

in ligations of the lingual artery would necessitate an incision lower down than is actually taught.

Although Ricard and Sebileau published their researches on the same subject somewhat prior to a preliminary communication of the author's, and published in the "Scientific Bulletin" of Pavia (Anno XI.), the latter claims the priority of his studies.

Jefferson Bettman.

Wright, Faulconer.—*A Case of so-called Angio-Neurotic Œdema.* "Brit. Med. Journ.," Sep. 19, 1896.

THE patient, a lady of sixty, has suffered for the last thirty-five years with the formation of localized cedematous swellings, sometimes as large as half an orange, with slight reddening of the skin and pitting on pressure. She is seldom free from an attack for six weeks at a stretch, and there is no marked general disturbance or urticaria. All parts of the body are affected, including the face, the tongue, and, presumably, the trachea and bronchi. In a few hours the tongue has swollen to the extent of making it impossible to shut the mouth; and, in two instances, attacks of dyspnoea, closely resembling true asthma, have occurred.

Ernest Waggett.

NOSE, &C.

Bois, R.—*Notes on Fistule of the Frontal Sinus.* "Thèse de Paris," 1896; and "Arch. Gén. de Méd.," July, 1896.

FROM the careful examination of thirty-four cases, these fistulæ were found secondary to (1) traumatism; (2) inflammation, acute or chronic sinusitis (the most frequent cause); (3) surgical operation in the region. Their intractability and the rarity of spontaneous cure of these fistulæ is due to the rigidity of the osseous cavity, which is, in fact, a nasal diverticulum. The symptoms are not characteristic: purulent discharge by the nose and the sinus—frequently by the sinus only, on account of obstruction of the passage into the nose; sometimes (one case) escape of air. Catheterism and exploration are necessary for diagnosis. The treatment must be surgical—breaking up one or both walls of the sinus, curettage of the suppurating cavities, and fronto-nasal drainage.

A. Cartaz.

Burnett, Charles H. (Philadelphia).—*Non-Fetid Ozæna and Chronic Aural Catarrh.* "Philadelphia Polyclinic," Oct. 3, 1896.

THE notes of two cases, mother and child, where there was absolutely no smell from the nasal discharge, although there was an abundant formation of the characteristic crusts and atrophy of the mucous membrane. Both cases were accompanied by tinnitus, and in the mother there was increasing deafness, the ear symptoms being apparently due to ill-regulated nasal douching. The cases improved under the application of thymol in glycerine and alcohol, five grains to the ounce.

St George Reid.

Chandler, H. B.—*Heterophoria from Nasal Reflexes.* "Ann. Opth. and Otol.," Oct., 1896.

THE author quotes four cases, viz.—(1) A female of twenty-seven, with headache; hypermetropic astigmatism, exophoria 14°, and hyperphoria 9°. Turbinal hypertrophy was found and relieved, with a diminution of the exophoria to 6° and hyperphoria to 3° in six weeks' time. (2) Male, aged thirty-four, headache, and

exophoria 5°. Intranasal treatment relieved headache, but exophoria increased to 9°, which glasses rectified. (3) Female. Exophoria 5° and headache, both cured by intranasal treatment. The fourth, also cured, was amblyopic on one side with vision one-tenth.

R. Lake.

De Simoni, Attilio.—*On the Unvarying Presence of the Bacilli of Diphtheria in Ozæna.* "Bollet. delle Malatt. dell' Orecchio, etc.," Aug., 1896.

