

Abstracts.

NOSE AND NASO-PHARYNX.

The Fossa of Rosenmueller.—Sidney Yankauer. "The Laryngoscope," December, 1917, p. 861.

Yankauer states that the fossa of Rosenmueller is nearly one inch in depth. The main respiratory air-channel in the nose is on a level with the tip of the Eustachian eminence. When the air current reaches the nasopharynx it divides, and part passes above the eminence through the fossa of Rosenmueller. The second part passes in front of the eminence over the soft palate, and the remainder courses between the two eminences. Any obstruction, such as adenoid growths in the fossa or in the space between them, interferes seriously with the smooth passage of the air. When adenoids become inflamed, the edge of the "lateral comb" becomes adherent to the eminence, and when the lymphoid tissue shrinks during adolescence these adhesions remain. Such adhesions can be easily recognised in the post-nasal mirror. They are sometimes so numerous that the mucous membrane appears to be continuous, and there is no sign of the usual deep fossa of Rosenmueller. Some adults complain of nasal obstruction, and yet no obstruction of any kind is found in the nose. Removal of the adhesions in the nasopharynx in such cases relieves the obstruction. Applications of silver to the raw surfaces may be necessary to prevent the re-formation of adhesions. Yankauer recommends that such applications should be made through his speculum. When healing is complete, the appearance of the nasopharynx is entirely changed.

The presence of secretion in the fossa of Rosenmueller is, in Yankauer's opinion, always suggestive of nasal sinus disease. If there are adhesions between the posterior lip of the tube and the posterior wall of the pharynx, the lower part of the fossa of Rosenmueller is converted into a pocket in which secretion can accumulate. As this secretion may be forced into the nasal cavity during the act of blowing the nose, all the classical symptoms of chronic sinus disease are reproduced. Yet, when the adhesions are cut and the drainage of the fossa restored, all the symptoms disappear.

J. S. Fraser.

LARYNX AND TRACHEA.

Tracheo-bronchial Diphtheria.—Henry Linah. "The Laryngoscope," October, 1917, p. 734.

Linah does not consider that a case of diphtheria is tracheo-bronchial in which O'Dwyer's intubation-tube relieves the stenosis. It is only those cases with membrane below the intubation-tube which call for bronchoscopic measures to relieve the obstruction.

Certain conditions may be mistaken for tracheo-bronchial diphtheria, *e. g.* (1) encapsulated empyema which has ruptured into a bronchus; (2) impacted foreign body in a main bronchus; (3) cases of bilateral broncho pneumonia.

Linah uses the smallest-sized tube possible when performing bronchoscopy—usually the 4 and 5 mm. tubes of Chevalier Jackson. Such tubes cause little traumatism, but make the recognition of objects difficult. It is very important to remove the obstruction at the first trial, whether it be a diphtheric membrane or a portion of food, such as a

pea-nut pulp. Linah states that his average time was from five to eight minutes, but the tube may be left *in situ* with no apparent bad result for a period of fifteen minutes after spraying or swabbing with antitoxin. The children breathe with perfect ease and often fall asleep with the bronchoscope *in situ* after the obstruction has been relieved. In the removal of the membrane by suction or forceps care should be taken to locate the uppermost part of the attachment of the membrane and follow it down to its distal attachment. As a rule the membrane is readily stripped off from the tracheal and bronchial wall. During 1915-16 Linah has dealt with 11 cases. Of these, 1 was an adult and all the others children of from one to eight years. Six of the 11 cases were discharged cured. Of the 5 which died, 3 were moribund on admission, while the other 2 died from pneumonia fifteen and twenty days after the removal of the membrane. The reports of the cases are extremely interesting but should be read in the original. No case of diphtheria should ever be anaesthetised for the removal of membrane, though morphia and atropine may be given. It is noteworthy that all the cases Linah has dealt with, in which tracheotomy had been performed, terminated fatally.

J. S. Fraser.

EAR.

Unusual Course of Pus in the Neck in a Case of Mastoiditis.—John W. Durkee. "The Laryngoscope," December, 1917, p. 901.

