manage the feeding, a tube being kept in the fistula, closed with a clamp, and no excoriation of the skin takes place.

Records of three cases are given.

1. Male, aged forty-eight, blind, but can manage the feeding through tube quite easily. Only on coughing has the gastric opening allowed of leaking.

2. Male, aged forty-two. He had lost thirty-two pounds weight before the operation, and gained twenty-five pounds after it. This he has begun to lose again and to look ill.

3. Male, aged fifty-eight. He had lost two stone in weight and was very feeble, and had lung complications. The wound healed by first intention, and he was relieved by the operation, but died a month later, and the *post-mortem* examination showed extensive disease in the gullet, and secondary infection of the trachea, bronchi, lungs, and liver. *Barclay J. Baron.*

Kelling, G.—*Endoscopy for Œsophagus and Stomach. Œsophagoscope.* "Münch. Med. Woch.," Aug. 24th, 1897.

THE author's instrument consists of a series of short cylinders, so hinged together that the whole instrument can be freely bent back and forwards in one plane, but is absolutely stiff in the plane perpendicular to this. Let the instrument be bent in one direction; along the convex surface let a series of eyes be fixed—one to each cylinder; through these let a wire be passed and fixed at the distal end. By dragging on this wire the instrument can be straightened and held straight. In the œsophagoscope the wire is pulled by means of a double lever, which fixes automatically. When in use an india-rubber tube is drawn over the cylinders, and the end rounded off by a piece of sponge, etc.

The patient sits on the edge of a table, and the operator, standing on a stool or low chair, introduces the instrument in the flexible condition; thereupon the patient lies back so that his head hangs over the other side of the table, where it is supported by an assistant. Now by pressure on the double lever (acting like the handles of scissors) the operator nearly straightens the instrument, twists it to right or left through 90°, and at the same moment completely straightens it. The object of twisting the œsophagoscope round through 90° is to take the strain of holding the œsophagus straight off the single wire, and to throw it on to the double row of joints. During the introduction of the instrument—which is as simple as introducing an œsophageal bougie—the patient must not suffer any pain.

Contraindications are practically the same as in the use of bougies. But this further precaution must be taken, viz., the œsophagoscope must not be straightened, except where it has been possible to introduce an olive about three millimètres thicker than the instrument; otherwise there is danger of producing ruptures, etc. For illumination the author uses a Leiter's panelectroscope or a Kasper's hand lamp; only on rare occasions is it necessary to obtain illumination on the principles of Oberländer's methroscope. *Arthur J. Hutchison.*

THYROID, &c.

Oppenheimer.—*On Inflammatory Processes and Deep Suppurations in the Neck.* "Archiv für Kinderheilk.," Band XXIII., Heft 1 to 3. Continued from Band XXII.

THE author directs attention to the danger of mistaking post-pharyngeal abscess for diphtheria unless careful digital examination is carried out.

The prognosis of post-pharyngeal lymphadenitis or abscess is always doubtful, owing to the numerous complications that may arise—notably, invasion of the mediastinum. The treatment should be by incision, either through the mouth or the neck. Spontaneous opening or resolution should never be waited for. Cases of undoubted abscess can be satisfactorily treated through the mouth by incision with a hidden-bladed knife, or a knife cutting only at the point. Care must be taken that the wound is not allowed to close too quickly, and that the pus is freely evacuated. Other cases remain which must be opened from without. These are mostly complicated cases—*e.g.*, cases with external abscess or tubercular cases—or, again, hard, swollen, but not suppurating, glands.

Pericesophageal abscesses arise from injuries or diphtheria (an interesting case by Baginsky) of the œsophagus.

Perilaryngeal or tracheal inflammations or suppurations arise chiefly in connection with diphtheria and scarlatina, and the treatment of the same by tracheotomy or intubation.

"1. Suppurations in the neck can arise from intubation, just as from tracheotomy. They are due to pressure and necrosis. The principal symptoms of peritracheal suppurations are (1) continued stenosis, (2) impossibility of removing the tube, (3) decrease of the period between extubation and reintubation, (4) the course of the fever, and (5) the local condition—tenderness.

"2. These conditions, as a rule, are indications for tracheotomy, which should not be put off too long, as frequently the diagnosis is made only with the incision.

"3. The length of time the tube is worn gives in itself no indication for tracheotomy, because in some cases the tube can be removed after eight to fourteen days. Extubation must be attempted every twenty-four hours. The time it can be kept out gradually increases in successful cases.

"4. Pneumonia is not a contraindication to intubation, but so soon as expectoration becomes difficult, the pulse small, and cyanosis and dyspnœa continue, tracheotomy must be resorted to.

"If one intubates a larynx with intact mucous membrane (laryngitis, acute spasmus laryngis) the tube must not be left long in position."

The author considers that there is more danger in intubating for scarlatina, or even laryngitis or laryngospasmus, than for diphtheria. In the latter the membrane seems to form a protecting coat on which the end of the tube can rest more or less harmlessly.

The rest of the paper treats shortly of the surgery of the mediastinum.

Arthur J. Hutchison.

EAR.

Claoué.—*Aural Affections and Fitness for Military Service.* "Annales des Mal. de l'Oreille et Nez," July, 1897.

A *résumé* is given of the regulations which exist on this point in the army medica departments on the Continent, together with the suggestions of Delstanche and Broemer and those of the author. The paper, interesting only in its details, should be read in full by those whom it concerns. Various stratagems for detecting malingering are quoted. It would appear that the most useful and least variable test-sound is to be found in the loudest whisper which can be produced with the air remaining in the lungs after a moderate expiratory effort (residual air).

Ernest Waggett.

https://doi.org/10.1017/S1755146300191668 Published online by Cambridge University Press