anything could then be followed by making a flap. An ordinary curved director was better than a knife. He had devised a director in quarter inches, which could be carefully introduced until a free flow of pus was obtained. He then inserted a cigarette drain of gauze, which could be left in place for twenty-four or forty-eight hours, and which would give all the drainage needed. This could be replaced, as the abscess cavity collapsed, with folded rubber tissue.

Dr. SMITH added that drainage of a brain abscess should be through the avenue of infection. All his cases which had recovered had been drained in that way, whereas cases which he had evacuated through decompression had uniformly died.

Dr. MURPHY, in closing the discussion, said he had seen two infections of the middle ear with temporo-sphenoidal abscess. He had brought up this subject in order to emphasize the belief that running ears were more often the cause of brain abscess than had been thought.

Abstracts.

NOSE.

Malignant Disease of the Nose or Accessory Sinuses.—Thomson, StClair. Advantages of operation through the face (Moure's Operation or Lateral Rhinotomy). Record of two cases with no recurrence after $5\frac{1}{2}$ and $3\frac{1}{2}$ years. "The Lancet," May 13, 1916.

Attention is directed to the recent advance in rhino-laryngology and in particular to the modern methods of nasal surgery which have supplanted the earlier and rougher methods of the general surgeon. The disfiguring and generally useless results of excision of the upper jaw, and of Ollier's or Langenbeck's operation on the nose, are only mentioned to be condemned. A full description is then given of Lateral Rhinotomy (Moure's Operation) including the preliminary preparation of the nose with a cocaine-adrenalin solution and strips of ribbon gauze; chloroform anæsthesia; two post-nasal sponge-plugs; and the drawing forward of the tongue with a tongue clip. As originally designed, two incisions were employed (Fig. 1), starting at the inner extremity of the eyebrow on the affected side and curving outwards and downwards. But later experience shows that, a single incision is quite sufficient in the majority of cases. This incision (Fig. 2) starts below the inner extremity of the eyebrow and halfway between the inner canthus of the eye and the centre of the root of the nose. From here it descends along the junction of the nose and cheek to the nasal orifice. If the growth has approached the nostril or is thought to be attached to the floor of the nose, it is well to carry the incision right into the vestibule, so as to detach the lobe of the nostril on that side, as in Fig. 1. But if the growth is in the higher or deeper parts of the nose there is no necessity to carry this descending incision further than the furrow behind the ala naris (Fig. 2). This incision should be planned to lie in the wrinkle which is seen in elderly faces along the side of the nose. This incision is carried down to the bone and, with suitable raspatories, the periosteum with all the soft tissues upon it, is raised and peeled back as far as the line of the bridge of the nose internally, and externally as far as may be necessary towards the malar prominence.

The soft tissues of the face are so lax and pliable that they can be raised and retracted outwards sufficiently to expose nearly all the area illustrated in Fig. 3. This single incision still further minimises the slight scar on the face; it does away with the puffiness of the lower eyelid which, otherwise, may persist for one or two months; there is much less tendency to epiphora; and it should be the only incision to begin with and also in any exploratory operation. The second incision, curving round below the eyelid (see Fig. 1), can be added if required. The single incision can be extended into the vestibule if it is found necessary to detach and raise the lobule of the nose.

The pyriform opening of the nose should be defined, as well as the margin of the orbit, the ascending process of the superior maxilla,

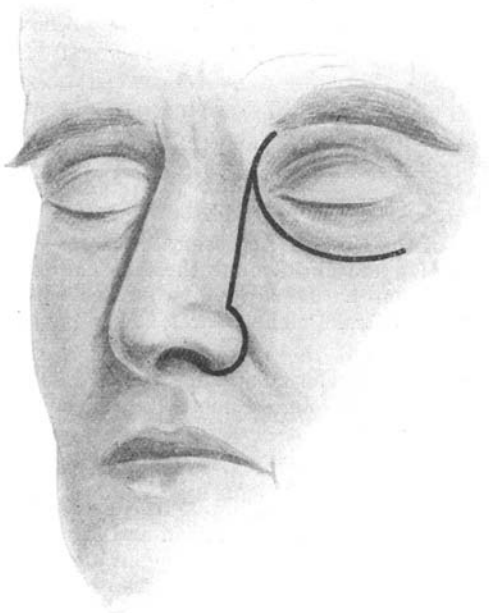

FIG. 1.—Moure's operation. Skin incision as originally employed.

