

posed, the eyes open and staring; he breathed quietly and maintained his seat without letting the head sink. After five seconds at the most he came to himself, and looked around smiling as if awaking from a refreshing sleep. He was quite himself immediately, and in a few minutes had forgotten the occurrence. Under climatic and dietetic treatment the cough was removed, and the attacks of laryngeal vertigo ceased for at least a year. Quite unexpectedly, however, he had an attack one evening similar to that above described. The following day, while conversing, the usual cough returned, he became unconscious, fell, and died in a moment.

There are only about fifty cases of laryngeal vertigo on record, the small number being probably due to the fact that persons suffering from this affection almost always seek medical advice solely on account of the subjective sensations in the upper air passages, and make no mention of the attacks of giddiness.

Laryngeal vertigo is merely a symptom. It is distinguished from fainting by occurring almost invariably in men, by its sudden onset, and by the patient's face becoming congested; and from spasm of the glottis, by the absence of any alarming symptom indicating long-continued closure of the glottis. Further, it has nothing to do with tabes, for as a rule it occurs without this condition being present, although the latter may be accompanied by laryngeal crises which assume the appearance of laryngeal vertigo. It is independent also of epilepsy; not one of the author's patients was an epileptic. Convulsions and subsequent exhaustion were absent.

The author explains the mechanism of the attacks as follows:—The irritation of the superior laryngeal passes to the expiratory centre, and excites the fits of coughing; at the same time it influences the inhibitory cardiac centre and causes cessation of the heart's action and consequent cerebral anæmia and loss of consciousness.

A certain pathological state must exist before these attacks can take place. Garel and Collet regard changes in the vessels due to age and arthritic conditions as the predisposing cause. The author attaches importance to alcoholism, all of his patients but one having been heavy drinkers.

The prognosis hitherto has been favourable, perhaps because the cases have not been sufficiently long observed. A cure is not to be looked for from symptomatic treatment, but rather by controlling the predisposing fundamental condition.

A. B. Kelly.

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## ŒSOPHAGUS.

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**Delatour, H. B.**—*Removal of Foreign Body from the Œsophagus by Œsophageal Forceps, guided by the Aid of the Fluoroscope.* "Med. Record," N.Y., May 1, 1897.

ON February 13th a boy of four years was brought, with a history of having swallowed an iron washer on the 9th, and inability to swallow solids and only a little fluid since. It was located by auscultation during swallowing to the level of the fourth dorsal vertebra. A skiagraph was taken, and shows the washer very distinctly. The ease with which it was visible with the fluoroscope determined the writer to attempt its removal with its aid. Accordingly the following day the boy was chloroformed, and after two attempts it was withdrawn. The total time occupied was twenty minutes.

R. Lake.

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**Franken, Fr.**—*An Artificial Palate and Teeth in the Œsophagus.* “Münchener Med. Woch.,” Feb. 9, 1897.

REPORT of a case. When first seen the patient's breathing was noisy, strained, and rapid; the face and lips were cyanosed; and frothy, bloody-serous sputum flowed in large quantities from the mouth. Pulse good. Swallowing was painful. Gradually improvement in the breathing took place, but swallowing became impossible. The larynx and sides of neck were very tender to touch. The plate and teeth were accidentally discovered on the second day and removed with the fingers through the mouth.

*Arthur J. Hutchison.*

**Rumpel, Th.**—*The Clinical Diagnosis of Spindle-shaped Dilatation of the Œsophagus.* “Münchener Med. Woch.,” April 13 and 20, 1897.

RUMPEL describes the symptoms, etc., of a case under his observation in which he diagnosed diffuse spindle-shaped dilatation of the Œsophagus. The following experiments were carried out on this patient:—

1. On introducing a tube into the Œsophagus a turbid milky fluid (about three hundred cubic centimètres) flows out whilst the tube is passing from twenty-eight to fifty centimètres from the teeth. This fluid is alkaline, and contains sugar. At fifty centimètres from the teeth the sound is resisted, and only after considerable difficulty is passed into the stomach (typical stomach contents now flowing out).

2. Introduce a tube, attached to a filler, thirty centimètres into the Œsophagus; pour in three hundred cubic centimètres of neutral fluid, coloured with blue litmus. By raising and lowering the filler the fluid can be poured backwards and forwards between the filler and the Œsophagus. Not a drop is lost into the stomach, and it remains blue, thus showing that it does not come into contact with the stomach or stomach contents.

3. Pass a large-sized stomach tube right down into the stomach, and leave it there. Pass alongside of this a second smaller tube forty centimètres into the Œsophagus (*i.e.*, not far enough to by any possibility enter the stomach), and connect this with a filler. Pour into this three hundred cubic centimètres of fluid. It can all be got back again. This proves that the watertight division between the Œsophagus and stomach is produced either by contraction of the lower end of the Œsophagus round the thick tube, or else that the second tube passes into a large œsophageal diverticulum. This point is settled easily by a slight variation in experiment No. 3. Thus, instead of the thick stomach tube, with only one hole at its distal end, introduce a similar tube with one or more holes in its side. Now pour the fluid, as before, through the thin tube. If this lies in a large diverticulum the fluid will behave as in experiment No. 3; but, if not, the fluid will all flow through the holes in the large tube into the stomach.

4. Lastly, after pouring into the Œsophagus fluid containing five per cent. of bismuth subnitrate in suspension, the size, shape, and position of the dilatation can be demonstrated by the X rays.

*Arthur J. Hutchison.*

## THYROID.

**Jaboulay.**—*The Section of the Cervical Sympathetic Nerve in Goitres and Graves' Disease.* “Lyon Méd.,” Feb. 7, 1897.

JABOULAY first advocated resection of the sympathetic nerve for the relief and the cure of thyroid hypertrophy. He relates three cases of that surgical proceeding.