THE observations generally accepted on the parasitic nature of ozæna have recently been modified by the researches of Belfanti and Della Vedova, communicated to the Royal Academy of Turin in March last. The exact nature of the large pneumococcus of Löwenberg—although the latter, Marano, Abel, Paulsen, and others regard it as the specific element of ozæna in contradistinction to the latest researches of Belfanti and Della Vedova, who found and described a bacillus bearing all resemblance to the microbe of diphtheria, and only differing from it in degree of virulency—still remains to be established. The latter base their conclusions not alone on the constant occurrence of these bacilli in ozæna secretions, but on the clinical experience of thirty-six cases, either cured or improved by antidiphtheritic serum treatment. According to the author, this fact in itself goes far to confirm the specific nature of the bacilli of Belfanti, etc. To further substantiate this he examined twenty-five cases of ozæna according to the methods described by Belfanti. In all of these, the specimens being stained with Gram-Weigert solution, on repeated examinations he invariably found a small, slender bacillus, almost fusiform in shape, one extremity larger than the other, at times straight, and again bent at a right angle, isolated or in groups, with a tendency to parallel arrangement. He further lays great stress on the staining methods employed. Whilst those coloured with Gram-Weigert solution demonstrated the bacilli in abundance, the latter were wanting or but sparse in quantity in others stained with the usual methods of colouring adopted in bacteriological research. At the same time the author devoted attention to Löwenberg's diplococcus, using the simple method of Ziehl. Thus in all the cases he was able to find the diplococcus present, most numerous in the secretion of those cases of ozæna that had been neglected, or where measures of cleanliness had not been applied. Repeated examination of small pieces of the mucous membrane, removed by scraping and treated according to Belfanti's method, always revealed the presence of the diphtheritic bacilli, and never that of the diplococcus. According to numerous observations, the latter have only been found either free in the secretion or but adhering to the mucous membrane. According to this fact and the presence of both types of micro-organisms no deductions can as yet be formulated. Time and clinical experience alone can decide what influence they have in the etiology of ozæna.

Jefferson Bettman.

Dickermann, E. T.—*Nasal Papilloma or Papillary Fibroma.* "Ann. of Ophth. and Otol.," Oct., 1896.

A COMPLETE *résumé* of the subject, with a careful differentiation between true and pseudo papillomata, together with a case. The patient, a man of sixty-two years of age, gave a history of nine years' right nasal obstruction. The right nostril, from the vestibule to the posterior choana, was filled with a pinkish cauliflower mass. It arose from the upper and anterior portion of the quadrangular cartilage. The growth was removed, with part of the thickened septum, by means of scissors, and part with the cold snare, and up to the present time there is no recurrence (since May, 1896). The microscope proved the growth to be a true papillary fibroma.

R. Lake.

Dionisio, Prof. J.—*Rare Forms of Tertiary Nasal Syphilis.* "Gaz. Med. di Torino," June 11, 1896.

THIS condition is rarely or but slightly treated of in most handbooks on diseases of the nose. The three cases presented by the author have a certain importance in showing that tertiary syphilis of the nose may demonstrate itself by a simple tumefaction of the mucous membrane, running its course without any signs of ulceration or purulent secretion. This initial period of tertiary infiltration may exist some time before degenerating into the characteristic ulcerative type. Accordingly, it is of importance to distinguish this form from the various conditions requiring surgical interference; it, itself, is very amenable to specific treatment.

Jefferson Bettman.

Goodall, J. L. (Massachusetts).—*An Experimental Study of the Respiratory Functions of the Nose.* "Boston Med. and Surg. Journ.," Nov. 5 and 12, 1896.

THE author deals at length with the question of the action of the nasal mucous membrane upon respired air with regard to heat and moisture, with the alteration in intranasal air pressure during the respiratory act, and with the normal route taken by respired air within the nose. With regard to the question as to the rise of temperature within the nose of inspired air, he finds that at 1° C. to 5° C. atmospheric temperature the air is raised in the nose to 28° C., and with 21° C. to 25° C. external temperature it is raised to 31° C. to 32° C.

As to the accession of moisture. With an atmospheric absolute humidity of 1.4 grammes of vapour at 1° C., the nose evaporates 25.6 grammes of water per cubic metre of air; while with practically the same humidity at 25° C. there are evaporated 24.8 grammes of water. In experimenting on intranasal air pressure the author used a water manometer in place of a mercurial, water being thirteen times lighter than mercury; the excursions of the column of water were therefore thirteen times greater than those of a column of mercury. On placing the manometer in connection with the healthy naso-pharynx of an adult the following figures were obtained as a mean after numerous trials:—

Quiet respiration	{ Inspiration	6 mm.
	{ Expiration	4 ,,
Deep respiration	{ Inspiration	30 ,,
	{ Expiration	20 ,,

The author then proceeds to deal with the variation in these figures caused by pathological changes in the nasal passages, and raises the question as to how far the variations in air pressure affecting the intranasal blood supply and nutrition may be a factor in the production of the facial peculiarities of subjects of adenoid disease. He found, as regards the direction taken by the air within the nose, that it was first deflected by the alæ against the septum, and then passed upwards against the anterior end of the middle turbinate and along the middle meatus.

