ABSTRACTS.

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PHARYNX.

Can Granular Pharyngitis be the Cause of "Febricula"?—V. Grazzi. "Boll. della Mal. dell'Orecchio, etc.," May, 1919, No. 5, Ann. xxxvii.

Prof. Baccarani in 1918 made a statement that many "febriculas" generally attributed to intestinal intoxication are really due to granular pharyngitis. There may be pains in the region of the appendix which he regards as secondary to the throat condition. The author, Prof. Grazzi, in the course of a long experience has only had one case of this kind, so the conditions cannot be regarded as common.

A lady, affected with granular pharyngitis, had been troubled for a considerable time with slight rises of temperature. After cauterisation of the granulations these symptoms disappeared. After a long interval the patient came back on account of her throat, which was again giving her trouble. She was also having slight rises of temperature and some pain in the region of the appendix, which came on at the same time as the throat trouble. She had had her appendix removed contrary to the advice of Baccarani, whom she had consulted, and had found that her fever, instead of improving, had rather got worse. After treatment of the granulations which had reappeared in the throat the patient's condition returned to normal.

The case is reported more with the idea of promoting discussion than of attempting to prove the presence of a definite "febricula pharyngea."

J. K. Milne Dickie.

NOSE.

Acute Suppurative Hypophysitis as a Complication of Purulent Sphenoidal Sinusitis.—T. R. Boggs and M. C. Winternitz. "Johns Hopkins' Hosp. Reports," xviii, 1919.

This is as far as is known the first case on record of this condition.

The patient, a woman, aged forty-three, was admitted to hospital June 17, 1915, complaining of stiffness and soreness of the neck muscles, headache, pain behind the eyes and tenderness of the scalp. The illness began with an ordinary coryza on May 7. On May 20 had soreness of the right side of the neck. Feeling of fulness in throat. Slight tenderness over both mastoids. Examination of ears and throat negative. No fever till May 21, when temperature rose to 101° F., pulse 101, respirations 20, blood-pressure 135. Some albumen and a few casts in the urine. On May 30 had improved a little, but had sudden severe pain in back lasting a day or two. Had a second attack of pain in neck and back on June 10. X-ray showed a little opacity of the left antrum. On June 17 had pain

in head and neck. Optic discs normal; movement of eyes caused pain. Semicomatose; no paralysis; no Kernig. Temperature 104° F. Leucocytes 11,600. Nitrogen coefficient in blood normal. Blood-sugar 0·243 per cent. Urine contained 2½ per cent. of sugar after two slices of bread. Acetone and diacetic acid + +. Orifices of nasal sinuses normal. Antra and frontal sinuses illuminated.

On June 19 the patient became comatose and her temperature shot up, rose to 107° F. and patient died. After death temperature 108·5°.

There had been no strabismus or ptosis; no convulsions.

Post-mortem examination showed purulent sphenoidal sinusitis with an extension through the sella, involvement of the hypophysis, subacute hæmorrhagic basilar meningitis and acute encephalitis on the right side. The hypophysis showed as a dark red friable body with pus exuding from the sella round it. The vessels and sinuses round the hypophysis were occluded by thrombi. The anterior lobe of the pituitary was infiltrated by polymorphs. There was also a large V-shaped infarct.

The case was interesting from the complete absence of localising or neighbourhood symptoms.

The presence of hyperglycæmia and glycosuria may be a possible indication of involvement of the pituitary gland in a person previously not glycosuric who shows signs and symptoms of intra-cranial inflammation.

The normal appearance of the orifices of the nasal sinuses does not exclude sinusitis of the severest type, as is shown by this case.

J. K. Milne Dickie.

Sphenoidal Empyema and Epidemic Cerebro-spinal Fever.—D. Embleton. "Brit. Med. Journ.," January 3, 1920.

The association of sphenoidal sinusitis with cerebro-spinal fever was first noticed by Westenhoeffer, who found it in one-third of his twenty-nine necropsies.

The primary site of a meningococcus infection is undoubtedly the nasopharynx. Many "carriers" suffer from colds and nasal discharge, and it thus appears that the meningococcus can give rise to a nasal discharge catarrh. The frequency of sphenoidal sinus empyema suggests that this might be the determining factor in the onset of meningitis, the infection passing by way of the lymphatics from the sphenoidal sinus direct to the meninges. Infection by the blood-stream is also possible.

The author found empyema of the sphenoidal sinus in thirty-two out of thirty-four cases of cerebro-spinal fever examined *post-mortem*. The sphenoidal sinus contained pus in every one of ten cases of hydrocephalus following cerebro-spinal fever. This complication is probably the result of a chronic infection about the foramina of Luschka and Magendie.

Douglas Guthrie.

Congenital Occlusion of the Choanæ.—Prof. Barraud. 'Rev. Méd. de la Suisse Romande,' June, 1919.

