCall.*

**Prota, Dr. G. (Naples).**—*Two Cases of Carcinoma of the Ethmoidal Cells.* "Archiv. Ital. di Laringologia," Naples, April, 1901.

The author gives an account of the normal anatomy of the ethmoid and the displacements produced in surrounding structures, especially the eyes, varying with the point of origin and direction of growth of ethmoidal neoplasms.

The symptoms of an ethmoidal tumour vary, as it is limited to the periphery, or arises within the sinuses, or as the growth is still limited to the ethmoid or has already invaded the orbit and adjacent cavities.

Usually from the first there are pain, increased nasal secretion, sense of local heat, cephalalgia, epistaxis, etc., symptoms common to many intranasal affections. Later these become more intense and changes take place in the walls. As the *lamina papyracea* which forms so large a part of the inner wall of the orbit is the most slender boundary, it is the first to give way and to be pressed upon the eyeball, so that the latter is thrust forwards and outwards. In the nasal fossa the tumour may invade the middle meatus with deviation or destruction of the middle turbinal.

At a more advanced stage there may be more or less complete invasion of the orbital cavity with exophthalmos and ultimate destruction of the eye and proliferation in the frontal and sphenoidal sinuses. complete occlusion of the corresponding nasal fossa with destruction of the septum and projection of the tumour in the naso-pharynx. Later, diffusion to the ethmoidal cells of the opposite side and finally to the base of the cranium with the usual meningeal phenomena.

The nature of the tumour will be confirmed by the removal and microscopic examination of small pieces.

On account of the delicacy of the *lamina papyracea* and of the ethmoidal cells a cyst may produce pressure in the eyeball, as in the cases of Zuckerkandl and Bayer, and in that of Pinard,<sup>1</sup> in which the diagnosis of encephalocele was disproved at the moment of intervention. Strazza<sup>2</sup> has reported a cystic tumour of the ethmoid in a girl of twenty, which had compressed the orbit and nasal fossa.

The diagnosis of a tumour of the ethmoidal cells is not always easy, especially at the beginning, when the tumour is confined to the mass of the ethmoid, since the only symptoms are the fronto-occipital pain and an increase of secretion in the middle meatus. It is only when there are ocular disturbances together with distinct objective rhinoscopic evidences that we can suspect a neoplasm. These tumours are capable of developing at a given moment towards the orbit with more or less rapidity. There are also cases of malignant growths of the inner angle of the eye which invade the frontal sinuses and the ethmoidal cells. In these the history and the primary seat of the tumour enable us to make the diagnosis.

Treatment consists in the removal of the growth, either through the nasal fossa or by external operation. The author believes, however, that one may interfere only when the tumour is still of small size, and that it can be removed through the nasal fossa, as in this way hæmorrhage can best be controlled.

James Donelan.

<sup>1</sup> Quoted by Brisson "Études des Tumeurs des Sinus de la Face," *Archiv. Provinc. de Chirurg.*, vol ix., n. 12, 1900.

<sup>2</sup> *Bolletino*, 1892.

**Rudloff, Dr. P.** (Wiesbaden).—*Adenoid Operation on the Pendent Head under General Anæsthesia.* "Arch. of Otol.," vol. xxx., No. 3.

The writer uses Boecker's ring-knife and Hartmann's for Rosenmüller's fossæ. He refers to the proximity of the internal carotid to Rosenmüller's fossa, and quotes the fatal case described by Schmiegelow. He calls attention to the occasional projection of the atlas, and enumerates it among the indications for the adoption of the hanging-head posture during adenoid operation. (We confess to feeling a difficulty in following him in this respect, as the hanging head would seem to exaggerate rather than diminish this obstruction, whereas pulling the head directly upwards in a line with the vertebræ, and bending it if anything slightly forwards rather than backwards, would straighten the cervical portion of the spinal column, and bring the vault of the pharynx more readily within reach.—D. G.)

*Dundas Grant.*

### LARYNX.

**Brownlee, H. F.**—*Foreign Body lodged for Four Months in the Trachea of a Thirteen-months-old Child.* "Med. Record," July 6, 1901.

The child was at first supposed to be suffering from croup. Gradually dyspnoea became more marked, and called for tracheotomy. This was performed under chloroform anæsthesia. The foreign body proved to be a flake of coal, about  $\frac{1}{4}$  inch in width and  $\frac{1}{2}$  inch in length, and of about the thickness of a finger-nail. Inflammation around the foreign body had suddenly and markedly increased the stenosis. Rapid recovery followed the tracheotomy.

*W. Milligan.*

**Killian** (Freiburg).—*Hysteria in Reference to the Larynx.* "Münchener Medicinische Wochenschrift," No. 26, 1901.

His investigations tend to show that the appearance of paresis of the vocal cords, as seen in hysterical dysphonia and aphonia, should not be described as a muscle paralysis, as the muscles are not persistently paralyzed; the appearance is only the peripheral expression of a deficiency in cerebral will movement. This idea has already been expressed by Rosenbach, who talks of "voice paralysis," not vocal cord paralysis. All the hysterical appearances—even the unusual form of spasm movements—can be produced at pleasure by healthy persons, only it requires long practice.

*Guild.*

**Krebs.**—*Derangement of Voice after Injury to the Cervical Sympathetic.* "Münchener Medicinische Wochenschrift," No. 27, 1901.

During an operation for the removal of an angioma under the angle of the jaw the sympathetic was injured. There was ptosis, anomalous salivary secretion, and other symptoms. The voice was also impaired, although the recurrent nerve was not damaged. Krebs states that the laryngoscope showed no change in the thyro-arytenoid muscle, unless the recurrent nerve is affected; but delicate tests of the voice showed that a part of the muscle not supplied by the recurrent was paralyzed.

*Guild.*

**Natier and Rousselot.**—*Cases of Nodular Laryngitis.*—"Transactions of the Laryngological Society," Paris, May, 1901.

These cases are not always singers, and if they are, they must be inferior artistes who fatigue the vocal cords. A general neurotic con-