LARYNX.

W. W. Keen.—*A Case of Total Laryngectomy (unsuccessful), in which Massage of the Heart for Chloroform Collapse was employed.* "The Therapeutic Gazette," April 15, 1904.

The patient was a man, age not given, who developed squamous epithelioma of both vocal cords. A partial laryngectomy was performed on December 16, 1902, from which he recovered. Total laryngectomy was performed on February 6, 1903. Death ensued from chloroform collapse at the end of the operation. The abdomen was opened and the heart massaged for half an hour by the hand introduced into the wound, without effect. The whole subject of heart massage in such cases is discussed fully. *Macleod Yearsley.*

L. Revol (Lyons).—*A Case of Bilateral Paralysis of the Inferior Laryngeals due to Aortic Aneurysm.* "Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx," February, 1904.

A man aged fifty-eight, by trade a mattress maker, was admitted to hospital July 10, 1903, suffering with aphonia, sometimes better, at other times worse. His general condition was good, save that he thought he was wasting. Examination of the lungs revealed harsh inspiration, expiration prolonged and slightly blowing with scattered rhonchi, predominating at the bases and under the axilla of the left side.

The right subspinous fossa was a little depressed, and at this level there were some signs of induration. Expectoration was sero-mucoid and rather copious. Cough frequent and muffled, devoid of barking character. Voice equally inaudible, hoarse, but not bitonal. There was no true dyspnœa, but there was pseudo-dyspnœa consequent upon the exaggerated expenditure of air during speaking; when this ceased the breathing became normal.

About the heart there was nothing much to note. Cardiac dulness normal, apex beat in fifth interspace a little inside the nipple line. No bruit present. The first aortic sound was a little rough. Pulse regular, no asynchronism. Digestion functions normal, but patient experienced a sensation of arrest of food on swallowing at the level of the mid thoracic region, lasting sometimes several hours. No regurgitation or vomiting.

A laryngoscopic examination showed the cords to be fixed in the cadaveric position, the glottis was always open and resembled an elongated triangle with slightly curved margins.

During respiration very slight adduction and abduction were noticed, due to the passage of inspired and expired air.

On phonation the inter-ligamentous glottis remained stationary, the inter-cartilaginous became slightly narrowed; no laryngeal vibration.

Radioscopy allowed one to observe a shadow elongated transversely above and passing to the right border of the sternum.

By oblique examination the shadow appeared in the anterior mediastinum; the posterior was clear. Lungs clear except the right apex, which was dark. Heart seemed normal.

M. Destot, who undertook this examination, concluded that there was a cylindrical dilatation of the aorta involving its ascending and transverse portions.

January 26, 1904, the patient was suddenly seized with a violent fit of coughing, and, after rejecting about a litre of blood, expired.

The author says that in this case we had the complete picture of

bilateral recurrent palsy. There were the trio of symptoms present, viz. aphonia, absence of dyspnœa, and leakage of phonatory air, and the laryngoscopic investigation gave unequivocal evidence, but to discover the cause of the paralysis was more difficult; here radioscopy came to the rescue, and through it a correct diagnosis was arrived at.

Clayton Fox.

EAR.

A. J. Brady (Sydney).—*A Case of Temporo-sphenoidal Abscess of Otitic Origin.* "Australasian Med. Gazette," April, 1904.

H. C—, male, who had suffered from left middle-ear suppuration for five weeks, was admitted to hospital in a semi-conscious condition; pulse 52; respiration 11; temperature 98·4° F.

A radical operation and intra-cranial intervention were decided upon. The usual method of operating was adopted. On opening the antrum pus welled up. The roof of the attic and tympanum was removed and the overlying middle lobe explored with a needle and syringe, with the result that a large quantity of pus was withdrawn. The dura was then incised and a Simms' forceps introduced along the needle, when the blades of the forceps were separated one ounce of pus escaped. The abscess cavity was cleaned out with strips of gauze and a rubber drainage tube subsequently inserted.

After the operation there was a marked improvement in the condition of the patient, but he still, however, remained restless, complained of headache, and the slow pulse persisted.

An examination of the left eye revealed marked hyperæmia and swelling of the disc, its margin blurred, and the adjacent retina œdematous. The left eye was somewhat similarly affected, but in a very mild degree; partial aphasia and word-deafness were also present. This group of signs and symptoms was manifest for seventeen days following the operation, after which the patient recovered.

The author points out that the interesting feature about the case is the fact that the symptoms usually significant of intra-cranial pressure persisted so long after the operation, notwithstanding that perfect drainage of the abscess cavity obtained. He is of the opinion that the symptoms may be attributed to cerebritis involving a fairly large area of the brain.

Clayton Fox.

Roosa, D. B. St. John.—*On the Treatment of Chronic Non-suppurative Disease of the Middle Ear.* "The Post-Graduate," January, 1904.

The author distinguishes three great classes of this disease:—(1) The catarrhal form dependent upon or resulting from nasal and pharyngeal catarrh; (2) the proliferous, when there is no sign of pharyngeal or Eustachian catarrh, but a proliferating process has occurred in the tympanum; (3) adhesive thickening and opacities and cicatrices, the result of a suppurative process that has entirely and definitely run its course, with a membrana tympani intact, although altered.

The effect of operations on the nose and naso-pharynx, tympanotomy, ossiculectomy, and electricity are discussed, and the author thinks that the most one can do is to take care of the nutrition, use the Eustachian catheter or Politzer apparatus and the masseur. Better results are obtained by following the catheter with the Politzer bag.

Macleod Yearsley.