Two cases of occlusion of the choanæ out of seven seen by the author are here reported.

Case 1: Female, aged thirteen. On examining the nose the right side was found to be full of pus and polypi and to be obstructed behind; the left side was almost normal but slightly obstructed by a soft curtain at the back. Posterior rhinoscopy revealed complete absence of the right choana and partial obstruction of the left. With a probe the right side

of the nose was found to be 2 cm. shallower than the left and the obstruction bony. The child had frequent severe headaches, often lasting several days. She had completely lost the sense of smell on the right side and could neither breathe through nor blow it. The inferior and middle turbinals in both sides were hypertrophied and the septum was markedly deflected to the right. After removing a considerable piece of the right middle and inferior turbinals, Barraud tunnelled through the osseous obstruction with hammer and gouge, then enlarged this opening with cutting forceps and kept a drainage-tube in for four weeks. The result was good; there was no appreciable retraction and the sense of smell became normal on both sides.

Case 2: Baby, three days old, with copious purulent discharge from both nares due to nasal diphtheria and double maxillary sinusitis. This was treated with lavage and the child fed from a spoon. A probe could not be passed through either side of the nose, air could not be blown through by a Politzer's bag, and some drops of methylene-blue run into the nose did not appear in the pharynx. Four days later Barraud perforated the left choana with a trocar 4 to 5 mm. in diameter, then passed a catheter, bringing it out through the mouth. A week later, although the discharge had ceased, as the child's condition seemed hopeless the catheter was removed and the child sent home.

To Barraud's great surprise the child was brought back to hospital still alive and in a fairly satisfactory condition three months later. The artificial choana had contracted so as to make nasal respiration almost impossible. Barraud then enlarged this opening, perforated the right choana, and passed a catheter from one side of the nose round into the other. This was changed daily, and after about a month nasal respiration was almost normal and the child slept with its mouth shut.

A year later the child died of broncho-pneumonia following influenza, still breathing well through its nose. *Arthur J. Hutchison.*

LARYNX.

The Prognostic Importance of Tuberculosis of the Larynx.—Sir StClair Thomson. "Lancet," 1919, vol. ii, p. 689.

The author analyses 1750 patients seen at Midhurst during the last eight years, and deals with 833 seen during four years. He divides these cases into non-laryngeal and laryngeal. These compared show that the prognosis as shown by the percentage of deaths is rendered graver in both sexes by the presence of laryngeal involvement, and that this increased gravity is manifest whatever the extent to which the lungs may be involved. The detection of a laryngeal lesion, therefore, renders the prognosis more gloomy than in a case of more advanced pulmonary infection with a free larynx. *Macleod Yearsley.*

A Large Cyst of the Larynx.—H. I. Schousboe (Odense). "Acta Oto-laryngologica," vol. i, fasc. 2 and 3.

The patient was a woman, aged forty-five, who had noticed for several years the sensation of a lump in the throat, slight interference with swallowing, but no marked respiratory difficulty. A soft fluctuating swelling had been present for about a year on the front of the neck in the interval between the hyoid bone and the upper margin of the thyroid cartilage. The left pyriform fossa was filled up by a smooth rounded

tumour, which pressed the left arytænoid and the left half of the epiglottis towards the mid-line. Bimanual palpation with a finger in the pyriform fossa and a finger on the swelling on the front of the neck elicited a definite sensation of fluctuation. The cyst was removed entire by external operation without wounding the very thin mucous membrane of the pharynx which covered it, and the patient made an uneventful recovery. It proved to be a retention cyst arising from a mucous gland. The author suggests that this method of removal by external operation might be suitable for similar cases of large retention cysts in the pyriform fossa, even when they do not, as in the case he describes, present on the surface. *Thomas Guthrie.*

TONSILS.

Tonsillitis and Pharyngitis as a Result of Oral Sepsis.—H. B. Anderson (Toronto). "Amer. Med," vol. xiv, No. 9, September, 1919.

The fact that tonsillitis is often secondary to oral sepsis and that marked cases of the latter are almost invariably associated with tonsillar infection has not received from either throat specialists or general practitioners the recognition which its practical importance warrants. The author tersely points out that it is not even mentioned by many authors of recent standard works in diseases of the throat.

The author for some time has made it a point to examine closely the throats of all office patients suffering from dental infections. Two spatulæ are used—one to press backward and outward on the anterior pillar so as to extricate the tonsil, while the other spatula is used to press the tonsil itself. Often this will show liquid pus when least expected. The appearance of the tonsil offers little indication as to its disease. Clipped tonsils and tags are potent factors in retaining foci of infection.

