

and with practically no discharge from the meatus. The hearing was slightly improved on the affected side. The patient remained well up to the time when she was last seen, viz., two years after date of operation.

CASE 2.—A girl, ten years old, had persistent purulent discharge from the right meatus for two years. An operation, the nature of which could not be exactly made out, had been performed at another hospital. There was purulent discharge from the right meatus, the deeper part of the meatus was full of polypoid growth, and there was a depressed scar over the right mastoid. The patient was anæsthetized, and the ear carefully examined. A vascular tumour was found filling the tympanum and extending backwards towards the antrum. This was removed with a Volkmann's spoon, and the walls, which were carious, were curetted. The cavity was irrigated and packed twice a day for several weeks. The cavity diminished in size and discharge almost ceased. The patient was discharged. The tumour consisted of vascular tissue covered with a large amount of stratified squamous epithelium. A few weeks later the patient returned in much the same condition as when first seen. The second operation was now performed. The antrum and tympanic cavity were opened from behind, cleared of tumour, and the walls scraped. The post-auricular wound was left open. The cavity filled up three times with cholesteatomatous tissue before it finally was rendered aseptic. It was then freely laid open and filled with bone and cartilage, as in Case 1. The effects were not satisfactory; a purulent discharge occurred and brought away the bone and cartilage with it. Later the operation described by Mr. Ballance was performed with moderately good results.

The author considers the condition of the patient is better when the cavity is filled up with new bone than when it is left as a cavity lined with epithelium. He attributes the failure of the bone grafting in Case 2 to the fact that the cavity was probably never rendered thoroughly aseptic.

Arthur J. Hutchison.

ŒSOPHAGUS.

Downie, Walker.—*Four Cases illustrative of the Local Lesions resulting from the Swallowing of Liquid Ammonia.* "Glasgow Medical Journal," January, 1901.

The local effects of drinking liquid ammonia depend largely upon the strength of the solution. Acute inflammation usually develops immediately in those parts with which the fluid has come in contact. Within about six hours a fibrinous exudation appears, usually over the uvula, free border of palate, lip of the epiglottis, and over the arytenoid and aryepiglottic folds. Healing of these abraded surfaces takes place satisfactorily, but in the gullet cicatricial stenosis is the rule, and usually sets in in from one to three months after swallowing the ammonia. The author has usually found two strictures, one close to the mouth of the gullet and the second at a variable but usually much lower level.

Treatment by gradual dilatation, if adopted sufficiently early, is followed by satisfactory results. For the purposes of dilatation, the author uses a bulbous cylindrical gum-elastic bougie, or flattened bougie (oval in section), as in order to give permanent relief complete dilatation is necessary.

W. Milligan.

F. Edmunds.—*A Successful Case of Gastrotomy for Impacted Foreign Body in the Œsophagus.* "The Lancet," February 23, 1901.

When a foreign body is impacted in the lower portion of the œsophagus, and cannot be displaced by the use of bougies, three courses are open to the surgeon. He may, firstly, open the œsophagus in the neck, and endeavour to remove the foreign body by forceps; this is the oldest method, and is not unlikely to prove successful unless the body is situated very low down. The second method is to perform an intra-mediastinal œsophagotomy; this is an operation extremely difficult and dangerous in itself, and it has, so far as we are aware, never been successful. E. Forgue* has described a case in which he attempted to perform this operation for an impacted coin, but he was obliged to desist on account of temporary cessation of breathing, and a fortnight later he was able to remove the coin through the mouth by means of a coin-catcher. In the third method, which is especially suitable when the foreign body is impacted near the cardia, a gastro-tomy gives the surgeon access to the lower part of the œsophagus, whence the impacted body is removed by means of a finger or forceps. In a case recorded by Mr. D. Wallace† of Edinburgh an œsophagotomy was first performed for the removal of an impacted tooth-plate, but the forceps introduced could not dislodge it, so a gastrotomy was tried, and the plate was successfully removed by means of a pair of forceps. The diagnosis in such cases as these can be much facilitated by skiagrams.

