conservatism." The least indication of any form of intracranial complication of course renders operation imperative; when, however, conditions outside the labyrinth itself do not call for operation, a rational conservative treatment is suitable, at any rate to begin with, even if the labyrinth is quite unresponsive to any of the other tests.

The last section of the work is devoted to the mechanism of the pressure and vaso-motor symptoms, and the author's opinion is that many of the phenomena may be explained by purely mechanical conditions within or outside the labyrinth. As the result of experiments on guinea-pigs in whose horizontal semicircular canals fistulæ were made after removal of the otoliths by centrifugal force, he arrived at the conclusion that the otoliths play no prominent part in the production of the pressure fistula symptom.

The last seventeen pages of the volume are occupied by references to the literature of the subject and form a complete bibliography.

THOMAS GUTHRIE.

LETTER TO THE EDITORS.

MÉNIÈRE SYMPTOM-COMPLEX

TO THE EDITORS,

The Journal of Laryngology and Otology.

SIRS,—I have had two patients who showed the Ménière symptom-complex without the end-result of complete unilateral deafness usual in a case of true Ménière, *i.e.*, apoplexy of the labyrinth.

The first occurred nine or ten years ago in a man about 43 years of age. He was the owner of a large business, which he took and continues to take rather seriously. His attack began with vertigo and "rushings" in the head, and he would fall down or off his bicycle, but he never became unconscious. On most occasions he vomited at the zenith of the attack, which lasted about six hours. One of his ears showed slight adhesive otitis media with (?) some otosclerosis. The attacks came on about every second or third day. As I could do nothing for him, he endured it and in three years the attacks abated, and six months later they ceased, "because he used his will." One ear is moderately deaf but not markedly so.

The second case is that of a lady of 50. Eighteen months ago she came to me complaining of deafness in the *right ear*, of gradual onset, with "roarings." There was otosclerosis present as well as slight adhesive otitis media. She also suffered markedly from hay fever. I gave her a course of galvanism and oto-massage, without any improvement. The deafness in her right ear was

peculiar; to low sounds and fine high sounds she showed ½. To medium range and voice, there was very little evidence of defect.

In September last, her hay fever began to be more troublesome, and the first symptoms of the Ménière complex showed themselves. These came on about once in ten days. Some years ago I had told her that a submucous resection would do her good, because the nose was narrow outside and much obstructed inside. The operation was done in October last and relieved a sense of weight in the right ear, also the noises to some extent, *i.e.*, it affected the otitis media by allowing air to enter freely. Valsalva's experiment was now possible, whereas, formerly, she had been unable to perform it.

Unfortunately, the pseudo-Ménière attacks began to occur more frequently, happening thrice weekly with great regularity. First would arise a heaving in the brain followed by ataxia, which made her seek her bed. The blood pressure, usually 100-130, now rose till the pulse was pounding. Within half an hour, vomiting came on and continued until the stomach was emptied. Nystagmus and vertigo were very violent.

The attack lasted on the whole less than twelve hours. Next day she was quite well except for slight lassitude and some pallor. Bromides, strychnine, iron, arsenic, luminal, and other things have been tried. Luminal controlled the attacks simply by its soporific action.

My own opinion was that the causation was outside the ear, and arguing from the hay fever, that it was a vaso-motor disturbance produced by some irritant.

Professor Carmalt Jones, of Otago University, was called in with a view to discovering a protein which might be the exciting cause. Dr Pearson, our pathologist, is now giving her sera from flowers and grasses. These are controlling the attacks, which are less frequent and not so violent. I think the case will wear itself out like the former.

My theory is that the otosclerosis has so affected the labyrinthine bone as to obstruct the ductus endolymphaticus, and the internal ear cannot adjust itself to sudden vaso-motor changes. The cure will depend on arterio-sclerosis of advancing years, thus making the arteries less distensible and so obviate the changes in pressure. It is noteworthy that the patient is not very deaf.

These two cases are not, of course, examples of true Ménière's disease, which produces profound deafness and where there are rarely more than from one to three attacks.

I shall be glad to get any light which may be thrown on these cases.—Yours faithfully,

T. A. MacGibbon.

Christchurch, N.Z.