scar in the neck. Since this the left vocal cord has become paralysed, but there has been no sign of returning disease until the last few weeks, and now several nodules have appeared in the scar along the clavicle and in the posterior triangle. There is also a large nodule which has commenced to ulcerate over the carotid sheath close to the angle of the jaw. An expression of opinion is sought as to whether any further attempts should be made to remove the disease.

The patient is presented in conformity with the recommendation of the Council of the Section that the after-history of cases shown in the past should be recorded.

The PRESIDENT: I think it would be well to excise the outlying nodules, which are all quite small. It must be a chronic type of case. If the ulceration can be stopped, a great advantage will be gained. Are there any signs of secondary growths anywhere?

Mr. SCOTT: None, so far.

A Post-mortem Specimen of a Temporal Bone from a Case of Cerebellar Abscess.—W. M. Mollison.—The left temporal bone from a patient who died with a cerebellar abscess which gave rise to no symptoms. The posterior surface of the petrous bone shows a small collection of pus lying in the pocket of dura mater over the meatus vestibuli.

Dr. H. BANKS DAVIS exhibited Anatomical Specimens of the Petrous Bone.

Abstracts.

PHARYNX.

Excision of the Retro-pharyngeal Gland.—Norman Patterson. "Lancet," 1917, vol. i, p. 487.

Describes two cases and mentions a third, in which the author has performed this operation. He states that nearly all cases of retro-pharyngeal abscess in children especially, are due to suppuration taking place in one of the two retro-pharyngeal glands.

The operation is described. *Macleod Yearsley.*

Pharyngeal Pouches.—N. S. Finzi. "Proceedings of Royal Society of Medicine," February, 1917. Section of Electro-Therapeutics, p. 33.

The author is concerned only with the radiographic examination, appearances, and diagnosis of these cases.

The method used is the administration of a thick paste of bismuth oxychloride and water of such a consistency that, when heaped up, it has practically no tendency to flow back to its level.

The fluorescent screen examination of these cases is most important, as they may be very difficult to distinguish from stricture unless it is seen how the bismuth leaves the pouch. A pouch can be observed to fill, and when full, the bismuth passes into the œsophagus, going past the upper end of the pouch with ease, but being held up lower down in those cases in which the pouch is big enough to press on the œsophagus: in some cases the pouch can be observed to empty into the œsophagus when the patient contracts the neck muscles.

On the other hand in stricture the bismuth passes, if the stricture is not complete, from the lower end of the dilated portion of the gullet. The author finds that when the pouch does not extend into the thorax a true lateral view gives a far better picture than the oblique antero-lateral view, though the latter is always useful. A posterior or an anterior view must also be taken, the former usually giving the clearer picture. He always examines the patients standing up.

What a pouch generally has to be distinguished from is a malignant stricture, but a fibrous stricture may also simulate a pouch; a spasmodic stricture is unlikely to occur in this position.

The cardinal difference between a pouch and any form of stricture, however, is the fact that the former must empty from its upper and the latter from its lower end, and this can generally be made out by a careful screen examination on the lines indicated.

A carcinomatus stricture is usually conical in shape, and has not the bulbous appearance seen in the case of a pouch.

A fibrous stricture may be more difficult to distinguish though it is fortunately rare in this situation. The stricture is likely to give a conical lower end to the bismuth shadow.

If the pouch were so large as completely to obstruct the œsophagus either directly or as the result of inflammation or adhesions, the diagnosis might be extremely difficult. One of the author's cases was very near to this condition, and the patient had, in fact, had a gastrostomy for three years before his pouch was diagnosed and removed.

Archer Ryland.

EAR.

