

resort to the tube again, and he was considering the question of further operation by thyro-fissure and extending the laryngostomy upwards before falling back on intubation.

### SEVENTEENTH INTERNATIONAL CONGRESS OF MEDICINE (LONDON, 1913).

THE following are the programmes of the discussions which will take place in the Sections of Otolology and Rhino-Laryngology :

#### IN THE OTOLOGICAL SECTION.

1. *Thursday, August 7.*—Pathology of Deaf-Mutism.
2. *Friday, August 8.*—Results of Treatment of Syphilis of the Nose, Throat, and Ear by Salvarsan and other Arsenical Compounds. (With the Section of Laryngology and Rhinology.)
3. *Saturday, August 9.*—Treatment of Non-suppurative Diseases of the Labyrinth.
4. *Monday, August 11.*—The Special Treatment of the Throat, Nose, and Ear during the active stages of certain infectious fevers, namely—scarlet fever, measles, German measles, mumps, influenza, typhoid, whooping-cough, smallpox, cerebro-spinal meningitis, erysipelas (diphtheria excluded). (With the Section of Laryngology and Rhinology.)
5. *Tuesday, August 12.*—Climatic and Occupational Influences in Diseases of the Ear.

#### IN THE SECTION OF RHINOLOGY AND LARYNGOLOGY.

1. *Thursday, August 7.*—The Disorders and Pathological Changes produced in the Pharynx and Larynx by the Overuse and Misuse of the Voice.
2. *Friday, August 8.*—See Section of Otolology.
3. *Saturday, August 9.*—The Question of Treatment of Diseases of the Throat and Nose by Therapeutic Inoculation, exclusive of tuberculin and diphtheritic antitoxin.
4. *Monday, August 11.*—See Section of Otolology.
5. *Tuesday, August 12.*—Malignant Disease of the Post-cricoid Region.

It is to be noted that on August 8 and 11 there will be combined discussions of the Sections of Otolology and Laryngology.

The names of the *rapporteurs* or introducers of the discussions, who are at present under consideration, will be reported at a later date.

## Abstracts.

### NOSE.

**T. K. Hamilton (Adelaide).**—The Treatment of Nasal Obstruction. "Australasian Medical Gazette," May 20, 1911.

Hamilton points out that in the treatment of nasal obstruction it is advisable to avoid the destruction of important structures such as the in-

ferior turbinals, and endorses the treatment of hypertrophy of the same by submucous resection of a portion of the structures. Some cases of inferior turbinal turgescence do not require operative interference; these are due to general anemia as predisposing cause, and vaso-motor paresis as exciting cause. A course of iron will effect a cure. In cases of a spur in one nostril with swelling of turbinals on both sides, the removal of the spur is sufficient to relieve both sides. The spine is the exciting cause; by causing a vacuum in one nostril it leads to increased blood-supply. As both nostrils have a common blood-supply, the turgescence of both turbinals is explained. Nasal headache is now well recognised as a distinct clinical entity. Children with post-nasal adenoids may suffer from symptoms of eye strain without any error of refraction being present. Children may suffer from marked photophobia and lacrymation from the same cause. Immediate relief follows removal of the growths. This result is partly brought about by the depletion. Nasal depletion by submucous puncture of the inferior turbinals has a diagnostic value, as it aids in differentiating cases of head pain due to nasal hypervascularity from those due to eye strain.

Young infants with snuffles and nasal obstruction are soon restored to normal by rubbing twice a day into abdominal wall ung. hyd. co. This applies to non-syphilitic cases as well as syphilitic. The surgery of the accessory sinuses is also discussed. *A. J. Brady.*

**Bonnier, Pierre (Paris).—Treatment of Asthma by the Naso-bulbar Route.** "Arch. Internat. de Laryngol., de Otol., et de Rhinol.," March-April, 1911.