and its junction with the frontal and nasal bone. This latter bone is exposed right up to its junction with its fellow by reflecting the flap of skin, soft parts, and periosteum on the nasal side of the field of operation. With chisel and hammer the bone is now divided along three lines: (*a*) the first divides the nasal bone from its fellow, just external to the site of the nasal septum; (*b*) the second passes outwards from the upper part of this division into the orbit and follows the line of junction of the frontal bone with the nasal and maxillary; and (*c*) the third passes from the lower and outer corner of the pyriform opening upwards and outwards into the orbit (Fig. 2). In this last cut it is well to try and avoid the infra-orbital nerve in its canal. The piece of bone included in these lines is now seized with lion forceps and twisted out. Immediately below it we come directly on the ethmoid region, the antro-nasal partition, and the upper part of the maxillary sinus (Fig. 4). The lacrymal canal should be defined and carefully

retracted under the lacrymal bone. The ethmoid can now be dealt with directly On plucking it away with some instrument like Luc's forceps we are able to see into the maxillary sinus from above, like looking into an egg-cup. This clearing away of the ethmoid brings the front wall and orifice of the sphenoidal sinus so well into the field that it is now hardly 1 in. distant from the surface, instead of the $2\frac{1}{2}$ to $3\frac{1}{4}$ in. which is the average distance from the anterior nares. This dissection also exposes the roof of the nose. Diseased growth is

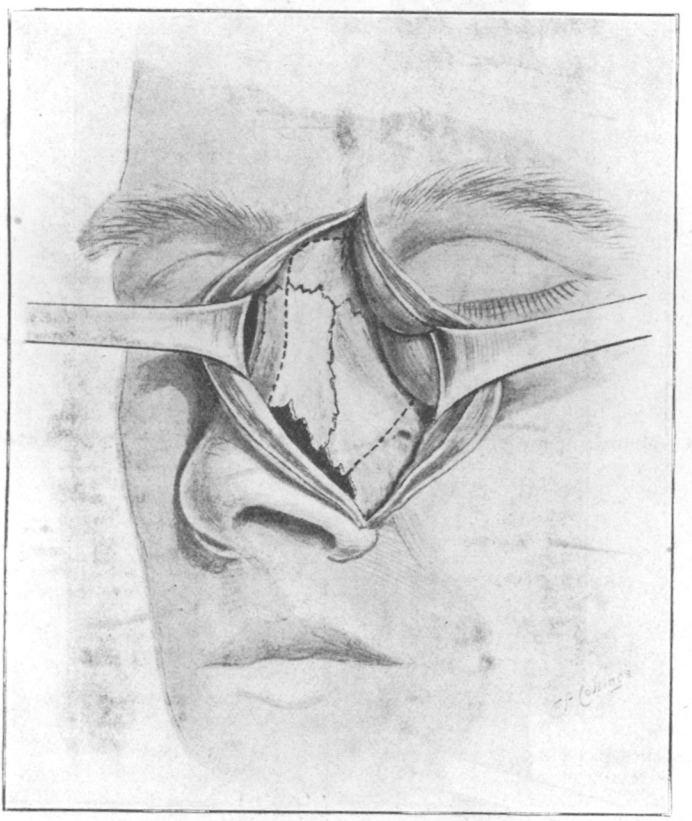

Fig. 2.—Moure's operation. Shows the single incision recently recommended.

attacked with Luc's forceps, conchotomes, sharp spoons, or ring knives, and can readily be followed back into the nasopharynx and sphenoid, outwards into the orbit, and downwards right on to the floor of the nose and the maxillary sinus. If required, the whole of the orbital, nasal, and facial walls of the latter cavity can be removed with bone forceps. If the growth is attacked boldly, and cleared away quickly, the hæmorrhage is not alarming. It can be controlled by pressure and packing with 2-in. ribbon gauze, moistened with adrenalin or 5-volume peroxide of hydrogen. Thanks to the two post-nasal sponges there is no trouble with blood descending into the air passages. When the operation is completed and the bleeding arrested the skin incisions are