St George Reid.

Fränkel, B. (Berlin).—*Tampon Carrier for the Naso-Pharynx.* "Archiv für Laryng. und Rhinol.," Band 4, Heft 3.

THIS instrument is the same as B. Baginsky's, excepting that, instead of being angular, it is curved to suit the naso-pharynx, as, e.g., in Gottstein's curette.

A. B. Kelly.

Guamaccia, E.—*Bacteriological Researches upon Caseous Rhinitis.* "Archiv. Ital. di Laringologia," fasc. 4, 1896.

BACTERIOLOGICAL studies upon a case of caseous rhinitis observed by Prof. Massei in his ambulatorium, undertaken by Dr. Guamaccia, and under the control of

Prof. de Giaxa, to prove that the micro-organism variously described by Perier, Sabrazis, and others is the streptothrix alba, described by Rossi, Doria, Cohn, and Garperini under the name of streptothrix Foersterii.

Dr. Guamaccia was able to cultivate it in agar, gelatine, bouillon, blood-serum, potatoes, and milk; and though inoculations did not succeed, it is probable that the large mass which represents the caseous product is no other than the growth of the streptothrix, which has only been differently interpreted. *Massei.*

Hajek, M. (Vienna).—*On the Pathological Changes in the Ethmoid Bone in Consequence of Inflammatory Hypertrophy of the Mucous Membrane and Polypi.* "Archiv für Laryng. und Rhinol.," Band 4, Heft 3.

I. *History.*—Commencing with E. Woakes's communication in 1885 on "necrosing ethmoiditis," in which the relations of the diseased nasal mucous membrane to the underlying bony structures were first pointed out, the author gives a critical account of all that has since been written on the subject.

II. *The Material for the Investigation.*—This was obtained entirely from the living subject. The pieces included bone and mucous membrane, and most of them consisted of hypertrophied anterior ends of middle turbinates. These represented:—1. Hypertrophies which owed their origin to a genuine catarrh of the mucous membrane without other evident complications (five cases). 2. Hypertrophies which appeared in the course of muco-purulent and purulent inflammations of the accessory cavities (seven cases). 3. Hypertrophied middle turbinates with polypoid vegetation on the outer side, and at the same time in the middle meatus (five cases). 4. Polypi, with their bony attachments obtained by evulsion; eight of the growths were from cases in which there was suppurative of the accessory cavities, while in four instances there was no such complication.

III. *Contribution to the Normal Anatomy of the Ethmoid.*—The condition of most importance to us is the intimate relation of the mucous membrane covering to the marrow-like substance lining the cavities in the bone. On the concave side of the middle turbinate the deep layers of the mucous membrane sink uninterruptedly into the large lacunæ which are present in places. These lacunæ are more numerous, and consequently the connection between mucous membrane and medullary substance more intimate, where the middle turbinate is continued into the wall of the ethmoidal labyrinth.

The structure of the medullary substance and of the periosteum are described, also the conditions peculiar to the bulla ethmoidalis and uncinata process.

The author shows by his researches that the mucous membrane and bone (including the medullary substance) form an anatomical entity. This is further supported by the fact that all the structures are supplied by the same arterial branch.

IV. *Examination of the Middle Turbinate and other Parts of the Ethmoid which have undergone Chronic Inflammatory Changes.*—These changes vary with the severity and duration of the inflammation, and have therefore been considered under the following heads:—1. Superficial inflammation, in which only the superficial layers of the mucous membrane are affected. 2. Deep inflammation, when the soft tissues between the bony trabeculæ are also involved. 3. Inflammatory changes of the whole involucre. This classification is quite arbitrary, for, in the same specimen, different stages of the affection may be present in different situations; besides, there are numerous transitions.

1. *Superficial Inflammation.*—If the mucous membrane of a slightly hypertrophied middle turbinate is examined, the inflammatory infiltration is found at most places confined to the superficial layers. Here and there, however, it extends to the glandular layer, and even to the periosteum.