The writer records the case of a male, aged fifty, who complained of pain in the right side of the head. Six weeks later the pain was so severe as to keep him from business. Otorrhœa began eighteen days after the last note and at the same time a swelling formed behind the auricle. After two weeks this swelling disappeared, but a few days later there was a swelling in the upper part of the neck at the tip of the mastoid. Durkee first saw the patient a month after the discharge began and found sagging of the wall of the right meatus, which was filled with thick pus. Temperature, 98.2° F. The urine contained sugar and a trace of albumen. Incision in the neck opened a large abscess. Durkee states that the pus was external to the sterno-mastoid. There was a necrotic spot in the mastoid cortex over the antrum and from this granulations protruded. From this spot a sinus connected with the upper part of the neck abscess. The mastoid was broken down and filled with pus and granulations. Some deep cells were present below the antrum, between the sigmoid sinus and the bony meatus. The sinus itself and the dura of the temporo-sphenoidal lobe were covered with granulations. Four days later the patient complained of difficulty in swallowing relieved by holding up the larynx. The wound was dressed and thick pus welled up from the deep cells mentioned above. The irrigation passed from these cells into the patient's throat. On swallowing, air came through the deep cells into the wound. Efforts to locate the opening in the throat were without success. Deep fluctuation was now detected low down in the neck behind the sterno-mastoid and a large abscess was opened here. On irrigation of this the solution went into the patient's throat and also came through the deep cells into the mastoid. On May 7 erysipelas appeared around the wound and involved the face and head: death.¹

J. S. Fraser.

¹ Obviously one of those interesting cases of deep cervical cellulitis opening into the pharynx of which a collection was made in the JOURNAL OF LARYNGOL., RHINOL., AND OTOL., vol. xxx, p. 12.

A Method of Medicating Eustachian Bougies.—Lee M. Hurd. "The Laryngoscope," December, 1917, p. 879.

Hurd recommends the following method: In a narrow test-tube make a saturated solution of gum acacia in a water-bath, then add the silver nitrate solution, making the solution from 1 per cent. to 10 per cent. strength of silver as desired. The bougie is dipped about $1\frac{1}{2}$ in. into this solution, and when the bougie has a uniform coating it is placed to dry; then Hurd usually gives the bougie a second coating. When dry, the gum acacia and silver coating looks and feels like varnish to the dry fingers. The silver bougies, when kept dry, will last fairly well for a week or more.

Method of Introduction.—A plain gum elastic or celluloid bougie, of the proper size, is passed through the tube to make sure of the position of the catheter and the size of the bougie the tube will admit, and also to dilate the tube. Then the plain bougie is withdrawn, and the coated bougie readily passed as far as desired and allowed to remain about two minutes in order that the moisture of the membrane may dissolve the gum and deposit the silver.

Result.—One to four per cent. is usually strong enough to contract the membrane; if not, the strength can be increased up to 10 per cent., but these stronger bougies should be used cautiously. Hurd has on several occasions produced a serous exudate in the tympanum with pain, tinnitus, and some deafness for several days. The ultimate results vary. Some tubes remain perfectly patent, while others relapse and require a repetition of the treatment.

J. S. Fraser.

The Surgical Treatment and Cure of Suppurative Otitis Media Chronica in Childhood.—James B. Horgan. "Brit. Journ. of Child. Dis.," January–March, 1918, xv.

A *resumé* of the modern surgical treatment of a disease, the prevalence of which the writer is firmly convinced may be ascribed to the indifference with which it is so often treated in its acute or early stages, and at a later period to a lack of thoroughness in ascertaining and removing all sources of tympanic blockage and re-infection.

The opinion is expressed that, at least in the case of children, the radical mastoid operation is too often performed with undue celerity and before other and simpler surgical procedures have been given a legitimate trial.

Another voice cries from the wilderness for the routine aural examination and treatment of children *before* they are discharged from fever hospitals.

Author's abstract.

The Value of the Galvanic Method of Testing the Functions of the Inner Ear and Eighth Nerve.—G. W. Mackenzie. "Annals of Otolaryngology," xxvi, p. 733.

The author concludes that the galvanic test is more accurate than the caloric or rotational, is least annoying and easiest to control. That it has the additional advantage of being applicable as a unilateral test. That it is the only test we possess for testing the function of the eighth nerve in neuritis or secondary degeneration, and for making a differential diagnosis between labyrinth destruction and eighth nerve neuritis. Finally, it is the only test available for determining the progress of eighth nerve neuritis, whether favourable or unfavourable.