Modified Radical Operation for Chronic Suppurative Otitis Media.—H. B. Blackwell. "Annals of Otology," xxv, 908

Paper based on eight cases. Purpose, to cure discharge *and conserve hearing*. The operation consists of: (1) Usual post-aural incision. (2) Usual opening of antrum. (3) Widening of antrum and lowering of posterior bony wall. (4) When short process of incus seen, external attic wall removed. (5) Further lowering of posterior bony wall till facial ridge reached. (6) Necessary curetting of granulations, etc., care being taken not to injure suspensory ligament of malleus or its external lateral ligament. Drum and ossicles are left *in situ*. (7) L-shaped flap cut and sutured to temporal fascia. Antrum and attic region plugged; posterior wound sutured.

[It may be supposed that in the near future no otologist will perform the classical radical mastoid operation in every case. The growing sense of responsibility in the conservation of function will lead him to modify his operation to that end whenever he can do so without danger to his patient.—M.Y.] *Macleod Yearsley.*

Syringomyelia with Vestibular Symptoms.—G. E. Shambaugh. "Annals of Otology," xxv, 891,

This case is fully described. The diagnosis of syringomyelia rested upon a long-standing disturbance of sensation of temperature, marked disturbance to pain, and much less marked disturbance of sensation to touch. The nystagmus in the case probably depended upon an extension of the syringomyelic process up into the region of the fourth ventricle (syringobulbia). *Macleod Yearsley.*

Involvement of the Labyrinth by way of the Ductus Endolymphaticus. —**N. H. Pierce.** "Annals of Otology," xxv, 881.

The author has met with two cases in five years. These are described. All recovered. The author concludes that the duct may be involved more frequently than is supposed in acute softening processes of the mastoid and that the region of the saccus should be explored preferably to opening the bony labyrinth. *Macleod Yearsley.*

MISCELLANEOUS.

Endothelioma of the Right Bronchus Removed by Peroral Bronchoscopy. —**Chevalier Jackson** (Pittsburg). "Amer. Journ. Med. Sci.," March, 1917.

The patient was a clerk, aged thirty-five, whose illness had begun five years previously with a "heavy cold." He complained of wheezing and a feeling of compression in the right side of his chest, also of a sensation as of a ball valve suddenly shutting off sometimes inspiration, and at other times expiration. Hæmoptysis had occurred on several occasions. He had spent two years in a sanatorium for the tuberculous, but no tubercle bacilli had been found in the sputum. X-ray examination showed opacity of the lower lobe of the right lung continuous with the hepatic opacity. Physical examination pointed to obstruction of the right main bronchus. By a process of exclusion the diagnosis was reached of pedunculated intra-bronchial growth. Bronchoscopy, under local anæsthsia, showed a tumour of slightly nodular shape with smooth shining surface almost filling the dilated right main bronchus, and attached to the right wall of the latter just above the orifice of the middle-lobe bronchus. The growth was immediately removed with cutting forceps and the patient was well in a week, and had, when the report was published, been in good health for nine months. Microscopic examination showed the growth to be an endothelioma with evidence of malignancy. The author concludes that diagnostic bronchoscopy is indicated in cases of "monolateral asthma," bronchial obstruction, and in cases regarded as tuberculous when persistent search fails to reveal tubercle bacilli; and that peroral bronchoscopic removal of an endobronchial tumour is feasible under local anæsthesia, and may be justifiable in a malignant endobronchial growth if small, circumscribed, and not ulcerated. As this is the only recorded case of apparent cure of an endothelial endobronchial tumour by peroral bronchoscopy, and only the second endoscopic removal of any form of malignant growth from a bronchus, the author deprecates too many or too sweeping deductions. He adds that one and a half years have now elapsed since the operation, and the patient is in perfect health without expectoration or any other symptom. *Thomas Guthrie.*

OBITUARY.

ALFRED JOHN MARTINEAU, Major, R.G.A., F.R.C.S.(Ed.), M.R.C.S., L.R.C.P.(Lond.).

READERS of this Journal will regret to hear that Major Martineau was killed in France on April 17, shot by a sniper, whilst doing reconnaissance work in connection with his battery.

The youngest son of the late Judge Martineau, he was born in 1873, and was educated at University College School and St. Thomas's