The superficial inflammations are known clinically as simple hypertrophy; they are either the result of diffuse catarrhs or of affections of the accessory cavities, the discharge from the latter keeping up a constant irritation of the mucous membrane of the middle turbinate. Simple hypertrophy is only of interest as the beginning of the later stages in which the periosteum and bone are involved.

The histological appearances in this stage, as also in the more advanced, are fully described by the author.

2. *Deep Inflammation of the Middle Turbinate (Inflammation of the Medullary Substance).*—In this stage the infiltration extends to the glandular layer, the periosteum, and medullary spaces, which it more or less fills.

Clinically, this stage includes cases of marked polypoid degeneration, and the majority of those in which hypertrophy has been associated with empyema or with polypi; deep inflammation may be present, however, without any apparent external indication.

From the examination of three cases of deep inflammation of the middle turbinate—in which œdematous vegetations resembling polypi were found on the concave side, while the ordinary form of dense hypertrophy was present on the convex side—the author holds that there is no essential difference between dense hypertrophy and œdematous hypertrophy, which is the structure of polypi.

In deep inflammation of the middle turbinate, the periphery, therefore, is first affected, and subsequently the medullary spaces. The opposite view, viz., that the tissue proliferates from within the medullary spaces, is disproved by the fact that here and there the mucous membrane on the surface has undergone œdematous hypertrophy, while no trace of inflammation can be detected with the microscope in the spongy spaces.

3. *The Implication of the Bony Parts of the Ethmoidal Labyrinth.*—This may be manifested in two ways, viz., by new formation (six cases), and by absorption (three cases).

(a) The new formation of bony substance results from the congestion of the periosteum and consequent formation of osteoblasts. The new bone is deposited diffusely or in circumscribed projections. In the same way bony substance may be developed in the medullary spaces, leading sometimes to their narrowing. These changes are not always recognizable on making a microscopic examination. It is not invariably the voluminous middle turbinates that are most affected. Only in those cases in which thin spinous processes are formed is the resistance to probing deficient, and a crackling produced.

The new formation of bone takes place at different spots on the same preparation to different degrees. In two middle turbinates the author found all the stages, from superficial inflammation to deep inflammation and new formation of bone, proving that the inflammation begins on the surface.

(b) *Rarefying Osteitis.*—In three middle turbinates which presented the symptoms of deep inflammation, marked bony absorption was observed.

Numerous osteoclasts appear in Howship's lacunæ, and the bony trabeculae become eroded and gradually thinner. These changes may advance so far that the trabeculae are broken down into irregular loose pieces. In this way the bony foundation of the turbinate may come to be made up rather of a number of loose fragments than of a connected bony framework.

In most of the specimens new formation of bone and absorption changes were found going on side by side, sometimes the one predominating, sometimes the other. It is difficult to explain with certainty why hyperplasia chiefly takes place in one case and absorption in another: possibly, the former may be due to the congestion of the periosteum, while the latter may follow the stagnation caused by

compression of the veins by the inflammatory infiltration. The final result will depend upon the predominance of the one or other factor.

If we now consider the clinical picture presented by Woakes—the thickening of the middle turbinate, the appearance of bony plates which offer but slight resistance, and the subsequent growth of polypi—it must be said that this observation, as such, is not at all remarkable, for it corresponds to the changes described above.

The term “necrosing ethmoiditis” is inadmissible, however, for two reasons:—

1. Because the presence of friable bony plates does not always indicate a necrosis, this quality of friability belonging also to bone which has become thin by absorption, and to newly-formed bony plates. 2. Because the term does not characterize the nature of the affection; the necrosis being merely one of a series of changes, it is never to be regarded as the cause, but as one of the consequences, of the deep inflammation. If a term is necessary, “ethmoiditis profunda” would be much more suitable.

V. *Examination of Polypi and their Bony Attachments.*—The examination of the bony attachments of twelve polypi yielded essentially the same result as in the hypertrophied turbinates. In five of the polypi nothing abnormal was observed at the bony insertions, excepting in those specimens in which the periosteum had undergone cellular infiltration. At three of the attachments there was hyperplastic bone formation, while in some situations there was young bone, *i.e.*, large bony cavities with relatively scanty substance between, and with numerous osteoblasts; in three preparations, however, there were distinct signs of absorption.