Macleod Yearsley.

MISCELLANEOUS.

A Splint for Facial Paralysis.—C. E. Dennis. "Brit. Med. Journ.," September 21, 1918.

In the case of injury to a motor nerve—for example, the radial (muscular-spiral)—the muscles supplied by it are paralysed, and the contraction of opposing sound muscles, aided in the above case by gravity, when splinting is not resorted to, overstretches the flaccid paralysed muscles.



Where recovery is going to take place it will be delayed and rendered imperfect if this overstretching is permitted to take place. In injury to the facial nerve of one side, with resulting facial paralysis, overstretching of the paralysed muscles will be caused by the contraction of the muscles of the opposite side, especially when the latter muscles are put into use, as in smiling, laughing, talking, and during mastication. Moreover, the sound muscles will be placed at a disadvantage, as their points of attachment are drawn nearer to the point of origin. Not only is one side paralysed, but the sound side is hampered in its range and power of action. Consequently the patient experiences a double difficulty in talking and masticating.

To avoid this, the following simple yet effective appliance has been invented. It consists of a piece of malleable German silver wire, bent

so as to hook into the corner of the mouth and over the ear of the affected side, like the curl side of a spectacle. It is easily adjusted by bending the ear-piece till the tension is correct and comfortable. Its advantages are: (1) Simplicity and lightness; (2) prevention of overstretching of the paralysed muscles, and so rendering recovery more rapid; (3) it gives the sound muscles a fixed point to work against, and by preventing shortening renders them more effective in action; (4) it is greatly appreciated by the patients, who state that they feel more comfortable and can masticate much better. If properly adjusted there does not appear to be any tendency to make the mouth sore, and it is so simple that anyone can easily make the splint in a few minutes with a pair of pliers.

Dan McKenzie.

Double Facial Paralysis of Traumatic Origin.—G. L. Halley. "Rev. de Laryngol.," January, 1918.

The writer points out that this condition is very rare indeed. Only six cases have already been recorded. The writer adds two cases which he had observed during the war.

CASE 1.—Double total facial paralysis of peripheral type of six weeks' duration. Paralysis absolute on left side, on right slight movement of closure of eye. Characteristic face. Absence of expression and wrinkles. Dribbling of saliva. Speech almost incomprehensible. Eating and drinking difficult. Reaction of degeneration on both sides. Mode of production. Head of patient squeezed between cart and wall. Bleeding from left ear. Face swollen and bruised for several days. Lesion attributed to transverse fracture of the base, although both eighth nerves were intact.

CASE 2.—Soldier blown up by large shell at Douaumont in October, 1916. Immediate loss of consciousness followed by loss of memory. Sent down from dressing-station labelled "no external lesions, facial diplegia, bleeding from both ears and from nose, slight left mydriasis." During first few days patient again relapsed into coma, and on regaining consciousness complained of intense nausea and vertigo. Quite deaf in the left ear, almost totally deaf in the right. Developed double otorrhoea. On examination had typical double facial paralysis. No sign of ocular paralysis nor alteration of vision. Left pupil slightly larger than right. No nystagmus. No trouble with deglutition. Movements of palate normal. Loss of taste in the anterior two-thirds of the tongue. Reaction of degeneration on both sides. Examination of ears showed: Right drum cicatrised. Left drum retracted. Hearing almost completely lost. Diagnosis: Commotio without lesion of vestibular tracts.

Examination, September, 1917: Considerable improvement. Can shut eyes now. Reaction to faradism returned.

The lesion was probably peripheral and localised in the aqueduct of Fallopius. As the sense of taste was affected, probably the lesion was in the tympanic part of the facial nerve. No other nerves were involved.

J. K. Milne Dickie.

REVIEWS.

Eye, Ear, Nose and Throat. By H. C. BALLENGER, M.D., and A. G. WIPPERN, M.D. Pp. 524. New York: Lea & Febiger. Second edition, 1917.

The authors have rewritten nearly every chapter of this volume in response to the demand for a short work for students and practitioners.