Abstracts.

DIPHTHERIA.

Freyche, J.—*Clinical and Bacteriological Study on Diphtheritic and Ulcerous Angina with Fusiform Bacilli and the Spirillæ of Vincent.* Thèse de Toulouse, 1899.

The author considers this disease as a morbid entity which is due to fusiform bacilli and spirillæ. He develops the ideas of Vincent, and does not dispute the possibility of similarity, and even relationship, between the anginal ulcerative lesion and the ulcero-membranous stomatitis. *A. Cartaz.*

De Guy.—*Hæmatemesis in Diphtheria.* "Bull. Soc. Anat.," Paris, July, 1899.

The author relates the case of a child who in the course of severe diphtheria, for which intubation had been practised, was subject to repeated hæmatemesis.

At the autopsy the mucous membrane of the stomach was found dotted with little purple petechial spots. *A. Cartaz.*

Sendziak.—*Diphtheria of the Pharynx and Naso-pharynx, complicated by Multiple Abscesses of the Tonsils (Palate, Pharyngeal, as well as Lingual), also by Empyemata of both Antra of Highmore. From the Rhino-Laryngologic Casuistic.* "Kronika Lekarska," Nos. 15-17, 1898.

The patient was a young girl of eighteen years of age with affection of the apex of the right lung.

It is interesting because the complication with peritonsillar abscesses, so common in so-called follicular angina (*vide* author's papers on the so-called follicular tonsillitis, and a contribution to the diagnosis and treatment of purulent inflammation of the tonsils, "Kronika Lek.," 1894 and 1898), took place in true diphtheria; further, because the complications were so numerous (several peritonsillar and tonsillar abscesses) and so rare (abscesses of pharyngeal and lingual tonsils). This latter gave rise to profuse bleeding, simulating hæmoptysis (the laryngoscopic mirror discovered the true localization of the bleeding). Finally, the case deserves to be mentioned on account of the acute empyemata of both antra of Highmore, which were demonstrated by transillumination.

The recovery, however, ensued without surgical intervention, proving the opinion of Avellis, that the acute empyemata of these cavities mostly disappear *sua sponte.* *John Sendziak.*

MOUTH, Etc.

Aviragnet, E. C.—*The Treatment of Disorders of Digestion associated with Chronic Rhino-pharyngitis and Tonsillitis.* "La Presse Médicale," December 20, 1899.

Children suffering from chronic rhino-pharyngitis often present symptoms of gastro-intestinal dyspepsia, which resist all ordinary treatment—diet, calomel, etc.—but disappear whenever the diseased

condition of the throat and nose is cured. The dyspepsia is the effect of the naso-pharyngeal condition, and is due probably to the constant swallowing of muco-pus. The author cites four cases of his own in proof of these assertions. Treatment consists in nasal irrigations and the injection of resorcin in olive-oil (5 per cent.). The child is laid on its back, and ½ c.c. of the solution is injected into each nostril, so that the solution runs through the nose into the naso-pharynx. The resorcin may occasionally be replaced by menthol or calomel. At the same time the naso-pharynx and pharynx should be painted with borax or iodine in glycerine; granulations in the pharynx and hypertrophied tonsils should be cauterized. *A. J. Hutchison.*

Bergé. — *Erosive Angina after Scarlatina.* Soc. Pediatrie, Paris, October 10, 1899.

Bergé relates a case of superficial ulceration of the tonsil supervening in a girl of four years of age, fifty-four days after the evolution of a slight benign scarlatina. This erosion, which was accompanied at first by fever and adenitis, and later by nephritis with albuminuria, lasted nearly a month. Complete recovery took place, but there remained on the tonsil a cicatricial patch of a yellowish-gray tint, which was still quite visible six months after cicatrization.

A. Carta.

Buisseret.—*Surgical Treatment of Gingivitis.* "Journ. Méd. de Brux.," No. 27, 1899.

The treatment suggested is removal of tartar, scarification of the gums, the application of a mixture of tinctures of iodine and aconite, and daily washing of the mouth with an antiseptic. This usually cures in one month. In other cases the scarifications have to be repeated and deep, and months may elapse before cure is obtained.

B. J. Baron.

Dorner.—*Case of Sarcoma of the Tongue.* "Wien. klin. Rundsch.," 1899, No. 29.

Man, forty years old, with tumour on the left side of the tongue as big as a hen's egg. Operation. Cure. Microscopical examination showed the tumour to be a spindle-cell sarcoma of the tongue. These cases, as well known, are very rare. *R. Sachs.*

Leland, George A.—*Tonsillar and Circumtonsillar Abscess.* "New York Medical Journal," October 7, 1899.