The author compares his results with Martin's, Luc's, and Zuckerkandl's, with all of which they partly agree.

He then points out that what he has stated proves rarefying osteitis and hyperplastic bony change to be merely accessory and secondary conditions in the development of polypi. A polypus is merely an œdematous hypertrophy of the mucous membrane, in which, as also in the firm hypertrophies, the process is either confined to the superficial layers or passes more deeply. Woakes's theory that necrosis is the cause of polypi is a mistake. That writer deserves, nevertheless, the credit of having given an impulse to the study of polypi and of the pathological anatomy of the ethmoid, and of having added considerably to our knowledge of these subjects by his publications.

The article is illustrated by beautifully executed drawings of microscopic sections.

A. B. Kelly.

Hamilton, T. K. (Adelaide).—*A Case of Bilateral Empyema of the Frontal Sinus.* “Australasian Medical Gazette,” May 20, 1896.

A WOMAN, aged thirty-six, had experienced pain over the left frontal region for two years. Six months previously an abscess was opened under the orbital arch; since then a fistula had persisted. Bare bone was felt on the floor of the sinus. In the middle line above the root of the nose there was a puffy swelling, pressure upon which caused pus to flow into the right middle meatus, but none into the left. Both nasal cavities were normal. Empyema of both frontal sinuses was diagnosed. A median incision was made, commencing below the glabella and passing upwards for two inches, the periosteum was pushed aside, and the trephine (half-inch) applied at the point where a line on a level with the upper margins of the orbits intersects the median vertical line. Both sinuses were thus exposed, and contained granulations and pus. After thorough curetting, the walls of the cavities were carefully examined and a large mass of dead and partially loosened bone was found on each floor and removed. These sequestra

represented considerable portions of the orbital plates. The infundibula were then cleared, and a piece of drainage tube extending from the external wound to the nasal orifice was introduced. The operation was followed by complete and permanent relief from pain. On the third day, in order to allow perfect union of the margins of the wound to take place, the drainage tubes were withdrawn from the wound, the ends being pulled down into the sinuses under each orbital arch, and tied in as before. Daily irrigation was the only treatment afterwards employed, and when all discharge had ceased for about a week the drainage tubes were removed. Three days later, when the patient was exhibited, the central wound had united and the opening above the right sinus had closed. That above the left still remained open, and by syringing through it, fluid could be readily made to pass down both nostrils.

A. B. Kelly.

Hansell, Howard F. (Philadelphia).—*A Case of Acute Loss of Vision from Disease of the Ethmoid and Sphenoid Cavities.* "Med. and Surg. Reporter," July 25, 1896.

A LAD, aged seventeen, awoke one morning with severe frontal headache and an almost absolute loss of vision. He had gone to bed the night before in his usual health, free from any disturbance of sight. During the week following the onset of the attack his vision became worse and his mental powers somewhat dulled, but the excruciating headache passed off.

On examination of the eye, dilated pupils which were unresponsive to light, punctate hyalitis, and œdema of the retina with detachment towards the periphery were detected. In the absence of an assignable cause for the ocular and cerebral œdema the condition of the nose was investigated. It was found to be completely blocked anteriorly by greatly swollen turbinals, while posteriorly muco-pus flowed from the choane. On further examination pus was observed to issue from the superior and middle meatuses of both sides, and from the upper and back part of the left fossa; the maxillary and frontal sinuses proved to be normal. The disease was diagnosed as acute purulent inflammation of the anterior and posterior ethmoidal cells on both sides, and of the left sphenoidal sinus. Atropine internally, with appropriate local treatment of the intranasal congestion, quickly caused the inflammation to subside.

Notwithstanding the nasal treatment whereby a cure of the ethmoidal and sphenoidal disease was effected, the improvement in vision has been slight. The fields have gradually enlarged and now include the unbroken periphery, in which light projection has returned, and the fingers can be counted on the temporal sides, but a large central scotoma persists. The pupils have become responsive to light. The optic nerves have markedly atrophied and the retinae degenerated.

