In the primary tumour no ganglion cells were to be found; here and there a nerve fibre was visible. In the second division at the foramen rotundum a few small bundles of nerve fibres were found. The tumour was an alveolar sarcoma.

The author gave the following *résumé*:—

1. Incurable otalgia, without aural changes, ought to suggest disease of the fifth, or of its ganglion.

2. On the right side of the tongue taste was absent as far as the circumvallate papillæ.

3. There were no eye symptoms—trophic changes—such as one might have expected. *William Lamb.*

ABSTRACTS.

MOUTH, &c.

Buys.—*A Frequent Cause of Lacunar Tonsillitis.* "La Policlinique," Jan. 15, 1898.

THE lessening of the power of the tonsil to resist invasion by microbes is looked on as the cause, and this, in turn, is due to nasal obstruction, especially from adenoids. *B. J. Baron.*

Hessler (Hallé) discusses the question, *When and How to Remove Tonsils and Adenoids in Cases of Acute Otitis Media.* "Monats. für Ohrenheilk.," Feb., 1898.

THE author advises early operation—"immediately after the inflammatory symptoms have reached their height." In mucous catarrh of the middle ear he waits till the membrana tympani is less bulging, and the crepitation on auscultation less copious.

In doubtful cases of muco-purulent catarrh with slower course, more caution is necessary. In pure suppurative cases he first performs free paracentesis; and, as soon as the discharge and congestion begin to diminish, he proceeds to remove the tonsils and adenoids.

The beginning of the stage of absorption is the time to operate.

Hessler has never seen any ill effects from the operation; on the contrary, his experience of the method has been entirely favourable. The Eustachian tubes become more quickly pervious, and the secretion in the middle ear diminishes more rapidly

Beckmann confirms this from an experience of two hundred and eighty-five cases. He removes the adenoids during the height of the attack.

Early tonsillotomy has, further, the advantage that it is much easier to remove thoroughly a swollen tonsil than one that has shrunk back between the pillars of the fauces.

Hessler recommends Schütz's pharynx tonsillotome, as modified by himself, for the removal of adenoids.

In conclusion, Hessler discusses the question of anæsthesia. For the last three years he has operated with increasing frequency without any anæsthetic, removing first the adenoids and then the tonsils at the same sitting. The children are described as sitting "as still as mice." *William Lamb.*

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Jessen, F. (Hamburg).—*The Tonsils as Sources of Ingress for Severe General Infection.* "Münchener Med. Woch," June 21, 1898.

THE author points out diphtheria as a classical example of a tonsillar affection producing secondary intoxication of the organism. He considers that the evidence in scarlet fever is greatly in favour of mixed infection being derived from the angina. Various authors have made out a close connection between angina and rheumatism. Buschke demonstrated from four cases, examined bacteriologically, that acute osteomyelitis may be caused by the entrance of staphylococci and streptococci through the tonsils. Richardière, Peterson, Hanot, and Heddæus have described cases where descending lymphangitis, pleurisy, septicæmia, and death have followed a non-phlegmonous angina. Dennig, one of the first investigators of "krypto-genetischen" septicæmia, states that many of these cases are preceded by an angina. Jessen has observed several cases in which he attributes the disease to a tonsillar origin.

1. Man, thirty, with severe general malaise, articular pains, stupor, and sore throat, had on one tonsil a dirty green, on the other a yellow exudation. Temperature, 39°. Painful swelling on the neck. On the third day there was on the leg and forearm a large papular eruption, on the back and face smaller papules; these were not multiform, nor showed the characteristic nodes of erythema nodosum. At the same time patient had severe articular pains. In about eight days erythema and articular pains decreased with intermittent fever. Internal organs were healthy. Case resembled gangrenous diphtheria, except that, bacteriologically, only staphylo- and streptococci were found on the tonsillar exudation.

