history, of which so little is known up to the present, would make great progress if authors were more precise in their description of their cases, distinguishing as far as possible the primary from the secondary tumours, and one anatomical form from the other. This is an indispensable foundation for our knowledge and for decision as to treatment, on the accuracy of which the result greatly depends. Dr. Bellotti's report is full of interesting clinical history and of practical data illustrating this difficult question. *V. Grazzi.*

Broeckaert, Jules (Ghent).—*Contribution to the Surgical Treatment of Hypertrophy of the Nose.* "La Presse Oto-laryngol. Belge," March, 1908.

The problem of treating this disfiguring condition is discussed. The author treated a case in which the deformity was of very large dimensions by removing a wedge-shaped mass of tissue from the end of the nose and bringing the edges of the flaps together by sutures. Hæmorrhage was free, but easily controlled. The result was very good.

Chichele Nourse.

Gallemaerts, E., and **Delsaux, V.** (Brussels).—*Double Frontal Sinusitis Complicated by Suppuration in the Left Middle Ear with Obliterating Thrombosis of the Corresponding Lateral Sinus.* "La Presse Oto-laryngol. Belge," January, 1908.

Chronic frontal sinusitis in a woman, aged sixty-one, was followed by perforation of the anterior wall of the left sinus, the formation of an orbital abscess, and displacement of the eyeball. The case was operated on by the method of Kuhnt. About a week afterwards acute purulent otitis media on the left side supervened, with mastoid pain, necessitating operation. The antrum contained no pus or granulations. As the patient's condition did not improve, and there was marked leucocytosis, a further operation was performed two days later. Two cavities containing granulations were found in the bone, and the lateral sinus, which contained a clot, was opened and curetted. The patient recovered.

Chichele Nourse.

LARYNX.

Strazza, Prof. G. (Genoa).—*On a Case of Grave Laryngeal Stenosis due to Amyloid Degeneration of the Subglottic Region.* "Archiv Ital. di Otologia, etc.," November, 1907, p. 458.

The author describes the case of a man, aged fifty-two, who had good health until 1903, when he had a severe influenza followed by chronic bronchitis, with frequently recurring attacks of what was considered to be asthma. He was admitted to hospital for dyspnœa. There were no thoracic physical signs beyond the noisy respiration. The laryngoscope showed very slight evidence of catarrh and impairment of muscular action. Below the vocal cords, however, there was an intense infiltration of the trachea, the lumen of which was reduced to a narrow ellipse. The patient died in the night unexpectedly, and before his attendants were aware of it. At the autopsy the swelling was found to occupy the whole extent of the cricoid down to the second tracheal ring. Posteriorly it was 6 mm. thick and 4 mm. anteriorly. A similar patch of thickening occurred at the level of the fourth, fifth, and sixth tracheal rings. The

microscopic examination and the results of the chemical tests enabled the author to conclude that the case was one of gradual diffuse hyperplastic perichondritis of the cricoid region, with secondary amyloid degeneration and a similar degeneration of other tracheal rings. The author discusses the pathogenesis at considerable length, with references to the previous literature, and inclines to the view of so many authors that the amyloid change is the consequence of degenerative changes in the blood-vessels. The paper is well illustrated with photographs and micro-photographs.

James Donelan.

Rieser, W.—*The Laryngeal Complications of Typhoid Fever, with Report of two Cases.* "Amer. Journ. Med. Sci.," February, 1908.