The author thinks the least unsatisfactory explanation of the ocular complication is that of a localized meningitis, accompanied by marked swellings and œdema of the periosteum covering the body of the sphenoid, induced by purulent disease of its cells through contiguity of tissue.

It is worthy of note that in this case the symptoms common to ocular involvement in disease of the nasal cavities were in large part absent.

A. B. Kelly.

Herck.—*Note on the Treatment of Abscess of the Septum.* "Archiv. Internat. Laryngol., Rhinol., Otol.," July-Aug., 1896.

To prevent closure of the incision, the author recommends that loops of horsehair be introduced, reaching the deepest part of the cavity. These may be withdrawn one by one to permit of healing and obliteration of the cavity. Strips of gauze are apt to be expelled prematurely.

Ernest Waggett.

Knight, C. H.—*Supplementary Note on a Case of Martin's Bridge for Depressed Nose.* "New York Med. Journ.," Dec. 19, 1896.

THIS note concludes the report of a case which was eminently satisfactory at first, but in which cicatricial contraction of the nares demanded operative measures in the author's absence, and the patient was given a vulcanite tube to keep the passage patent. This tube was used by the patient himself, and by the force used not only displaced the bridge, but caused it to ulcerate through the skin. The author proposes further treatment, and notwithstanding these unexpected troubles maintains his confidence in the method in proper cases. *R. Lake.*

Krebs, G. (Hildesheim).—*Remarks on the Exploratory Puncture of the Maxillary Sinus and the "Serous Affection" of this Cavity.* "Archiv für Laryng. und Rhinol.," Band 4, Heft 3.

1. THE author inquires whether the exploratory puncture of the antrum of Highmore is quite harmless. The procedure is employed chiefly in cases of nasal suppuration, in order to discover the source. Asepsis in the nose being impossible, a healthy antrum may become affected. A number of cases in which operative measures in the nose have led to suppuration in the antrum have been described, although there is no instance on record, to the author's knowledge, in which exploratory puncture of the antrum led to its infection. He regards as suspicious, however, the reference of Noltenius to "an almost clear serous fluid which subsequently became cloudy and then purulent"; also Grünwald's statement that in some cases he explored the antrum four times before he found pus. Grünwald holds that exploratory puncture with a negative result proves nothing. The author, on the other hand, points out that in antral empyema, pus is always present in the cavity, so that when exploratory puncture yields a negative result we have conclusive proof that the antrum is unaffected.

2. While surgical principles point to the inferior meatus as the proper place for perforating when we have the treatment of the antrum in view, the author reminds us that for exploratory purposes the middle meatus is better suited, owing to the thinness of the wall.

3. In consequence of frequent trial puncture, a new form of disease has appeared—the "serous affection" of the antrum, as described by Noltenius. Since the publication of this writer's paper, the author has found serous contents in the antrum in two cases. In both there was empyema of the frontal sinus of the same side. As none of the subjective or objective symptoms could be attributed to this "serous affection," it was not treated. In both cases, after a week, the antrum was again punctured, and found empty. In one of the patients this procedure was repeated a year later, with a similar negative result. These cases do not explain the significance of the temporary collection of serous exudation in the antrum; they show, however, that the disease does not call for any operative interference. *A. B. Kelly.*

Makuen, G. Hudson (Philadelphia).—*An Unusual Alveolar Abscess, with Antral Complications.* "Med. and Surg. Reporter," July 25, 1896.

A MAN, aged forty, consulted the author in regard to pain in the gum covering the buccal surface of the first molar tooth of the upper jaw on the left side. The teeth were healthy; there was slight redness at the seat of pain.

A week later a scanty discharge of thin pus appeared from beneath the gum along the tooth. Under the supposition that the pulp at the apex of the root was diseased the tooth was opened, but found to be healthy. It now appeared

that there was an abscess external to the tooth substance, probably situated at or near the bifurcation of its roots. The crown of the tooth was therefore drilled through, but no collection of pus was discovered.