The writer of this article opens his remarks by stating some of the older methods for opening abscess of the tonsil, notably the method of "discission" first suggested by Hoffmann, who performed the operation by means of a stiff probe. One of the cases so treated was a woman of about thirty-five, who had suffered untold misery lasting over a period of weeks at each attack. After having reduced the tonsils by the above-mentioned method to their normal size, at about the regular expected time another attack occurred. A large crypt, evidently not previously reached, was involved, and the tonsil was slightly enlarged in the circumscribed area. The writer, when called to the case, found that, though the incision made by the knife was partly open, very little pus was exuding, the whole region taking on a marked inflammatory action. This incision he enlarged, and after some persuasion the patient allowed him to introduce his finger into her mouth for the ostensible

purpose of determining the extent and consistence of the swelling. Having found the opening, he pushed his finger into a cavity about as large as a filbert, whose walls were hard and resisting. He tore the opening downwards as much as possible with the finger, thereby greatly enlarging it, and evacuating the contents. Judging from her former experiences, the patient expected to have several weeks of painful illness, instead of which she was up the following morning and attending to her household duties as usual. And from that day—May 31, 1893—she has not had an attack.

The experience gained in this case has led the writer to make use of this instrument of Nature—the sterilized index finger—in many clinical observations in cases of tonsillar and circumtonsillar suppuration. This method of digital exploration has thrown some light on the etiology of this affection; it seems to show conclusively that circumtonsillar inflammation most frequently starts from within the tonsil, in one or more of the lacunæ, and is an extension of the suppurative process in the direction of least resistance, as is the case with abscess formation in other localities. This conclusion has been confirmed by Moritz Schmidt, who says that, according to his experience, peritonsillitis arises almost only from tonsil plugs; that these take on suppuration from streptococcus infection, and that the products find their way outwards into the peritonsillar tissue. Dr. G. Finder, of Berlin, in his article on the "Pathological Anatomy of the Tonsil," states that, by swelling of the epithelial lining of one or more of the crypts and by other changes, the outlet may be closed so that even by the microscope it may not be found that then the contents of the crypt, consisting of epithelia, lymph corpuscles, mucus, and micro-organisms, go on increasing till the crypt becomes an encysted abscess. Formerly, exposure to cold, rheumatism, etc., were mentioned as being the principal cause of this disease, but since bacteriology has opened up its new fields, the septic origin is recognised as the proper explanation, and the former causes put down as simply reducing the resistance of the tissues. Now, by the use of the finger-tip after the tonsil has been split by the sickle-knife, the enlarged and distended crypt can be often made out and followed upward and outward through the tonsil into the circumtonsillar cavity. The exact size of the abscess cavity can also be frequently determined in the same way, and, to give proper exit to the pus, it is often well to complete the operation by tearing through the tonsil inwards into the throat, thus passing the finger nearly round and through the organ. Another advantage claimed for this operation is, that it drains the abscess from the bottom, though it may leave an objectionable scar, but it also insures complete granulation of the cavity from the bottom. In the cases operated on by the author, there has been no recurrence, and though their number is too small for definite conclusions, and the time since operation too short, still, it is a satisfaction that with some the usual period has elapsed without an attack. Another advantage is the very quick recovery, and patients thus operated on are able to swallow liquids in six hours and solids in twelve, and some have been well enough to be discharged from the hospital the next day. This saving of time is of much importance, not to mention the suffering caused by waiting for several days, or even weeks, for the abscess to burst.

Arthur Sandford.

Panoff, A.—*The Chancriform Ulcero-membranous Angina and Ulcero-membranous Stomatitis with Vincent's Fusiform Bacilli and Spirillæ.* Nance Thesis, 1899.

Ulcerated stomatitis and amygdalitis seem to be one and the same disease, but differently located; they co-exist, in point of fact, in some cases, and in both we find the fusiform bacilli described by Vincent, as well as spirillæ.

This form of amygdalitis has two stages, which correspond to the two types described by authors: First, the diphtheroid form, in which there is a grayish false membrane on the inflamed tonsil, covering an erosion which bleeds easily. At a later period the false membrane invades the tonsil in its deeper part, and sets up a more or less deep ulceration.

Clinically, this form of amygdalitis is characterized by submaxillary adenitis, dysphagia, and general pyretic phenomena. The duration of the disease is from a fortnight to three weeks.

