Abstracts.

MOUTH, Etc.

Armstrong, George E.—*Excision of Half of the Tongue.* "Montreal Medical Journal," December, 1898.

THE patient, male, aged 63, exhibited on right side of the tongue a hard, indurated mass, about the size of a bean, which appeared to involve the lingual nerve. Hot and cold liquids caused the patient pain. Microscopical examination of a section proved it to be carcinoma.

It was decided to remove half the tongue by Butlin's modification of Kocher's method.

Preliminary tracheotomy was performed under ether. Then the pharynx was packed. An incision was made from the mastoid process to the hyoid bone, and thence along the anterior belly of the digastric muscle to the jaw, slightly to the right of the median raphe. The platysma was divided, and the lingual and facial arteries tied. The submaxillary and lymphatic glands were extirpated. Then the mucous membrane along the jaw and the mylo-hyoid muscle was divided. The tongue was split down the middle line, the right side drawn well out of the wound, and excised behind the disease.

The oozing being stopped, the wound was closed. The tracheotomy-tube was left in, and the pharynx freshly plugged. For three days the patient was fed by the rectum; after that by a tube through the mouth. On the eighth day the tube was removed; and on the thirty-first day he was discharged as cured.

Ten weeks after operation he presented himself for examination. The remaining half of the tongue lay in the middle of the floor of the mouth. It was straight and moist, as well as materially useful both in mastication and speaking. *Price Brown.*

Henke, Dr. (Clausthal).—*Anomalies and Morbid Conditions of the Uvula.* "Monatschrift für Ohrenheilkunde," July, 1898.

IT is very rarely absent, but may be rudimentary. It may be elongated, but slender, as if pulled out lengthways. Generally the upper part is conical and contains muscle, while the terminal portion is much smaller, and consists only of mucous membrane and a little connective tissue. Sometimes there is a bleb-like swelling at the end. An elongated uvula is generally anæmic, but in true hyperplasia the organ is thickened, elongated, highly vascular, and contracts sluggishly, or not at all. The end of such a uvula may be greatly enlarged with a smooth knobby outline like a cluster of grapes. The anterior surface is chiefly affected in hyperplasia; the muscle lies close to the posterior surface. The uvula may be bent like a bow, with the concavity upwards, and the mucous membrane transversely folded. Very large tonsils may cause it to assume this position. Oblique uvula may be due to local hyperplasia of one side, and the same process at the extremity may produce a polypoid appearance, while the mucous membrane of the palate at the base of the uvula is transversely folded. Chronic catarrh is generally assigned as the cause of these changes. Paresis of the palate (as from adenoids) is considered by some to play a part. Pronounced anomalies of the uvula may interfere with speech and deglutition, giving rise to the sensation of a foreign body in the throat,

with a constant desire to swallow. A very long uvula may cause retching and vomiting, cough, and even laryngismus. The uvula may be grooved, generally vertically, on the anterior surface, with a broad lobed extremity, or it may be split, the parts lying in close apposition; or bifid, the parts diverging. The right lobe is generally the larger of the two. Perforation of the uvula may, it is said, be congenital. Syphilitic perforation generally begins on the posterior surface, and comes as a surprise.

Neoplasms are rare, especially cancers, which are generally epithelial, and often begin on the posterior surface of the velum, very seldom affecting the uvula alone.

The so-called *mixed tumours* are supposed to originate from aberrant embryonal epithelial cells. They show mucous and cystic degeneration, are never limited to the uvula, and are not malignant. One (congenital) chondroma has been observed by Henke.

Cavernous angioma is not rare, and always congenital. It originates at the point of junction of the palato-pharyngeal arch and the uvula, probably because at this point the ascending and descending palatine arteries anastomose.

Adenoma is very rare. It springs from the submucous glands.

Papilloma comprises about 70 per cent. of all tumours of the uvula. They may be large and solitary, hanging by a thin pedicle, often from the point of the organ; or they may be multiple, implicating generally the arch of the palate.

Sessile fibromata occur, and *leprosy* may infiltrate the uvula. It is rarely involved in adhesions. *William Lamb.*

NOSE.

Baumgarten (Budapest).—*Bony Occlusion of the Choanæ.* "Monatschrift für Ohrenheilkunde," September, 1898.

Occlusion of the choanæ may be:

(*a*) True, and then is generally congenital and bony, or chiefly bony.

(*b*) False, the result of ulceration and adhesion, and generally membranous.

He recounts the following cases:

(1) *True Unilateral Occlusion.*—A healthy youth of eighteen had never been able to breathe through the left nostril, but breathing and speech were normal. With the post-nasal mirror, the choana could be seen to be completely closed by a partition which felt like bone to the probe. The nose was otherwise normal. A hole was bored through the partition, and then with a long gouge and mallet it was detached all round its circumference, some stray fragments being removed with forceps. No anæsthetic was used, and there was little bleeding.

(2) *Partial Bilateral Occlusion* in a boy of fourteen. From behind, the semilunar edge of a bony obstruction could be seen stretching like a bridge from the middle turbinal to the outer wall. From the front (after cocaine), part of the semilunar edge could be seen.

William Lamb.