2. Woman, twenty-eight, was admitted to hospital as a case of typhoid (?). Widal's reaction was negative. She died in twelve hours. Diagnosis, septicæmia and uræmia. Temperature 40·8°. Albuminuria and epithelial casts, twitching in left arm, small hæmorrhages in the skin. *Post-mortem:* Numerous small hæmorrhages in the pleuræ; slight hypostasis in lungs; numerous ecchymoses in peri cardium; small abscesses in heart, recent ulceration on valves; lentil-sized ulcers on left false cord; tonsils, smooth on surface, on section thickened abscesses on both sides; liver, fatty degeneration; spleen, much enlarged; kidneys, large with numerous small abscesses and hæmorrhages. The older appearances of the suppurative processes in the tonsils indicate them as the cause of the general pyæmia. While the patient was under observation there was no external exudation on tonsils. Case shows the difficulty in determining the primary tonsillar affection.

3. Girl, seventeen, with angina of the left tonsil, from which streptococci were obtained; became affected twelve days later with pneumonia, pericarditis, pleurisy, renal inflammation, and other signs of septic infection. Streptococci were found in the pneumonic sputum, but no pneumococci nor influenza bacilli.

4. Woman, twenty-four, after an angina developed pericarditis, double pneumonia, then general septicæmia.

He considers such cases are not unfrequent, but that they are frequently overlooked, as they usually come under observation after the angina has disappeared. Cases 2 and 4 showed a collection of pus in the interior of the tonsil with a normal surface. He thinks that by careful attention one may distinguish an angina clinically without bacteriological examination, and determine whether it belongs to the variety from which a fatal general infection may be expected. The exudation has not a lacunar situation, but extends, as in a culture tube, in long rows of a yellow or yellowish white colour from above downwards into the tonsil. It must from the first day's illness be looked on as a dangerous symptom and must be energetically treated. He also considers many cases of scrofula to be due to absorp-

tion from the naso-pharyngeal tonsil, and has seen great improvement from its removal, when there is no secondary tuberculosis. Such cases must be carefully examined for enlargement, even although nasal respiration is free. He confirms other authors that primary tonsillar and cervical glands tuberculosis proceeds from the tonsils. *Guild.*

Lenzmann.—*Tuberculosis of the Mouth following Tooth Extraction.* "Münchener Med. Woch.," June 21, 1898.

WOMAN, twenty-six, had had a tooth removed by a dentist three weeks before. She was of slight build, highly nervous, otherwise had been always healthy. Mother, brother, and sister had died of tuberculosis. Lungs were normal. For a few days there had been an exudation on the gum where the tooth was removed, and on the inside of the cheek in the depression between a ragged ulcer. During the next few days a hard infiltration developed around this, and spread to the lower lip. This ulcerated. Mercury and iodide of potash had no effect. After frequent microscopic examination a few tubercle bacilli were found. Lactic acid and scraping did no good. Actual cautery seemed to benefit a little, but in spite of this process spread to the upper lip. The affection in the mouth lasted about three weeks before it was arrested. Then the patient showed infiltration of the apex of the right lung, with hectic fever. She died three months later.

Blumenfeld reported an analogous case. *Guild.*

Sharp, Arthur X.—*Case of Kerostomia (Mouth Dryness).* "Lancet," April 23, 1898.

