by X-ray. The inner half of both eyelids on the right and the inner third of both eyelids on the left were removed, and nothing was left of the nose except half the tip and the rim of the right nostril. Extensive grafting by spiral flaps from the cheeks was done, and the case healed well by first intention. The author specially calls attention to the method of using a spiral incision in the flabby part of the cheeks to obtain flaps.

Macleod Yearsley.

LARYNX.

Broeckaert, Jules.—*The Operation of Election for Exposure of the Superior Orifice of the Larynx; Sub-hyoid Pharyngotomy with Temporary Resection of the Body of the Hyoid Bone.* "La Presse Oto-laryngologique Belge," December, 1904.

The author finds that when the tumour to be removed is extensive, the operations usually performed do not give a sufficiently free exposure. In trans-hyoid pharyngotomy, moreover, there is the additional disadvantage that it is difficult to readjust the halves of the hyoid bone at the conclusion of the operation, without leaving some deformity.

By temporary resection of the body of the hyoid bone, during the performance of sub-hyoid pharyngotomy, it is claimed that an excellent view can be obtained of the whole region to be dealt with. The author's procedure is described at length, together with valuable observations upon the after-treatment.

Chichele Nourse.

Revol, L. (Lyons).—*A Case of Bilateral Paralysis of the Recurrent Laryngeal Nerves.* "Annales des Mal. de l'Oreille, du Larynx, du Nez et du Pharynx," February, 1904.

A man aged fifty-eight, a mattress maker, was admitted to hospital suffering from aphonia. Family history good. He was a chronic alcoholic and had indulged very freely in smoking in his early days. No history of syphilis. At various periods he had suffered from rheumatism, influenza and pleurisy. When seventeen years old he was troubled with pseudo-anginal attacks, considered to be due to tobacco toxæmia; these left him at the age of forty-five, when he ceased smoking. Four months previous to entering hospital he experienced violent pains in the right side, which were constant night and day, and were neither influenced by breathing nor coughing. Shortly afterwards he awoke one morning to find his voice gone.

He had never experienced any suffocative attacks. An examination of the lungs revealed harsh inspiration with prolonged and slightly blowing expiration; numerous rhonchi were in evidence; chiefly about the bases and under the left axilla. The supraspinous fossa of the right side was depressed, and there was evidence of induration there. Expectoration was sero-mucous and rather abundant, cough frequent, feeble and muffled, not barking in quality. The voice was equally weak and hoarse, but not bitonal. Dyspnœa was absent, save that of a pseudo character due to exaggerated expenditure of air which occurred during the attempt to speak. Tracheal tugging was absent. There was nothing particular to note about the cardiac area, no pulsations, no bruits, only a slight roughness of the first aortic sound. The pulse was regular, 88, tension feeble, no asynchronism. The radials were slightly hard and tortuous. The digestive functions were good, but patient complained of the sensation of arrest of food at the mid-thoracic region; no regurgitation or vomiting.

Laryngoscopic examination showed the cords to be fixed in the cadaveric position; the glottis was always open and resembled the form of an elongated triangle with slightly curved sides. During breathing slight movements of abduction and adduction were noticed, due to the passage of inspired and expired air. On attempting to phonate, the inter-cartilaginous glottis closed slightly, but the inter-ligamentous portion remained unaltered. There was no laryngeal vibration.

On subjecting the man to a radioscopic examination, an elongated shadow was visible on the screen transversely above the heart, passing to the right border of the sternum. An oblique examination proved the shadow to occupy the anterior mediastinum; the posterior was clear. Dr. Destot, who conducted this examination, diagnosed a cylindrical dilatation of the aorta occupying the ascending and transverse portions of the arch.

In January, 1904, the patient expired suddenly after a copious hæmoptysis, having previously experienced several slight attacks. In this case a diagnosis of bilateral recurrent paralysis was obvious; the difficulty lay in discovering the cause; here radioscopy came to the rescue and decided the question. The author strongly emphasises the value of this method of examination as an aid to diagnosis in these cases, and insists that it should never be neglected. *Clayton Fox.*

EAR.

Claoue, **R.** (Bordeaux).—*Two Cases of Voluminous Cholesteatoma.* "Archives Inter. de Laryngologie, etc.," November—December, 1904.

The first case, a boy, aged fourteen years, had aural polypi, accompanied by deafness and discharge.

Three years previously he noticed a discharge from the right ear, but with no pain or other symptoms.

His general health was good, the mastoid region was normal save for slight pain on pressure. After removal of the polypi the posterior wall of the canal was seen to be necrosed and a quantity of pus was found in the middle ear.

There was no facial paralysis, only a slight nystagmus, the pupils were equal and the retinæ normal. On making the usual retro-auricular opening the periosteum was found intact; the bone, however, was very thin, and on making an opening a cholesteatoma as large as a hen's egg was found invading the mastoid, the antrum and the attic. After clearing out the cavity it had the following measurements: height one inch; width, one inch and a quarter; length, two and a quarter inches; the dura mater was exposed for about half an inch. A fistulous opening in the semi-circular canal as well as one extending towards the jugular vein were curretted. The cavity was allowed to gradually fill in, two sutures finally closing the small fistulous opening left.

The other case presented no special features of interest.

Anthony McCall.

King, **Gordon** (New Orleans).—*Some Manifestations of Influenza in the Ear and Upper Air Passages.* "New Orleans Medical and Surgical Journal," January, 1905.

The author discusses nasal and aural complications in influenza and illustrates the former by a case of polysinusitis. *Macleod Yearsley.*