Subsequently, when exploring the seat of the trouble, the probe passed into the antrum. The inflammation now rapidly extended upwards, and within three days there was acute inflammation of this cavity, the left nasal fossa, and post-nasal space. In spite of syringing the antrum from the alveolus, the inflammation became very severe, so that the affected tooth had to be removed. A small pus sac was then found in the peridentium of the inner margin of the anterior buccal root, about midway between its apex and base. The sac was so insignificant that at first it was not regarded as the sole cause of the disturbance, but on further examination the tooth was found to be quite healthy excepting at this small spot, while no disease was found in the alveolar cavity. Further, the discharge from the cavity ceased, and within three days the antral inflammation subsided and the patient was practically well.

A. B. Kelly.

Martin, E. D.—*A Case of Sarcoma of the Superior Maxilla, with Complete Relief of Deformity by Artificial Apparatus.* "New Orleans Med. and Surg. Journ.," July, 1896.

A PHOTOGRAPH is given of the excellent appearance obtained by means of a suction palate-plate, bearing teeth, together with an addition to fill the large cavity left after removal of a considerable portion of the superior maxilla.

Ernest Waggett.

Maxwell, P. W.—*The Effects of Nasal Obstruction on Accommodation.* "Brit. Med. Journ.," Sept. 26, 1896.

THE ocular defect produced was accommodative asthenopia, sometimes complicated with a secondary blepharitis. Five cases were recorded in which nasal treatment had relieved the defect. In the author's opinion habitual mouth-breathing was of more importance than the nasal condition itself.

Dr. RAYNER BATTEN considered that nasal conditions were responsible for myopia as well as impaired accommodation, and described fundus changes often associated with nasal disease apart from actual obstruction. He considered the asthenopia to be probably mainly congestive, and stated in support that during forced expiration, with nasal obstruction, slight myopia occurred, and slight hypermetropia on inspiration. Compression of the veins of the neck also produced myopia.

Ernest Waggett.

Moure, E. J. (Bordeaux).—*The Pathology and Treatment of Deviations and Spurs of the Nasal Septum in Young Children.* "New Orleans Med. and Surg. Journ.," July, 1896.

ALTHOUGH, as Zuckerkandl has stated, true septal deviations do not commence to develop until the age of seven—that is, at the time of the evolution of dentition—yet in children below that age septal deformities are to be found. The author believes these to be due to luxation, by traumatism, of the cartilaginous septum from the shallow groove in the superior maxilla into which it fits, complicated by subsequent thickening. Such a luxation can be readily produced experimentally in the cadaver. The deformity may be such that while the luxated end obstructs one nostril, the other nostril may be occluded by the convexity of the bent cartilaginous septum.

Although this variety is due to falls and blows, traumatism plays a purely secondary and accessory rôle in deviations developing in the course of the evolution of the superior maxilla, *i.e.*, in children over seven. In the cases of simple luxa-

tion the septum may be forcibly replaced, or gradually brought into position by the *redresseurs* devised by Delstanche. This treatment may require several months, but gives very satisfactory results.

Where the dislocation is complicated by antero-posterior fracture of the cartilage, with consequent spur-like ridge and corresponding groove, the *redresseurs* are useless. Surgical removal of the ridge must, however, be undertaken with great hesitation, necessitating as it does a weakening of the support on which the contour of the organ depends, at a time when evolution is taking place and when the support is most needed. The author says that, in spite of the greatest precautions, he has almost always seen, after a year or two, the cartilage continue to sink and the respiratory difficulties to reappear. Rather than interfere with the ridge it is sometimes preferable to obtain permeability by perforating the deflected septum.

Ernest Waggett.

Moure, E. J. (Bordeaux).—*The Influence of Disease of the Nose and Accessory Cavities on the General Health.* "New Orleans Med. and Surg. Journ.," July, 1896.

IN speaking of hypertrophic rhinitis and ozoena in relation to general health, the author draws attention to the frequent co-existence of atrophic rhinitis with tubercular disease. The enlargement of the nasal cavities, and especially their cutanization, would appear to permit of the penetration of the tubercle bacillus into the respiratory passages. Attention is called to the adenoidian appearance of children affected with nasal spurs, but with no post-nasal growths. Disease of the accessory sinuses may be responsible for the recurrent attacks of erysipelas so frequent in women at the catamenial period. The sinister import of a foetid suppuration—such as a maxillary empyema—is greatly enhanced by any general illness. It constitutes a focus of septic disease capable of inoculating other points in the organism when the latter is depressed by fatigue or general trouble.