A SINGLE woman, aged forty-one years, consulted the writer for constant dryness of the mouth. Her family and personal history were alike good, and except for the local trouble she had never been better in her life. She said she could smell and taste perfectly, and had no complaint to make about the nose. A brief examination gave the impression that the mucous membrane was pale and somewhat dry. No obstruction could be found nor any dry crusts, but a musty smell often associated with such conditions was recognizable. When she had a cold she used as many handkerchiefs as anyone else. The teeth were not specially bad; several had been stopped at various times and she had lost some of the back ones. Lately she had worn some artificial ones; the dryness was aggravated if they were disused. She had no difficulty in chewing or swallowing with the aid of frequent sips of fluid. The mucous membrane lining the lips, gums, cheeks, tongue, and palate was dry and glazed. The fauces and pharyngeal wall were granular, but the dryness only extended to the base of the tongue. One or two strings of dry mucus were seen in the mouth, and there was always a quantity adherent to the teeth and lips in the morning. The tip of the tongue was red; the rest of it was pale. The surface was granular with papillæ, some fungiform ones near the tip being especially prominent. There were no inflamed patches, and only a few very shallow transverse furrows. The papillæ of the salivary ducts were not prominent, and no secretion could be expressed from them. After moistening the tongue with water a very faintly alkaline reaction was obtained to litmus paper. The lips were dry and peeling. The angle of the mouth on the left side was scarred. The skin was not unduly dry, and the patient perspired freely on the least exertion. The patient's urine was not examined. She was not anæmic, and there appeared to be no urinary disorder. She was not subject to parotitis, and there were no signs of pressure on any part of the salivary apparatus. She had cooled her tongue with a solution of sodium carbonate followed by cold water. She has taken mercuric iodide in medium doses with quassia and describes herself as improving.

The condition appears to be a general absence of moisture from the mouth, with perhaps a slighter similar affection of the nose. One feels inclined either to attribute it to causes resident within the nervous system, or else to regard it as allied to those granular atrophic phases of deficient secretion met with in the nose, fauces, pharynx, and conjunctiva. Prof. Fraser's paper in the *Edinburgh Hospital Reports* for 1893 contains a table of the nineteen cases recorded up to that time. *St Clair Thomson.*

Von Engelen.—*Adeno-Phlegmon of the Pharyngo-Maxillary Triangle. Drainage. Cure.* Cercle Méd. de Brux., April 6, 1898; "Journ. Méd. de Brux.," May 19, 1898.

THERE had been tonsillitis of three weeks' duration; the tonsil was swollen and appeared to fluctuate. Incision of the tonsil reached no pus, but on cutting deeply behind the posterior border of the sterno-mastoid it was evacuated, and cure rapidly followed. *B. J. Baron.*

NOSE, &c.

De Greift.—*Ozæna.* "Annales et Bulletin de la Soc. de Méd. d'Anvers," Nov. and Dec., 1898.

FIVE forms of ozœna are to be distinguished:—(1) Due to adenoids. (2) Due to sinusitis, with degeneration of the pituitary mucous membrane. (3) The necrosing form, the ethmoid being affected. Curetting is here the treatment. (4) Purulent form, with hypertrophy of the mucous membrane in children, and passing on to the next form—the (5) atrophic or true ozœna.

Treatment must be according to the cause, *e.g.*, ablation of the mucous membrane, application of powders, antiseptic and irritant, spraying with solutions of nitrate of silver. Vibratory massage, electrolysis, antidiphtheritic serum, injections of iodine. *B. J. Baron.*

Guye (Amsterdam).—*The Plica Vestibuli and Indrawing of the Alæ Nasi.* "Münchener Med. Woch.," June 28, 1898.

THE plica vestibuli is prevented from lying on the septum by the tension of the alæ nasi. This may be lessened in sleep or by paralysis; so that stenosis—which may be assisted by irregularities of the septum—is produced. This stenosis, owing to abnormalities of the septum, is usually more marked on one side, and is a frequent cause of disturbed sleep.

If the patient lies on the right side the right nostril closes; if on the left, then the left closes. He is compelled to lie on the side of the narrower nostril. If this closes, enough air is obtained through the other; if the wider nostril closes, nasal respiration is obstructed. The patient cannot fall asleep, or else he speedily wakes up again. If the right side is obstructed sleep must be obtained on the left side, which is usually more difficult, as the heart movements are more obstructed in this position. Tossing about from side to side then occurs, usually with interrupted sleep. Some overcome the difficulty by sleeping on their backs; but few can sleep comfortably in this position.

The author recommends a rubber ring with a diameter of ten to fourteen millimètres, a lumen of six to eight millimètres, and a breadth of two to six millimètres. It should be cut to fit irregularities of the septum. A thread may be attached to it to prevent it passing into the nostril during sleep. *Guild.*