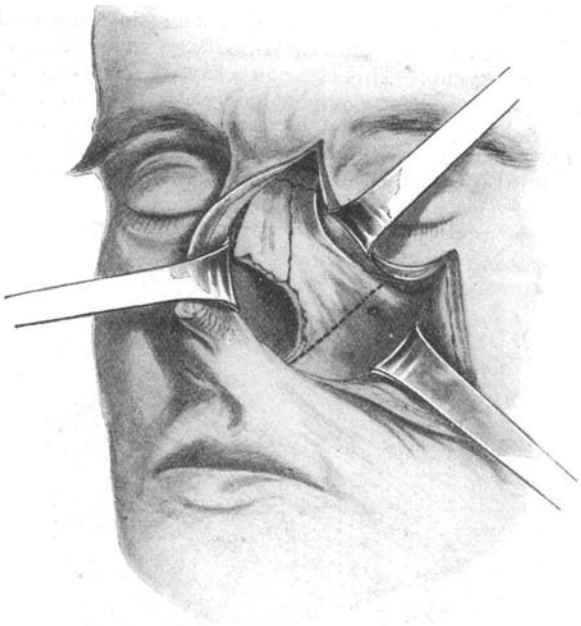

FIG. tf.—Moure's operation. Skin flaps have been retracted, and the dotted lines show where the bones should be chiselled through.

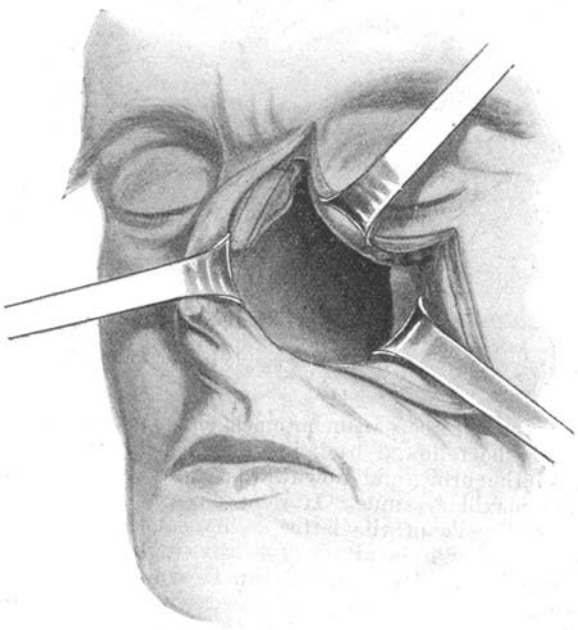

FIG. !.—Moure's operation. Exposure of the nasal and maxillary cavities through the side of the nose.

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carefully brought together with silkworm gut or horsehair sutures. The wound may be protected with a pad of dry gauze until the patient recovers consciousness. It is well to dispense with any dressing or plugging inside the nose, and to leave the cavity quite alone for four or five days. If oozing of blood should persist at the end of the operation, a piece of 2-in. ribbon gauze may be packed on to the spot and led out into the nostril through which it is removed within twenty-four hours and not replaced. The post-nasal plugs are, of course, removed before the patient leaves the table.