Ernest Waggett.

Mulford, H. J.—*Therapy in Acute Rhinitis.* "Amer. Med. Surg. Bulletin," Nov. 21, 1896.

THIS is a protest against the classical treatment of cold in the head.

Acute rhinitis is due to the accumulation in the blood of the products of tissue waste. This is brought about in two ways: (1) there is produced a local retardation of cell activity, as a result of which there are thrown into the circulation the products of a faulty tissue chemistry; (2) through the nervous system the function of remote organs—chiefly liver and kidneys—is interfered with and lessened. Urea, uric acid, and other by-products of tissue change, accumulate in the blood and irritate by their presence, as also by their reducing the alkalinity of the blood.

The treatment, then, is obvious: calomel or podophyllin to stimulate hepatic activity; alkalis—such as lithia, sodæ bicarb., etc.—to "overcome the condition of the blood"; and a free supply of water, to set the kidneys going. Pilocarpin would be an ideal drug, were it reliable; but its action is not always sure, especially when given by the mouth.

Lithæmic rhinorrhœa often simulates acute rhinitis, clinically. Examination of the nose, however, will clear up the diagnosis. This is a diathetic condition; consequently, special attention must be paid to treatment of the diathesis.

A. J. Hutchison.

Palazzolo, N.—*Leech in the Larynx removed through the Mouth.* "Bollet. delle Malatt. dell' Orecchio, etc.," Nov., 1896.

THE case was one of a large *hemopsis verax* implanted on one of the ventricles and successfully removed with laryngeal forceps. The author comments upon the

frequency of such accidents in Sicily, for of sixteen Italian cases thirteen belong to the island. The leech remained in the larynx for ten days. *Massei.*

Pyncheon, E. — *Dobell's Solution.* "Ann. of Ophth. and Otol.," Oct., 1896.

THE author has collected the following twenty-one solutions, giving their source. No. 14 is the original solution, but he himself uses No. 1, using the following prescription: $\zeta j.$ to $Oj.$ of water. $\mathfrak{B}.$ Sod. bibor., sod. bicarb., $\bar{a}\bar{a}$ $\zeta ij.$; listerine Oss., glycerine $Ojss. m.$

FORMULÆ FOR DOBELL'S SOLUTION AS GIVEN BY VARIOUS
AUTHORITIES.

	Sodæ, Bibor.	Sodæ, Bicarb.	Acid, Carbolic.	Glycerine.	Water.
1	Grs. 30	Grs. 30	Grs. 15	Drm. 4	Pt. 1
2	32	32	16	8	1
3	32	32	16	16	1
4	32	32	16	$21\frac{1}{3}$	1
5	40	40	32	8	1
6	60	30	12	16	1
7	60	60	45	8	1
8	60	60	45	...	1
9	71	71	14	14	1
10	78	78	21	4	1
11	96	96	38	$2\frac{1}{2}$	1
12	96	96	32	$5\frac{1}{3}$	1
13	116	116	23	$4\frac{1}{2}$	1
14	120	120	48	$3\frac{1}{5}$	1
15	120	120	24	4	1
16	120	120	24	8	1
17	120	120	24	...	1
18	127	127	27	$6\frac{1}{2}$	1
19	240	240	80	14	1
20	240	240	120	14	1
21	480	480	180	29	1

R. Lake.

Thelwall, Thomas.—*Exostosis of Frontal Sinus.* "Brit. Med. Journ.," Oct. 17, 1896.

A REPORT of a case in a woman of forty-six, who ascribed the trouble to a blow thirteen years previously. The growth was an ivory exostosis springing from the inner wall and herniating into the orbit. Dura mater formed the roof of the sinus. *Ernest Waggett.*

LARYNX.

Biaggi, C.—*Some Considerations on so-called Eunuch's Voice.* A Paper read before the Lombard Medical Association, May 30, 1896. "Bollet. delle Malatt. dell' Orecch.," Oct., 1896.

DUE to some change or arrest of development of the larynx at the period of puberty, the voice retains its infantile character, or presents alterations more or