LARYNX, Etc.

Hödemoser, Dr. C.—*Primary Sarcoma of the Larynx.* "Monatschrift für Ohrenheilkunde," June, 1902.

A man of fifty-seven complained of rawness and dryness of the throat. He became hoarse and, shortly after, aphonic. Dyspnœa set in, and his breath became fœtid. There were no swollen glands. On examination, the interior of the larynx was found to be completely hidden by a reddish-gray, uneven, cauliflower growth, ulcerating here and there, and covered with icterous secretion. The left side of the larynx was fixed. The surface of the tumour felt softish, but its deeper parts were very hard. Microscopic examination showed the growth to be a round-celled sarcoma. Constitutional symptoms were much less marked than the local appearances would have led one to have expected. *William Lamb.*

Lorthioir.—*A Clinical Lecture upon the Treatment of Croup and Diphtheria.* "La Presse Oto-Laryngologique Belge," February, 1902.

After a reference to the value of antidiphtheritic serum, the risks entailed by the use of an impure serum or by neglect of antiseptic precautions are alluded to. An injection given under bad conditions nearly always causes fever and sometimes leads to accidents, such as abscess, or even to embolism or infarcts; on the other hand, if carried out with good serum and with the strictest antiseptic precautions elevation of temperature never occurs. It is recommended that the serum should be preserved in hermetically sealed glass tubes, which can be sterilized externally with alcohol and sublimate solution before breaking off the neck, so that the operator runs no risk of contaminating his hands. Moreover, the absence of cloudiness in the liquid can thus be noted beforehand at a glance.

If threatened asphyxia calls for surgical interference, intubation is the operation of selection in all cases. The operator is, however, advised to have everything at hand requisite for tracheotomy should it be required. The chief accident to be dreaded is blocking of the tube by a piece of membrane at the moment of introduction. A case is cited in which this occurred: tracheotomy was immediately performed, and a large piece of membrane was expelled through the tracheal cannula.

Dr. Lorthioir advises that intubation should be done under light chloroform anæsthesia. The tube should not be left in place longer than forty-eight hours for fear of causing ulcerations of the trachea, and sometimes it is necessary to change it after twenty-four hours, replacing it by one of a different size, according to the indications.

The short tubes of Bayeux are easily removed by expression. The child is placed in the same position as for intubation, but no gag is needed. The operator steadies the patient's head with his left hand, while his right thumb, pressing firmly on the front of the trachea a little lower than the cricoid cartilage, moves from below upwards. A slight retching effort on the part of the child indicates that the tube has passed into the pharynx, whence it is made to fall into a basin by quickly bending the head forward.

The rest of the lecture is occupied with the details of tracheotomy, and finally a few statistics. *Chichele Nourse.*

Mourrut.—*Rheumatoid Arthritis and Pseudo-Rheumatism of the Larynx.* "Archives Internationale de Laryngologie, d'Otologie, et de Rhinologie," July, August, 1902.

Dr. Mourrut believes that this condition is often overlooked, and, in addition to causing considerable functional disturbance, may lead to permanent impairment of the movements of the larynx.

It is often met with after influenza, and calls for prompt treatment.

Anthony McCall.

THYROID AND TRACHEA.

Olmsted, Ingersoll.—*The Operative Treatment of Goitre.* "Canadian Journal of Medicine and Surgery," October, 1902.

This is a report of twelve cases operated on. The average stay in the hospital was seven days, and the resulting scar slight. The operation advised is the one usually performed by Kocher, and is done under cocaine anæsthesia.

Operation is recommended when any of the following conditions occur: when danger arises from dyspnœa, inflammatory changes, or suspicion of malignancy; when the enlarged thyroid threatens to enter the thorax; when the goitre has reached considerable development from the formation of a single colloid node; when symptoms of the presence of Basedow's disease appear. *Price-Brown.*

ŒSOPHAGUS.

Hamilton, George.—*Removal of Foreign Bodies from the Œsophagus by an Improved Method of Using the Roentgen Rays.* "British Medical Journal," February 7, 1900.

The coin-catcher is passed down whilst the patient is seated on a chair, the Roentgen rays being placed behind him. In the case of a child aged two and a quarter years, who had swallowed a halfpenny five days previously, the following plan was adopted: The child was placed in the horizontal position on the canvas couch. When the tube was placed below the couch the halfpenny was seen behind the second piece of the sternum.

Under chloroform the coin-catcher was passed, and seen by means of the screen to go 2 to 3 inches beyond the coin. The hook was now carefully adjusted to the middle of the coin, when a rapid and successful extraction was effected. *W. Milligan.*

Riviere, Clive.—*Perforation of the Œsophagus by Tuberculous Glands.* "British Medical Journal," January 24, 1903.

The writer describes three such cases, the first occurring in a male child aged two years, the second in a male child aged ten months, and the third in a male child aged one year and eleven months.

In these three cases the gland (or glands) affected was situated below the bifurcation of the trachea. In two of the cases the gland had completely emptied its caseous contents, the cavity having a smooth wall, and apparently a mucous lining. The author is inclined to think that many cases of œsophageal diverticulum occurring in this situation are due primarily to tuberculous disease of the "bifurcation gland." *W. Milligan.*