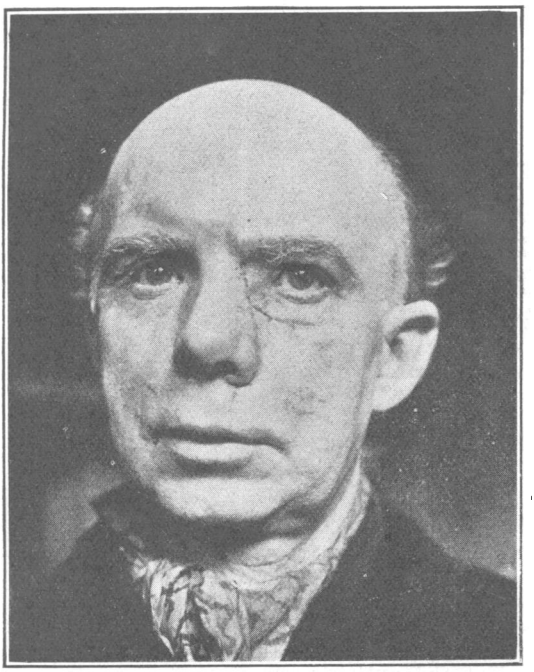

FIG. 5.—Moure's operation. Shows a patient seven days after operation.

Progress.—The writer recommends no dressings on the facial wound which, if exposed to the air, heals up as readily as a shaving cut (Fig. 5).

Results are well shown by photographs and by the patients who have been exhibited before several medical societies (Figs. 5 and 6).

Comparison.—The writer roundly condemns excision of the upper jaw in the following terms: "When the upper jaw is removed for cancer of the maxillary sinus, the antro-nasal wall, the ethmoid, the roof of the nose or the sphenoidal body, it is in the words of Macbeth, a 'most bloody piece of work.' It is chiefly the front maxillary wall and alveolus which are then removed, and this brings the surgeon but little nearer the origin of the growth, for which he has to grope in the dark depths of a bleeding cavity, where hæmorrhage is controlled with difficulty. If he can arrive at the ethmoid region or posterior part of the nasal chamber, it is difficult for him to do more than scrape away

portions of the growth, and it is not therefore surprising that recurrence is almost the invariable rule."

Advantages.—They are stated as follows: "In all cases there is no mutilation or disfigurement. Patients will readily consent to the operation. They are left with an intact roof to the mouth and require no troublesome obturator, as in the old operation of excision of the upper jaw. It is much easier after a Moure operation to keep a direct look-out in the nose and its accessory cavities for any suspicion of recurrence. Recurrences are more easily dealt with, either through the

FIG. 6.—Moure's operation. Shows the scar a few months after operation on the left maxillary sinus.

nasal orifice or by repeating the lateral rhinotomy, and patients are less likely to object to this than to a further facial disfigurement."

Cases.—Two of the author's cases are then related in detail. The first was a case of endothelioma of the ethmoid and antrum, in which there is no recurrence after six years, the patient being now seventy-three years of age, hale and vigorous, and with a good set of her own teeth in the alveolus of the undamaged upper jaw. The second case was one of epithelioma of the left maxillary antrum, in which there is no recurrence after four years. The scar on the face is discernible with difficulty (Fig. 6). *StClair Thomson.*

LARYNX.

Œdematous Laryngitis.—Kidd, Archibald. "Lancet," June 24, 1916, p. 1261.

The case was that of a marine fireman, aged twenty-two, who, at 12.45 p.m., showed sudden symptoms of suffocation. He was inverted and a finger stuck down his throat under the surmise of impacted food. He died at 1.30 a.m. *Post-mortem* showed a scar at the tip of the

epiglottis and a small ulcer at the base, extending to the adjoining mucous membrane, with acute œdema of the larynx. No history was obtainable.
Macleod Yearsley.

The Removal of Adenoids.—Aymard, J. L. "Lancet," June 24, 1916, p. 1251.

A long article, somewhat discursive. The author prefers to remove adenoids before dealing with tonsils. In the former he uses curved scissors.
Macleod Yearsley.

ŒSOPHAGUS.

Œsophagostomy for the removal of a Plate of False Teeth.—Bullock, Howard. "Medical Journal of Australia," June 19, 1916.

The plate was lodged in the upper part of œsophagus opposite upper end of sternum. It was *in situ* five days, and could not be removed by direct method on account of defective visibility from swelling. The plate had ulcerated through œsophagus. No stitches were inserted in œsophagus, which was too friable. Only water was given by mouth for a week. By the end of two weeks the fistulous tract had healed completely. Patient suffered no ill after-effects.
A. J. Brady.

EAR.

