Abstracts.

PHARYNX.

Fisher, A. G. Timbrell.—Sigmoid Tortuosity of the Internal Carotid Artery and its Relation to Tonsil and Pharynx. "Lancet," July 27, 1915, p. 128.

The author points out the conflicting statements of text-books relative to the proximity of the internal carotid artery and the tonsil, and discusses the normal and abnormal anatomy of the vessel. He considers that abnormal tortuosities are probably reversions to the lower mammalian type. The practical application of their anatomical abnormality is that, when the sigmoid curve lies in the coronal plane, it is liable to injury in operations involving the posterior wall of the pharynx. When in the sagittal plane it is more likely to be met with in operations on the tonsil.

Macleod Yearsley.

Stark, H. H.—Twenty-five Cases of Vincent's Angina successfully treated with Sodium Perborate. Special Report of Three Cases. "Annals of Otology, Rhinology, and Laryngology," xxiv, p. 48.

The perborate of soda (which is not the common borax of commerce) was prescribed in powder, two teaspoonfuls dissolved in a glass of water and used frequently as a mouth wash or gargle. The author thinks that Vincent's angina is a far more common disease than it is given credit for being. The diagnosis is difficult in gross lesions, and in suspected cases there should be an examination microscopically for the combined spirochetæ and fusiform bacilli. The sodium perborate in his hands has given uniformly good results. It is simple, without danger, eases pain promptly, and cures within a short length of time.

Macleod Yearsley.

Poynton, F. J., Higgins, T. N., and Pirie, G. R.—Inclusion Dermoids of the Pharynx. "Lancet," March 20, 1915, p. 595.

The authors describe a case of this very rare tumour in a female infant, aged five weeks. There was a round, pinkish tumour between the tongue and soft palate, only seen on "gagging." Under anæsthesia it was found to be attached to the left lateral pharyngeal wall between the anterior and posterior pillars of the tonsils by a narrow pedicle. It was easily removed. One and a half inch long and half an inch thick, it consisted of: (1) An outer covering of true skin, with hair follicles and sebaceous glands; (2) retiform tissue; (3) a bar of cartilage; (4) a central canal (? due to falling out of tissue in preparation). A short and useful bibliography is presented. *Macleod Yearsley.*

THROAT.

Bosviel.—Apoplexy of a Tonsillar Pillar. "The Proceedings of the Parisian Society of Laryngology, Otology, and Rhinology," November 10, 1911.

This case concerned a man, aged fifty, a great smoker, subject to slight congestive attacks, who, after a slight cold, experienced vague prickings in the throat. He did not trouble himself about it and went

to bed with the window open, as was his custom. But in the middle of the night he was startled from sleep by an enormous ball obstructing his pharynx, and which he tried in vain to expel. This ball was hanging loosely in the throat and occupied the whole of the right side, bulging down behind the base of the tongue. The patient on introducing his fingers felt it easily. It seemed to him to resemble an elongated sausage, invading quite a half of the bucco-pharyngeal isthmus. After continually manipulating the swelling with the fingers, he ended by pressing with so much force on one point as to burst it; he spat out a mouthful of blood and felt somewhat relieved.

Next day he consulted the author, who was only able to observe the following: The mucosa was everywhere markedly congested, left anterior and posterior pillars and right posterior pillar normal. Tonsils red and slashed by numerous discissions. Right anterior pillar was red, slightly violet, œdematous, projecting beyond its usual limit, and presented on the internal half of its anterior surface a little shred of blackish sanguinolent mucosa which could only be due to a scratch by the patient's finger-nail the preceding night. Swabbings with adrenalin solution and a gargle were prescribed. When the patient returned two or three days later, there was nothing more than a slightly thickened pillar, still red. All the other appearances had gone. Although he had not witnessed the entire evolution of the trouble, the author felt justified from the history and objective signs observed by himself, in diagnosing sudden congestion of one of the pillars and extravasation of blood. One has observed a similar condition in connection with the uvula, but not having seen anything like it involving the faucial pillars, he thought it would be interesting to report it here. *H. Clayton-Fox.*

NOSE.

Lubet-Barbon.—Peripheral Facial Paralysis following use of the Nasal Douche. "Proceedings of Parisian Society of Laryngology, Otology, and Rhinology," November 10, 1911.