The writer discusses the diagnosis, which is sometimes difficult, from syphilis and diphtheria, and in the way of treatment he recommends copious douches and the application of tincture of iodine or camphorated menthol. The work contains a résumé of all the published cases, as well as of fourteen which have not yet been published.

A. Carter.

Plücker.—*Phlegmona Submandibularis Acuta.* "Münchener Medicinische Wochenschrift," No. 41, 1899.

Cellulitis of the neck followed on inflammation of the throat in a patient twenty-nine years of age. The abscess was freely opened in the middle line by a perpendicular incision; at night, owing to œdema, tracheotomy was necessary. An incision was made across the perpendicular incision from one angle of the jaw to the other; the fasciæ of both maxillary glands were divided, and the salivary glands were incised below. At the beginning there was a high temperature; then the case improved, and the wound closed. As a cause of the suppuration, *Staphylococcus aureus* was found. Plücker points out the danger of such acutely occurring cellulitis, and the necessity for free incision and division of the rigid fascia of the submaxillary gland. *Guild.*

Ropke (Solingen).—*Additional Cases of Acute Osteomyelitis of the Upper Jaw in Infants.* "Arch. of Otol.," vol. xxviii., p. 259.

These cases occurred in very young infants, and were generally characterized by swelling of the cheek, discharge of pus from the nostril, swelling of the hard palate, and fistulæ either in the canine fossa or the palate. Necrosis of the maxillary bone was to be detected. Similar symptoms have been attributed to acute empyema of the antrum, a very unlikely occurrence at that age. *Dundas Grant.*

Saenger.—*Perverse Action of the Velum Palatinum.* "Wien. klin. Rundsch.," 1899, No. 32.

The patients elevate too early or too late the velum palatinum, and therefore speak with a nasal twang. *R. Sachs.*

Siegert, F. (Strasburg).—*An Epidemic of Angina Lacunaris and its Period of Incubation.* "Münchener Medicinische Wochenschrift," No. 47, 1899.

The author reports an epidemic of lacunar tonsillitis, and describes its distribution. The period of incubation was constantly four days.

The duration of the disease till convalescence was short; fever varied from 38·5° to 40·2°. Complications observed were: once croupous pneumonia, several times otitis media, once an eruption like scarlatina, which lasted only twenty-four hours; in all cases streptococci were found. He is convinced that angina lacunaris, or follicular tonsillitis, is an infectious disease, which is easily conveyed from those affected to those in contact with them; that its period of incubation is four days; that children under three years are little disposed to it; that isolation is demanded on account of the frequent septic and pyæmic complications. Those in contact should not be allowed to go to school till after five days. *Guild.*

NOSE.

Booth, Burton S.—*Nasal Stenosis.* "New York Medical Journal," Saturday, October 14, 1899.

The treatment of nasal stenosis due to deflected septa, with or without thickening of the convex side, was prior to 1886 rather ineffective and disappointing, the reason being that the resilient cartilaginous septum had not been thoroughly broken up, and herein lies the secret of successful correction of this deformity. The author having tried almost every operation worthy of mention for the treatment of deflected septum, and having met with only a moderate degree of success, was at length tempted to try that recommended by Dr. Morris Asch, of New York City. In order to be successful in this operation the cases must be selected, as it is not suitable in all, and is really only intended to relieve deflection of the cartilaginous septum. The operation is done under an anæsthetic. The instruments used are a pair of straight and a pair of angular cutting scissors, a compression forceps, a blunt separator for adhesions which may exist between the convex portion of the deviated septum and inferior turbinated body, and some tubular splint made of hard rubber. The nostrils should be thoroughly cleansed by means of cotton wound on probes and dipped in some antiseptic solution. The head of the patient is extended over the end of the table to prevent the blood running into the larynx and producing coughing, which might interfere with the operation; under full illumination the separator is then introduced into the stenosed nostril and any adhesions broken down. The scissors are next introduced parallel to the floor of the nose, the sharp blade entering the nostril on the concave side of the septum, and the blunt on the convex side; the blade should be at right angles to the septum, and over the most dependent part of the deflection. When sure that the blades are in the right position, the handles are firmly closed, and the sharp blade passes through into the opposite nostril with a distinct snap; the scissors are now opened and withdrawn, and are immediately reintroduced in the same manner as before. This time the blades are made to cross in a vertical direction the first incision at its centre and as far as possible at right angles, thus making a crucial incision with four segments. The operator next introduces his finger into the stenosed nostril, pushing it through to the opposite nostril, at the same time breaking each segment at its base, thus destroying the resiliency of the septum, and this is the most important part of the operation, for it makes it impossible for it to resume its old position. A straightening