Psychic Disorders Observed During the War.—Roussy Gustave. "La Press Medicale," April 8, 1915.

Amongst the varied nervous disorders incident to the war, the writer describes three cases of deaf-mutism. Three Zouaves with other soldiers whilst occupying a front trench, were injured by the bursting of a projectile from one of the enemy's mortars, designated by the men "crapouillaud." This form of munition explodes with a terrific crash and gives rise to an extensive displacement of air. A dozen men were entombed under the wall of the trench, two were killed, and others, some of whom were buried up to the neck, were extracted, and led away trembling, and stunned to a dressing station near by. Of the three Zouaves, two had hæmorrhage from the nose and ears, and all of them had been struck deaf and dumb. On admission to the Military Hospital three days later they could neither hear nor speak. At the first examination suspecting hysteria or pure simulation the patients were isolated, and the writer expressed the opinion to his colleague in their presence that they were suffering from nervous shock and promised them a complete return of their faculties by the next day or the day after. On the following day two of them, Arb —— and Chaz ——. had completely recovered speech and partially their hearing. The other, Via ——, commenced speaking on the third day. An examination of the ears by Dr. Chevalier, revealed that Chaz —— was suffering from middle-ear suppuration on the right side, Arb —— was affected in a similar way, but bilaterally and Via ——had suppuration of the left tympanum and a rupture of the right membrane. Hearing was still imperfect, but on a good way to recovery. The author reconstructs the sequence of events in these cases as follows: Bursting of the projectile,

by displacement of air caused a perforation of one or both membranes and induced a violent nervous shock and temporary loss of consciousness. The patients came to themselves, but the auricular lesions, probably exaggerated by the nervous condition of the patients, induced complete bilateral deafness; from this absolute hysterical deafness resulted. These troubles lasted four days. In conclusion, the author says that in these cases the important *rôle* played by an organic lesion should be remembered. Here it was evident in the production of manifestations of a hysterical order. *H. Clayton Fox.*

The Ætiology and Pathology of Otitic Cerebellar Abscess.—Frisner, J. "Annals of Otology, etc.," xxv, p. 92.

Discusses 86 cases from literature since 1906; 83·890 were due to chronic suppurations. This is because of the greater base destruction and the presence of cholesteatoma. Males are attacked to females as three to one. The connection between cerebellar abscess and sinus thrombosis is discussed, and also is the difference between abscesses occurring with acute and with chronic otitis. Cerebellar abscess may be labyrinthogenic and nonlabyrinthogenic. At least 50 per cent of the abscesses complicating chronic otitis belong to the former category, but of those due to acute otitis, from 90 to 95 per cent. are nonlabyrinthogenic. *Macleod Yearsley.*

MISCELLANEOUS.

Shell Shock.—Wiltshire, Harold. "Lancet," June 17, 1916, p. 1207.

Although not dealing immediately with disturbances of hearing and speech, specialists will find the conclusions drawn in this article to be of value. They are as follows: (1) The wounded are practically immune from shell shock, presumably because a wound neutralises the action of the psychic causes of shell shock. (2) Exposure and hardship do not predispose to shell shock in troops who are well fed. (3) While it is theoretically possible that physical concussion resulting from a shell explosion might cause shell shock, it is certain that this must be regarded as an extremely rare and unusual cause. (4) Chemical intoxication by gases generated in shell explosions cannot be more than a very exceptional cause of shell shock. (5) Gradual psychic exhaustion from continued fear is an important predisposing cause of shell shock, particularly in men of neuropathic predisposition. In such subjects it may suffice to cause shell shock *per se*. (6) In the vast majority of cases of shell shock the exciting cause is some special psychic shock. Horrible sights are the most frequent and potent factor in the production of this shock. Losses and the fright of being buried are also important in this respect. Sounds are comparatively unimportant. (7) A consideration of the causes and frequency of relapses favours an original cause of psychic nature. (8) Any psychic shock or strain may cause a functional neurosis, provided it be of sufficient intensity relative to the nerve resistance of the individual. Such shock or strain need not have any connection with "sex complexes." *Macleod Yearsley.*