This case goes to swell the numbers of accidents, already large, resulting from the injudicious employment of the nasal douche. Nasal lavage, the author holds, ought no more to be entrusted to our patients than the morphine syringe. It ought only to be carried out by the surgeon after having ascertained whether one or other fossa be obstructed, and care must be exercised to introduce the fluid from the narrow side towards the wider, so that the fluid enters under a minimal pressure and escapes without resistance. The patient does not know this, neither is he aware that he must not swallow whilst the fluid is passing. During deglutition the pharynx is contracted and the tubal orifice is opened, conditions favouring the entry of fluid into the tube. He is also unaware that the tongue must be protruded during the procedure; as long as this is done swallowing is impossible. There are many things to explain to one's patient; one does not always do it, and when it is done only half is returned. Moreover, nasal lavage is not advised without a cause, and this is most often a septic infection of the nose. Whence not only phenomena of injury to the contents of the tympanum, but grave infection of the entire middle ear.

A man, aged thirty-nine, suffered from chronic nasal catarrh, for which he used the hydrostatic douche daily. Towards the end of

September, whilst douching the nose, he felt his hearing dulled; he ceased, and a sharp pain supervened in the left ear, which passed off in a very short time, but returned more severely during the course of the day, accompanied by deafness with a sense of tension and fulness. He was seen by a colleague, who noted a slight redness of the drumhead, and after a summary dressing advised the patient to rest. Four or five days after the douche the patient awoke with facial paralysis, and consulted the author ten days after its onset. He found the usual symptoms of a complete paralysis. There was diffuse redness of the membrane with two little pulsatile reflexes in the postero-inferior quadrant. . Hearing was only slightly impaired—a third compared with the sound ear. The membrane was not bulged. Catheterisation, practised very carefully, showed that there was no fluid in the tympanum. Hearing was much improved. He considered the pulsatile reflexes must be the evidence of spontaneous punctiform perforations. Nothing more was done than to insert a strip of protective gauze into the meatus. For some days, whilst the patient was under observation, the gauze remained dry. The punctiform spots disappeared and hearing returned almost to normal. As regards the paralysis, it had lasted almost six weeks and had diminished spontaneously and progressively. He was not aware if this accident from use of the nasal douche has already been observed, but it did not make him more favourably disposed to the procedure. *H. Clayton Fox.*

LARYNX AND TRACHEA.

Eccles, H. A.—Foreign Body in the Left Bronchus. "Proceedings of Royal Society of Medicine, Electro-Therapeutical Section," April, 1915, p. 61.

The patient, a girl, aged three and a half, swallowed a foreign body of doubtful nature on February 9, 1915. Sixteen days after a slight cough developed.

On the twenty-sixth day a skiagram was taken, discovering a long pin lodged in the left bronchus with the point upwards. Two days later the bronchoscope was passed. The pin was seized by forceps and removed. Rapid recovery. *Archer Ryland.*

EAR.

Ellis, Arthur W. M., and Swift Homer, F. (New York).—Involvement of the Eighth Nerve in Syphilis of the Central Nervous System. "The Journal of the American Medical Association," May 1, 1915.

The onset of sudden or rapidly progressing deafness in patients with syphilis is a not uncommon occurrence. It is due to a syphilitic lesion of the eighth nerve or labyrinth, and the prognosis is unfavourable. These affections should not be considered and treated as instances of isolated disease of the organ of hearing, but as manifestations of syphilis of the central nervous system. The question of the frequency of syphilitic affections of the eighth nerve in the early stages of syphilis is intimately associated with the question of the ætiology of the so-called "nerve relapses," the paralyses of cranial nerves occurring in patients with secondary syphilis who have been inefficiently treated with salvarsan. These cases have now been definitely proved syphilitic, but the great

increase in frequency of such cases from the use of salvarsan has been exaggerated. The severity of these affections of the cranial nerves in early syphilis is rather markedly increased and somewhat more frequent in patients inefficiently treated with salvarsan.

In seven syphilitics with disturbances of hearing six of them showed definite evidence of extensive infection of the nervous system. The other case also showed signs of involvement, but the process was not extensive. It is to be emphasised that in all these cases the treatment previous to the onset of the affection of the eighth nerve had been quite inadequate, and the number of such cases occurring in any clinic is an index of the efficiency of the treatment of syphilis in that clinic.

All lesions of the eighth nerve should be considered as possible manifestations of a disastrous form of a general infection—syphilis of the central nervous system—and the value of repeated examinations of the spinal fluid in every case of this type emphasised in order to carry out the intelligent treatment and subsequent observation of all patients suffering from this serious condition. *Birkett* (*Rogers*).

