with a constant desire to swallow. A very long uvula may cause retching and vomiting, cough, and even laryngismus. The uvula may be grooved, generally vertically, on the anterior surface, with a broad lobed extremity, or it may be split, the parts lying in close apposition; or bifid, the parts diverging. The right lobe is generally the larger of the two. Perforation of the uvula may, it is said, be congenital. Syphilitic perforation generally begins on the posterior surface, and comes as a surprise.

Neoplasms are rare, especially cancers, which are generally epithelial, and often begin on the posterior surface of the velum, very seldom affecting the uvula alone.

The so-called *mixed tumours* are supposed to originate from aberrant embryonal epithelial cells. They show mucous and cystic degeneration, are never limited to the uvula, and are not malignant. One (congenital) chondroma has been observed by Henke.

Cavernous angioma is not rare, and always congenital. It originates at the point of junction of the palato-pharyngeal arch and the uvula, probably because at this point the ascending and descending palatine arteries anastomose.

Adenoma is very rare. It springs from the submucous glands.

Papilloma comprises about 70 per cent. of all tumours of the uvula. They may be large and solitary, hanging by a thin pedicle, often from the point of the organ; or they may be multiple, implicating generally the arch of the palate.

Sessile fibromata occur, and *leprosy* may infiltrate the uvula. It is rarely involved in adhesions. *William Lamb.*

NOSE.

Baumgarten (Budapest).—*Bony Occlusion of the Choanæ.* "Monatschrift für Ohrenheilkunde," September, 1898.

Occlusion of the choanæ may be:

(*a*) True, and then is generally congenital and bony, or chiefly bony.

(*b*) False, the result of ulceration and adhesion, and generally membranous.

He recounts the following cases:

(1) *True Unilateral Occlusion.*—A healthy youth of eighteen had never been able to breathe through the left nostril, but breathing and speech were normal. With the post-nasal mirror, the choana could be seen to be completely closed by a partition which felt like bone to the probe. The nose was otherwise normal. A hole was bored through the partition, and then with a long gouge and mallet it was detached all round its circumference, some stray fragments being removed with forceps. No anæsthetic was used, and there was little bleeding.

(2) *Partial Bilateral Occlusion* in a boy of fourteen. From behind, the semilunar edge of a bony obstruction could be seen stretching like a bridge from the middle turbinal to the outer wall. From the front (after cocaine), part of the semilunar edge could be seen.

William Lamb.

Finlay, F. G.—*Thrombosis of Cavernous Sinuses from Suppuration in Nasal Cavities.* "Montreal Medical Journal," November, 1898.

THE patient, a girl of fifteen, was admitted to the Montreal General Hospital October 1, 1898. Two years previously she was laid up for two weeks with acute rheumatism.

State on admission: Moderately well nourished. There had been a purulent discharge from the nose for some weeks, but no aural affection. There was intense headache, skin hot and dry, temperature 101°, pulse 120, and compressible. There was also a high arched palate.

October 2: Temperature varied between 102° and 105°. Left eye somewhat swollen.

October 3: Marked œdema of upper and lower lids. Protopsis of both eyes. Rigor in afternoon. Temperature rose to 106°.

October 4: Protopsis increased in both eyes. On left side eyelids bulged to level of forehead. Conjunctiva of right eye œdematous. No amelioration of symptoms occurred.

October 6: There was delirium. Red lines on the forehead indicated the occurrence of purulent phlebitis. Temperature rose to 108° followed by death.

Post-mortem revealed septic thrombo-phlebitis of cavernous sinus; suppuration and necrosis of ethmoid cells, orbits, and scalp; acute purulent meningitis; old suppuration in left antrum; small infarct of spleen; cloudy swelling and fatty degeneration of all organs.

There was a layer of lympho-pus extending from the Sylvian fissure to the front end of the lobe. Another pocket of pus was found on the left side of the pons; and a third at the base of the cerebellum beneath the arachnoid. The sella turcica and other regions likewise presented purulent infiltration. *Price Brown.*

Körner, O. (Rostock).—*Escape of Cerebro-Spinal Fluid through the Nose, in Conjunction with Atrophy of the Optic Nerves, probably caused by the Perforation of the Wall of the Sphenoidal Sinus by a Tumour of the Hypophysis.* "Archives of Otology," October, 1898.

THE author describes a case under his own observation with the above-described symptoms which lasted eight and a half months and ended in death, no autopsy being obtained. The discharge was continuous, amounted to about 15 cubic centimetres in the hour, and presented the outward appearance of cerebro-spinal fluid. There was slight prominence of the eyeball, rotatory nystagmus, great diminution of vision from bilateral optic atrophy. The supposed explanation was rupture of an intracranial tumour of the pituitary body into the sphenoidal cell. This was suggested by a case described by Gutsche, in which the course of events was proved by post-mortem examination. Short accounts are given of eight recorded cases, as follows: 1, **Baxter**, "Brain," vol. iv., p. 525 (January, 1882); 2. **Gutsche**, reference not given; 3. **Hardy and Wood**, "New York Med. Journ.," vol. ii., September 5, 1890; 4. **Leber**, Graefe's "Archiv für Ophthalmologie," vol. 29, Part I., p. 273; 5. **Nettleship**, "Opthalm. Review," January, 1883; 6. **Priestley Smith**, "Ophthalm. Review," 1883, p. 4, Case I.; 7. **Ibid.**, Case II.; 8. **Mackenzie Wallace**, "Transact. III. Session Intercolonial Medical Congress," Sydney, June, 1893, and "Centralblatt f. Laryngol.," vol. xi., p. 67.

Death took place in four of the cases, recovery once, and in the remainder the result was not known. In all there was bilateral optic atrophy. *Dundas Grant.*