that with the excitement of examination and strange surroundings. He advised arsenic, strychnine, and digitalis, and rest—mental and physical. He thought the iodide should be discontinued, for patients with exophthalmic goitre did not seem to tolerate the drug well.

Dr. BURT said he had kept the patient perfectly quiet, had forbidden tea, coffee, etc., all games, and everything tending to excite her.

Abstracts.

NOSE AND ACCESSORY SINUSES.

Goris, C.—*Technique of the Surgical Treatment of Chronic Sphenoidal Sinusitis.* "La Presse Oto-Laryngologique Belge," April, 1903.

In some preliminary remarks the author mentions three conditions especially demanding surgical measures: (1) Optic perineuritis, due to extension of inflammation from the external wall of the sinus; (2) retrobulbar abscess; (3) violent and continuous occipital pain, due to retention of pus in the sinus.

He then describes an operation of a radical character which he has performed fifteen times. The patient being deeply under chloroform, with the head turned towards the operator, his mouth is opened widely by Whitehead's gag, while the operator passes his index-finger through the naso-pharynx into the posterior nares. The middle turbinal body is then removed by means of Doyen's forceps for turbinectomy, guided by the finger, which also serves as a plug to prevent the blood, which flows rather freely, from entering the air-passages. A blunt-ended rugine is next used to break through the anterior wall of the sphenoidal sinus, after which its inferior wall is resected with Grunwald's punch forceps, still under the guidance of the finger.

A careful curetting of the sinus terminates the operation, which takes only three or four minutes altogether.

A strip of sterilized gauze is retained in the sinus for forty-eight hours. Generally there is no need of further after-treatment, but the application of topical remedies is now easy.

In those rare cases where fœtid suppuration persists, one of the causes is the unusual thickness of the inferior wall, which cannot be removed with Grunwald's forceps. The author then temporarily resects one nostril and separates the soft parts from the ethmoid, which he removes. By the help of a good light the sinus can then be seen, and its inferior wall resected with the gouge. *Chichele Nourse.*

Menzel, K. M.—*Treatment of Insuction of the Alæ Nasi.* "Münch. Med. Woch.," May 5, 1903.

The author discusses the causes and the consequences of alar collapse in the light of the teaching of Moritz Schmidt. He enumerates the various methods of combating it, according as the condition is

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transitory or permanent. In the transitory cases, as in those of temporary weakness due to enfeebling constitutional disease, the various dilators are recommended. In the irreparable cases he advises operative treatment. He describes Josef's method of stitching a wedge-shaped portion, cut from the septum, to the point of the nose. [He makes no reference to Walsham's ingenious plan of detaching a flap from the interior of the vestibule, rolling it up, and stitching it in such a position as to keep the anterior part of the ala away from the septum. —D. G.] The method which he most strongly recommends is that of the subcutaneous injection of paraffin, at a melting-point of 46° C. (114·8° F.), so as to give firmness and solidity to the ala. He had satisfactory results in two cases of bilateral insuction. In one of the alæ there occurred a contretemps [which one would naturally be prepared to expect—D. G.], namely, that the paraffin caused a bulging of the soft tissues into the vestibule, and thereby tended to defeat the object desired. This was, however, removed by means of an incision, and the ultimate result was quite satisfactory. *Dundas Grant.*

ŒSOPHAGUS.

Starck.—*The Etiology of Diffuse Dilatation of the Œsophagus (from the clinical point of view).* "Münch. Med. Woch.," May 12, 1903.

The following are the possible causes: (1) Primary inflammation of the mucous and muscular coats of the œsophagus, (2) cardiac spasm, (3) muscular atony, (4) developmental abnormalities. It is only in the early stage that the etiology of this dilatation can be studied, because post-mortem examinations show merely the sequential appearances. Spasm of the cardiac orifice, if found post-mortem, may only have occurred at the time of death. Further, fatty degeneration of the muscles may have resulted simply from the interference with nutrition. It can, however, be decided, if hypertrophy of the muscular coat has taken place, that the dilatation has not resulted from primary atony. No conclusions as regards etiology can be drawn from the clinical features when dilatation has already reached any considerable advance, as spasm of the cardia may be present at one time and absent at another; the only clearly defined form is diffuse spasmogenic dilatation, and the spasm of the cardiac orifice is apparently the result of some nervous mechanism acting through the vagus. *Dundas Grant.*

Wolf (Dresden).—*Contribution to the Etiology of Carcinoma of the Œsophagus.* "Münch. Med. Woch," May 5, 1903, p. 771.

The author enumerates the various mechanical causes mentioned by various authors as leading to carcinoma of the œsophagus, and in this paper he draws special attention to its association with spondylitis deformans, in illustration of which he narrates two cases seen by himself and a third in the practice of Professor Orth. He looks upon the chronic irritation caused by the presence of spondylitis as being the intermediate etiological factor. *Dundas Grant.*

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