In the present case a denture became fixed in the lower third of the œsophagus. An oblique incision $2\frac{1}{2}$ inches long was made about 1 inch below the costal border, to the left of the middle line. The stomach was found without difficulty, and was held up into the worm by two silkworm-gut sutures, passed through the serous and muscular coats only. Having packed it well round with sponges to prevent any fouling of the peritoneum, Mr. Edmunds made an incision through the wall of the stomach, transversely to its long axis, sufficiently large to admit the finger, but no trace of the plate could be felt in the stomach by finger or probe. The opening in the stomach wall was enlarged to about 4 inches, sufficient to admit the hand, which was inserted, and on passing the index-finger into the œsophagus one of the hooks of the plate could be felt about 2 inches above the cardiac orifice. The plate was firmly fixed by means of two of the hooks to the œsophageal wall, but manipulation with long curved forceps passed along the finger released it, and it was removed through the stomach. The opening in the stomach was closed by a long continuous suture of fine silk for the mucous membrane alone, and the serous and muscular coats were brought into apposition by means of between thirty and forty Lembert's sutures, also of fine silk. The parietal incision was closed by means of silkworm-gut sutures through the whole thickness of the wall.

No food was given by the mouth for three days. The wound was first dressed on the sixth day, and healed of first intention. The patient made an uninterrupted recovery.

The above case seems to be worthy of record, as, according to Mr. Treves's recent edition of "Operative Surgery," in the only two similar cases published, the operation was performed by American

* XII^e Congrès de Chirurgie, Paris, 1898, p. 220.

† The *Lancet*, March 24, 1894, p. 734.

surgeons (Dr. Bull of New York and Dr. Richardson of Harvard) in 1886 and 1887. The remarkable feature of the present case is that subsequently to the operation no pain whatsoever was complained of, either gastric or peritoneal, and the patient was entirely free from vomiting or any dyspeptic symptom whatever, and seven weeks after the operation he was following his occupation and felt in perfect health.

(*Note by Abstractor.*—This appears to be the same case which was already fully reported in the *British Medical Journal*, 1900, ii., November 17, p. 1438.)
StClair Thomson.

Isaacs, A. E.—*A Whistle in the Œsophagus.* "Medical Record," March 16, 1901.

The patient, a boy, was brought to the writer two days after having swallowed a toy whistle. Nothing could be felt by means of the finger, and œsophageal forceps of various kinds were passed without locating anything. By means of the X-rays the position of the whistle was ascertained, and was eventually successfully removed by means of the "hinged-bucket" œsophageal probang.

W. Milligan.

Lambret.—*Cicatricial Stricture of the Œsophagus; Gastrotomy.* "L'Echo Méd. du Nord," October 14, 1900.

At a meeting of the Société Centrale de Méd. du Départ. du Nord Lambret showed a young man, eighteen years old, who had swallowed some caustic potash in mistake for eau de vie a year ago. When brought to hospital at that period cicatricial contraction was well marked; it was impossible to catheterize the œsophagus. The patient left the hospital, but returned sometime afterwards in a very weak condition, and weighing barely 27 kilogrammes. Gastrotomy was performed two months ago with satisfactory results; increase of weight to 34 kilogrammes.

Arthur J. Hutchison.

PHARYNX.

Huber, Francis.—*The Diagnosis and Treatment of Adenoids by the General Practitioner.* "Archiv. of Pediatrics," March, 1901.

Among the many symptoms indicative of the presence of nasopharyngeal adenoids in children, a prominent vein running across the base or root of the nose will often be found emphasizing the existence of an impeded venous circulation in the pharyngeal vault. In older children nose-bleeding is common, and usually ceases when the patency of the naso-pharynx has been restored.

Diagnosis may be made from (1) the symptoms; (2) by means of the post-nasal mirror; (3) by digital exploration of the naso-pharynx. Reliance may be placed upon the existence of two symptoms (in cases where digital exploration of the naso-pharynx may not be desirable at the time), viz., the presence of two small lymph nodes, painless and freely movable, at the angle of the lower jaw, one upon either side, and the presence of numerous small lymphoid hypertrophies upon the mucous membrane of the post-pharyngeal wall. The author prefers Delstanche's curette for the removal of all growths, or in infants Hooper's forceps. For a week or so prior to operation he advocates