Moore, J. W. (Louisville).—**Fracture of the Base of the Skull, with Escape of Cerebro-spinal Fluid from the Ear: The Effect of Atropine and Epinephrin upon the Secretion.** "Amer. Journ. Med. Sci.," April, 1915.

A boy, aged six, as a result of a fall backwards downstairs, sustained a fracture of the squamous and petrous portions of the left temporal bone, which extended into the internal auditory meatus. He was under observation in hospital for about twelve days after the accident, during most of which time there was a copious flow of cerebro-spinal fluid from the left ear. Death was preceded by the onset of meningeal symptoms.

Both the amount and the chemical composition of the cerebro-spinal fluid which flowed from the ear under various conditions and at different times was carefully noted. It was found that injection both of atropine and of epinephrin exerted an inhibitory influence upon the flow. Regarding the choroid plexus as the organ which secretes the fluid, it is to be supposed that atropine depresses the secretory nerves of the cells of the plexus in the same way as it does those of other gland cells of the body dependent upon nervous stimuli for their secretion.

On the other hand, the diminution of the flow which followed injection of epinephrin is to be explained by the existence of an inverse relationship between the intracranial blood-pressure and the secretory activity of the choroid plexus. The general rise of blood-pressure resulting from injection of epinephrin leads to increased flow through the cerebral vessels, and it appears that when this occurs a reflex nervous mechanism comes into play, which results in diminished activity of the secretory cells of the choroid plexus; when general blood-pressure falls the reverse occurs, provision thus being made for equalisation of the pressure on the cranial contents. *Thomas Guthrie.*

MISCELLANEOUS.

Pernet, G.—Rodent Ulcer. "Proceedings of Royal Society of Medicine, Dermatological Section," May, 1915, p. 135.

The patient was a young man, aged twenty-six. The disease began two years ago as a small pimple in the left naso-orbital region, which had

gradually increased in size. The lesion was a characteristic rodent ulcer about ½ in. in diameter.

The case was shown on account of the age of the patient, who was comparatively young for rodent ulcer *Archer Ryland.*

REVIEW.

The Surgical Anatomy of the Temporal Bone.

Guide to and Catalogue of Specimens illustrating the Surgical Anatomy of the Temporal Bone in the Museum of the Royal College of Surgeons of England. By ARTHUR H. CHEATLE, Fellow of the College. Issued by Order of the Council of the College. London: Adlard & Son, 1915. Price 6d.

It is, perhaps, not too rash a prophecy to make that the next twenty-five years will see a complete revision in the style of the anatomy that will be taught to students of medicine. Points which have been hitherto emphasised will be quietly dropped as of no importance, while others, at present omitted or slurred over, will rise into prominence. This change, as everybody knows, was begun as long ago as 1860, when John Hilton first published his lectures on "Rest and Pain," but for years his was the voice of one crying in a wilderness where the pure anatomists had matters all their own way, and where students who intended to practise medicine and surgery in after life were drilled to regard importance of anatomical fact as relative to some embryological or evolutionary standpoint, the practical significance of anatomical details being quietly ignored.

Of recent years, however, a variety of causes, among which may be included the astonishing advances made in the surgery of special regions, have conspired to change the face of anatomy in such wise as to show us something alive, active, and practical.

In our own specialities the name of Onodi at once occurs to us as that of an exponent of the clinical and surgical anatomy of modern days, but the honourable memory of Zuckerkandl must not be forgotten—Zuckerkandl, of whom it has been jestingly said that for ten years after the appearance of his atlas all rhinological papers began and ended with his name.

Similar advances fall to be recorded in the matter of the anatomical varieties of the temporal bone, and it is to Prof. Mouret, of Montpelier, and especially to Mr. Arthur Cheatle, in England, that most of the recent work in this section has been performed.

Of Mouret's work we recently gave some account in our Reports of the last International Congress in London, and now the publication of the above Catalogue gives us an opportunity of renewing our acquaintance with Mr. Cheatle's researches, which, as most of our readers know, has been carried on in such a successful manner as to earn him the supreme honour of the Politzer Prize in otology.

The importance of the work requires no emphasising, and we advise all students of our speciality to spend as much time as they can spare in a detailed examination of the specimens in the Museum of the Royal College of Surgeons. Familiarity with them in their varying and yet classifiable types will confer upon the beginner as much skill in recognising the varieties of temporal bones as his seniors could only attain to after