The lesions met with in the larynx are submucous laryngitis, ulcerative laryngitis, and perichondritis. The site of lesion, as found *post-mortem*, does not agree with what has been observed clinically. In 4000 autopsies the posterior wall at the insertion of the vocal cords and involving the cricoid cartilage was the seat of the lesion in 60 per cent., the arytænoid cartilages and interspace the next, the ary-epiglottic folds, epiglottis, and thyroid cartilage being least affected in the order named; whereas Chevalier Jackson found in 360 routine laryngoscopic examinations ulceration to be present in 68 cases, involving the epiglottis 42 times, ary-epiglottic folds 22, interarytænoid space 18, and arytænoid cartilage 10. Inflammation may occur any time between the first and the tenth weeks. Over 70 per cent. of reported cases occurred after the third week. The onset is insidious. Extreme dyspnœa and spasm may be the first intimation, and the first attack may end fatally. In the greater number of cases these complications occur when the patient is convalescent and all danger supposed to be past. The symptoms begin mildly and in the following order of frequency: hoarseness, aphonia, stridor, dyspnœa, metallic cough, dysphagia. Any of these symptoms may be overlooked or misconstrued until, with tragic suddenness, an acute œdema of the glottis supervenes, or an asthenic apnœa, without the slightest warning of its approach, may terminate life. Therefore the slightest hoarseness, cough, pain in swallowing or breathing should immediately arouse suspicion and lead to a larnygoscopic examination being made.

The prognosis, if we judge from 243 collected cases, is very bad, as 65 per cent. in all died; of those operated on 58 per cent., and of the unoperated, 76 per cent.

In the first of the author's two cases, which are recorded in detail, the patient developed in the third week a parotitis with œdema of the pharynx and larynx. Tracheotomy was performed with relief to breathing, but the patient died the next day without recovering consciousness. Cultures for Klebs-Loeffler bacillus were negative, and at the *post-mortem* "the cartilaginous box of the larynx and the trachea were found absolutely normal."

The second case was admitted to hospital convalescent in the fourth week, after a mild attack without complications. Eight days later, though the temperature remained normal, he developed hoarseness with slight cough, and at times inspiratory stridor. Laryngoscopic examination showed congestion of the cords, but no impaired movement or any ulceration. Under treatment symptoms improved; only aphonia remained. Twelve days after admission the patient developed respiratory obstruction, so sudden and complete that the house-surgeon had to perform

laryngotomy with an ordinary pen-knife. Cultures for Klebs-Loeffler bacillus were negative. A month later it was still impossible to remove the tracheotomy tube. *Middlemass Hunt.*

Mosher, Harris Peyton (Boston). — *The Direct Examination of the Larynx and of the Upper End of the Œsophagus by the Lateral Route.* "Boston Med. and Surg. Journ.," February 6, 1908.

The author discusses the difficulties in direct examination of the larynx, and describes a special speculum designed by the author for use in the lateral position, a posture which does away with the necessity for holding the patient's head, and which does not put the larynx on the stretch, and so makes it more easily viewed. The speculum is a combination of tongue depressor and mouth gag, and is used on the left side. Its method of use is carefully described. *Macleod Yearsley.*

Rogers, J. (New York).—*The Treatment of Chronic Stenosis of the Larynx and Trachea.* "Amer. Journ. Med. Sci.," vol. cxxxv, No. IV.

The author's experience of stenosis of the larynx and trachea extends to 23 cases. Among these there were 3 deaths and 2 failures to cure, while the remaining 18 are all now "practically well," and all but one have good or perfect voices.

It has been shown by means of statistics that about 1 per cent. of patients intubated for laryngeal diphtheria will subsequently be unable for an indefinite period to breathe without the tube or a tracheotomy opening. The most common cause of this condition of "retained tube" is a "chronic hypertrophic subglottic laryngitis"—a chronic exudative and productive inflammation of the intra-laryngeal soft parts. This has been found after tracheotomy as well as after intubation, and cannot, therefore, be ascribed to faulty technique in "tubage." Another cause of "retained tube" is "abductor spasm," which is found in patients who have worn an intubation tube for some time. It is probably due to disuse atrophy of the abductors. Under general anæsthesia with the pharyngeal reflexors abolished respiration is normal. "Retained tube" may also be due to cicatrices and rarely to exuberant granulations.