Asthma is a bulbar trouble. Between the nose and the bulb runs a large trigeminal nerve. Why not interrogate the bulb by means of the trigeminal and find its secret? The state of the larynx in nasal asthma differs from that present in both coughing and sneezing, which are of the nature of a spasmodic systole, while the former may be described as a pulmonary asystole. If in a normal subject the nasal mucosa of the external wall a little in front and above the head of the middle turbinate is gently rubbed with a probe, one encounters almost immediately a point which provokes reflex movements, quivering of the eye-lids, at other times incoherent movements of the globe, which is drawn rapidly upwards and inwards. This the author attributes to irritation of Deiter's nucleus. Chronic convulsions and nystagmus may also occur and even alterations in the pupil and occasionally troubles of accommodation. All these phenomena vary in form and intensity according to individual susceptibility, but may remain absolutely unilateral. The author found that a slight cauterisation of this area is most likely to cut short an attack of hay-fever, although often momentarily exaggerating it. Occasionally the cure is permanent from the start. In approaching the head of the middle turbinate we provoke cough, and this indicates a communication with the respiratory region through its sensory or motor apparatus. The author has further demonstrated that by touching certain points of the mucous membrane of one side a bruit may occasionally be heard in the corresponding lung while the signs in the opposite organ remain unaltered. Hydrorrhœa thus provoked is unilateral. The author reports seventy-four cases which he has carefully followed, and on which he remarks that often muco-membranous enteritis associated with asthma disappears with this condition. In all these cases the symptoms were either immediately cured or very much diminished by cauterisation. The cases include many of nasal asthma associated with

mucous-membranous enteritis, chronic coryza, intense nasal pruritus, scarlet fever, hay-fever, intense nasal hydrorrhœa, paroxysmal sneezing, habitual coryza, laryngeal thyrotomy, and even constipation associated with œdematous rhinitis.

J. D. Lithgow.

## LARYNX.

### Moscoso.—Contribution to the Study of Congenital Stridor of Infants. "Thesis, Paris," 1909.

This condition, although not in itself a disease, is symptomatic of various diseases. It is characterised by marked inspiratory stridor with very little interference with expiration. There may be marked drawing in of the chest, and even considerable dyspœnea, sometimes amounting to cyanosis. The acute stage passes off shortly and the condition of slight stridor remains. The condition may be sufficiently serious to bring about a fatal termination, or at least may act unfavourably upon the general health of the infant. But more frequently the infection becomes less frequent and disappears about the end of the second year after having lasted almost from birth. The stridor, although nearly always inspiratory, may be of slight expiratory advent, but it is continuous and varies in intensity in many cases. It is most marked on awaking from sleep and becomes less during sleep, on suckling, and when occupying the lateral position, when it may even disappear. Anything which calls for an increased respiratory effort, mental excitement, etc., may exaggerate the intensity of the stridor; even sudden changes of temperature may bring on such an access. The bruit persists when one pinches the nostrils or when the mouth is closed. In spite of the stridor the voice remains normal and the cry is clear. There is nothing unusual about the cough; ordinarily the stridor does not seem to produce any respiratory embarrassment. In certain cases the stridor may only last a few weeks, but in most cases, where the stridor becomes worse during the first two or three months, it remains constantly so till about the eighth month and then slowly diminishes, disappearing about the second year.

*Diagnosis* is usually easy. It rests on a history of the attacks having come on shortly after birth, the inspiratory bruit being more predominant than the expiratory where the latter is also present. If, at the same time that the stridor continues, the cough and voice are unaltered, and the general state is low, while auscultation reveals nothing abnormal, one can be almost sure that this condition is present. In short, onset at birth, chronic progress, and respiratory without vocal trouble are the principal characters of congenital stridor in infants.

*Ætiology*.—In a certain number of cases the affection appears to be due to some latent or manifest parental infection, such as tubercle or syphilis. The nervous heredity has also been remarked upon as more common in boys than in girls. Hypertrophied adenoids, occurring often in newly born infants, would explain congenital stridor due to such causes. The causes may be grouped into four classes: (1) Malformations of the larynx; (2) adenoid vegetations; (3) nervous troubles; (4) compression of the trachea by hypertrophied thymus. If we turn to the results of the investigation of malformations of the larynx one sees that in these cases the vestibular orifice is contracted, the whole or part being mostly reduced to a mere chink. There is not only one variety of vestibular malformation capable of giving rise to congenital stridor, but there are at least two