In an analysis of 330 routine private cases where cultures were made on blood-agar, the *Staphylococcus albus* was found in 66 per cent., *Streptococcus viridans* in 24 per cent., non-hæmolytic streptococcus 35 per cent. The non-hæmolytic streptococcus was found most frequently in contrast with the *Streptococcus viridans*, which is found most frequently in suppurative lesions about the teeth. This, the author thinks, may be due to transmutation in streptococcal types in the passage of infection from the teeth to the tonsils. While the type of streptococcus varied considerably in different mouths, the presence of pathogenic bacteria in the tonsil does not necessarily mean that the patient is suffering from active disease, yet if pus and other evidences of inflammation are present, it suggests an active infection capable of producing systemic disease, and improvement of the latter following enucleation of the tonsils is additional evidence of the virulence of the organisms isolated.

The author asks: "What is the surgeon's proper course of action in cases of oral sepsis with associated tonsillar infection?"

Obviously if tonsillitis is frequently secondary to oral (*i. e.* dental) infection, the removal of the latter should precede operation on the tonsil. It is possible that this course would make more successful our efforts to deal with tonsillar infection by local treatment rather than by operation, though Billings says the infected tonsil cannot be successfully sterilised by any known method of treatment, and entire removal is the only safe procedure. *Perry Goldsmith.*

Tonsillectomy in Adults: The Advantage of Operating with Local Anæsthetic.—Bryan Foster. "Medical Journal of Australia," vol. ii, 1919, p. 349.

Under a general anæsthetic hæmorrhage is frequently alarming and too often dangerous. It is difficult to pick up a severed artery in a pharynx rapidly filling with blood. By blood obstructing his view the surgeon is guided by his sense of touch alone in his attack on the second tonsil, whereby damage may be done to the pillars. Foster regards the Sluder method of tonsillectomy as the quickest and simplest. It is much simpler under local than general anæsthesia. He regards the manœuvre of counter-pressure against the *eminentia alveolaris* as of somewhat fanciful value. The tonsil can be pushed through the ring by counter-pressure with a finger.

Operation under Local Anæsthetic.—Anæsthetic employed: 2 per cent. novocain, 7·2 c.c.; 1 per cent. adrenalin, 0·6 c.c. Patient sits upright facing light. Nurse supports head. Two punctures are made on each side, first at level of upper pole, second about middle of tonsil. Injection is not into tonsil but into peritonsillar tissue, as close to capsule as possible. If, in making the upper injection, the fluid escapes through supratonsillar fossa, the needle must be withdrawn and inserted further out. Not more than 7·2 c.c. is injected for each tonsil. Area is anæsthetic in three to five minutes. Heath's pattern of tonsillotome moderately dull is preferred. If a vessel bleeds it is tied before the other tonsil is attacked. When the removal of tonsils is finished the pillars are stitched together with a plain catgut suture. Foster says the operation is painless. It is simpler than when a general anæsthetic is used; hæmorrhage is less, and if it occurs it is more easily controlled.

A. J. Brady.

ŒSOPHAGUS.

Foreign Bodies in the Œsophagus requiring Œsophagotomy in Children.—Colledge and Ewart. "Lancet," 1919, vol. ii, p. 734.

The authors record two cases, a female child, aged two years, had swallowed an open safety pin. It was impossible to extract the pin without making it perforate the œsophageal wall, and, the point being caught in the mucous membrane, it could not be pushed down. It was successfully removed by œsophagotomy. In the second case, a male child, aged two, the object swallowed was a piece of iron, part of a toy puzzle, with six projecting blunt spikes, all at right angles, so forming a cross in all three dimensions. It lay just below the level of the cricoid, and measured $\frac{5}{8}$ in. across. It was easily removed by œsophagotomy. Both cases are well five and four years later respectively. The authors draw attention to the following points: (1) An attempt should always be made at removal by œsophagoscope first. (2) In the rare cases where such removal is impossible, it is much safer to make a clean incision in the œsophagus than to risk laceration. (3) The œsophagus when exposed in the living child is cylindrical and not a flattened band. (4) By suturing the wound in the œsophagus and lightly packing the outer part the risk of spreading cellulitis of the neck and mediastina is reduced to the minimum. (5) A clean vertical incision in the œsophagus does not lead to stenosis.

Macleod Yearsley.

EAR.

Outline of the Pathological Physiology of Otitic Sclerosis.—A. Raoult (Nancy). "Proc. French Soc. of Laryngol., Otol., and Rhinol."

The author considers the initial lesion to be a neuritis, inducing loss of power in the tympanic muscles. Consecutively owning to impaired mobility of the conduction apparatus the circulation is no longer normally affected. Eventually trophic lesions appear, degeneration of tissue, osseous lesions, etc. The neuritis manifests itself after general affections (intoxications, pregnancies, overwork, etc.). It may involve trophic, motor and sensory nerves and the terminals of the auditory nerve. Motor neuritis immobilises the ossicular chain with its consequences—ankylosis and trophic lesions. In chronic tympanic catarrh the author admits either a myositis or neuritis only attacking the tensor tympani, most exposed from its proximity to the Eustachian tube, whence relaxation of the membrane. It must be noted how this relaxation persists in chronic catarrh, even when air passes into the tympanum and there are yet no adhesions.