For the treatment both of hypertrophic laryngitis and cicatricial stenosis the author employs constant and long-continued dilatation, the passage being stretched to its largest normal calibre. With the patient under deep, general anæsthesia a number of ordinary O'Dwyer's tubes are passed through the larynx until one is found in which "the retaining swell distends the constriction to the limit the operator believes it will bear without sloughing." A "special tube" is then made of the length of the normal tube suited to the age of the patient, but with a retaining swell of the same diameter as that of the trial tube. If auto-extubation occurs, a tracheotomy is usually required, after which the "special tube" is fixed in position by a plug or clamp passed through the tracheal fistula.

After removal of these large dilating tubes, although the hypertrophy or cicatrices formerly present may have been overcome, obstruction due to "adductor spasm" may still remain. In such a case the obstruction disappears entirely under general anæsthesia. It is best treated by inserting for several days or weeks a tube with head, swell, and length, the same as those of the dilating tube but with the neck as small as possible so that the abductor muscles may be to some extent exercised.

In the case of a fibrous stricture the "special tube" should have its

widest part so placed as to correspond to the site of the stricture. No stricture is to be considered hopeless if any trace of mucous membrane remains.

In cases of cicatricial stenosis the dilating tube must be worn for from two to six years, but there is a reasonable certainty of ultimate recovery with a good voice. *Thomas Guthrie.*

Teets, C. E. (New York), and **Shearer, T. L.** (Baltimore).—*Malignant Tumours of the Larynx: or, Observations on the Management and Treatment of Cancer of the Larynx.* "The Homœopathic Eye, Ear, and Throat Journal," February, 1908.

Dr. Teets, while admitting that nothing has been found to cure cancer, states that the application of chromic and lactic acid do not irritate when properly applied; in using chromic acid only a small crystal should be fused on the probe and only a small area of the growth treated. He claims that in this way the patient's life is prolonged; there is less suffering, and a benign tumour, which might from instrumentation become malignant, might be cured.

Shearer, in discussion, advocated the removal of a portion of a growth for examination only under three conditions: (1) When the operator had sufficient skill to do so without injury to the neighbouring parts; (2) when a fragment from the deepest part of the tumour could be obtained, as otherwise the microscopic findings would probably be negative and misleading; (3) when the case had been fully placed before the patient and permission obtained for a thorough operation if the surgeon considered it necessary. He was of the opinion that any irritation, whether chemical, caustic, or instrumental, was apt to hasten the growth of a tumour already cancerous, but he doubted very much whether the use of endo-laryngeal instruments could cause the transformation of a benign to a malignant growth. He deprecated attempts at endo-laryngeal removal of laryngeal cancers, the only satisfactory way of doing it being by thyrotomy, quoting Semon's results in support of his views. He advised total laryngectomy if the disease, after the larynx was opened, was found more extensive or advanced than supposed. He quoted von Bruns' statistics of total laryngectomies performed since 1890. He narrated one remarkable case of laryngeal cancer being apparently cured by hypodermic injections of trypsin, namely one recorded by Dr. Homer Dupuy, of New Orleans. *Dundas Grant.*

Hoffmann, R. (Munich).—*Lasting Anæsthesia in Tuberculosis of the Larynx.* "Münch. med. Woch.," April 7, 1908.

On account of the transitory nature of the anæsthesia induced by the insufflation of cocaine, anæsthesin or orthoform at the hands of the physician, Hoffmann has devised a tube for self-inhalation of powders, which are placed in a receptacle like the bowl of a pipe. [He has apparently not known Leduc's tube.—D.G.] A lasting diminution of odynphagia was obtained by alcohol injections directed towards the superior laryngeal nerve. By means of a fine syringe he injects from $\frac{1}{2}$ to 1 c.cm. of 85 per cent. alcohol warmed to 45° C. through the skin to a tender spot discernable by pressure and corresponding to the point of entrance of the superior laryngeal nerve. The depth is about $1\frac{1}{2}$ cm., but it is best learnt by practice on the cadaver with a coloured fluid.

Dundas Grant.