Later, on the contrary, it disappears when the stapedius has become paralysed. These troubles maintain derangement of the transmission apparatus, whence aural pains and headache. The latter is often migrainous in character and is undoubtedly due to vaso-motor troubles. Vaso-motor disturbances engender acquired trophic lesions. The affection now truly enters the sclerotic stage. The preceding remarks explain the possibility of improving audition by kinesitherapy, which the author has experienced by employing the Zund-Burguet apparatus. The importance of muscular and vascular lesions thus accounts for the lasting improvement, even when the treatment is ended. It therefore depends on the condition of the muscle-fibres. *H. Clayton Fox.*

Chloroma Simulating Mastoid Disease.—E. Catherine Louis. "Lancet," 1919, vol. ii, p. 830.

The author has found 65 recorded cases of chloroma. The case described was that of a male, aged ten. There was pain and discharge from the right ear. Temperature 99·6° F., pulse 104. Tender swelling over right mastoid, enlargement of right upper cervical glands and right facial paralysis. Tuberculous mastoiditis was diagnosed. The antrum when opened contained pus and greenish-looking granulation-tissue. Improvement followed for a week, when retention of urine and marked constipation appeared. Blood-count showed apparent condition of lymphatic leukæmia. Sixteen days later epistaxis and pain at the level of the right dorsal spine occurred, and sixteen days after this left facial paralysis developed. The inguinal glands enlarged and blood-counts showed a steady increase in the number of leucocytes. Temperature fluctuated and death occurred seven weeks after the apparent onset of the disease. Autopsy was not complete, but masses of growth were found about the bodies of the dorsal and lumbar vertebræ, one mass pressing on the cord. Other masses were found on the ribs and right femur, cardiac surface of pericardium, stomach, duodenum, large intestine, pancreas and kidneys. There was hyperplasia of all the elements of the bone-marrow, with a variety of type in the cells composing the tumours.

Macleod Yearsley.

MISCELLANEOUS.

Meningo-encephalitis as the only Manifestation of Mumps: Report of Three Cases.—Tasker Howard. "Amer. Journ. Med. Sci," clviii, No. 5, p. 685.

This paper is of interest to otologists in view of the association of mumps with the sudden onset of deafness.

Metastatic lesions in mumps are well known, testifying to the general nature of the infection. Orchitis, mastitis, pancreatitis, arthritis, encephalitis and meningitis are at times met with. Orchitis is occasionally recognised in the absence of any involvement of the salivary glands. Three cases reported are regarded as instances of mumps meningo-encephalitis, in spite of the absence of inflammation of the salivary glands. They occurred in the presence of a mumps epidemic. In two of the three cases there was recovered from the spinal fluid a Gram-positive diplococcus. This was found in direct smear and grown in pure culture in both cases. The spinal fluid in each case presented a moderate pleocytosis, characterised by a predominance of mononuclear cells. The conditions with which we are familiar which show this picture are (*a*) syphilis, (*b*) sometimes tuberculous meningitis, (*c*) encephalitis lethargica and (*d*) mumps. Two of the three patients were certainly not syphilitic. Tuberculous meningitis and encephalitis lethargica are ruled out in all cases by the clinical course.

J. S. Fraser.

Enlarged Thymus Gland and some Remarks on Status Lymphaticus.—R. C. Newton (Montclair). "Amer. Journ. Med. Sci.," October, 1919.

The case described was that of a young man, aged twenty, who suffered from loss of muscular vigour, some dyspnœa and a soft œdema over his neck, upper chest and shoulders. X-ray examination showed the thymus gland so much enlarged that it covered all, or nearly all, of the anterior surface of the pericardium. As a result of X-ray treatment the œdema and other symptoms disappeared, but returned a year later, when only slight and temporary improvement followed a second course of this treatment. He finally developed an aortic aneurysm and died as a result of its rupture. The author discusses what is known as to the minute anatomy, physiology and pathology of the thymus and also the significance of the *status lymphaticus*. He is inclined to regard both the latter condition and anomalies in the structure and size of the thymus as due in some way to defective hygiene and diet, and so perhaps allied to rickets.

Thomas Guthrie.

REVIEW.

Compendium of Medico-Legal Oto-Rhino-Laryngology. By Drs. Ciro Caldera and Alberto Balla. Biella: G. Testa, 1916. Pp. 278.

A great deal of condensed information is presented by the authors in this book. While its use is strictly limited in English-speaking