

Taptas.—*Hypnotic Suggestion in a Case of Nasal Stenosis.* “Rev. Hebd. de Lar., Otol., Rhin.,” Jan. 29, 1898.

THE case of a woman of nineteen, the subject of chronic constipation, pelvic troubles, and nasal stenosis. Examination of the nose showed enlargement of the middle turbinates, particularly at the posterior extremity. The signs and symptoms of nasal stenosis and mouth breathing were present, and seemed to have existed for more than twelve months. Previous to the examination of the nose the patient had for several days been hypnotized, with a view of curing the constipation by suggestion. On the occasion of the nasal examination a further suggestion was made that the patient should breathe freely through the nose. After some resistance she obeyed, and after waking proved to be able to breathe quite naturally. Examination showed nasal patency to be due to considerable shrinking of the middle turbinates, which, of course, remained hypertrophied, particularly at the posterior end. The result was, no doubt, due to arterial constriction, due to vasomotor influences. The patient remained under observation ten days, during which time nasal breathing was maintained night and day. The author remarks that hypnotic suggestion may prove of real importance in the treatment of cocainomaniacs with nasal stenosis. *Ernest Waggett.*

LARYNX.

Barnick, Otto.—*Changes in Larynx and Trachea in Leucocythemia.* “Munchener Med. Woch.,” Nos. 19 and 20, 1898.

IN many cases of leucocythæmia the changes in the larynx and trachea are inconspicuous, or are of more pathological than clinical interest; on the other hand, marked dyspnœa, or severe coughing without physical signs in the lungs or heart, may be the first indication of this disease. Diffuse swelling of the laryngeal mucous membrane, or extensive lymphatic tumours, have occasioned tracheotomy. Laryngological text-books make little or no reference to this disease. Virchow and others have described small lymphoid tubercles on the inner surface of the epiglottis, the aryepiglottidean folds, and throughout the larynx and trachea. The pathological changes in the laryngeal and tracheal mucous membrane have been well described by Eppinger.

In the parts rich in glands, especially on the epiglottis and false cords, there occurs slight catarrh, with fine tuberculated swelling of the mucous membrane. On the processus vocalis and false cords a small ulcer may be seen here and there on the top of the tubercles, which seldom are larger than millet seeds; it resembles the well-known leukæmic ulcer of the intestine, and is characterized by a trough-shaped base and prominent, pale, soft edges. Apart from a large accumulation of white blood cells in the smaller and larger vessels and their surroundings, one sees the characteristic infiltration between the acini and ducts. These extravasations, in the form of small islands, composed of well-preserved white blood cells, well deserve the name of leukæmic infarctions. These extravasations on the surface may so stretch by their growth the epithelial covering that it exfoliates.

The soft membrana propria cannot long withstand it, and the cell masses are discharged into the gland ducts. The leukæmic process, whether infarction or ulceration, is characterized by the fact that the white blood cells remain uninjured, and never show a necrotic metamorphosis.

Ebstein and Mayer have reported cases where, owing to laryngeal stenosis from leukæmic infiltration, tracheotomy was required.

The author has observed three cases in Prof. Haberman's clinic in Graz. The first was a boy, thirteen years old. He was in hospital from June 25th to July 9th, 1892, with purpura; red blood corpuscles 2,562,000, hæmoglobin 45 per cent., no leucocytosis, enlargement of spleen, slight fever. On the 28th July he was readmitted for three days; slight hæmorrhage from gums and nose. September 13th, red blood corpuscles 1,800,000, white 17,000; treated outside with iron and arsenic. He was readmitted January 18th, 1893, with well-developed symptoms of leucocythæmia. On the 30th he had an attack of dyspnoea with noisy audible inspiration and barking cough, lasting for a quarter of an hour. Laryngoscopically, marked infiltration of the glottis, false cords much thickened and swollen. February 1st, rapid noisy respiration, voiceless, hoarse cough, death.

February 2nd, *post-mortem* by Prof. Eppinger. Larynx full of bloody mucus. Mucous membrane of epiglottis swollen, pale, and ecchymosed on the posterior surface; that of the false cords and sinus Morgagni is much swollen and infiltrated. Vocal cords are thickened; their mucous membrane likewise swollen, pale, and slightly granular; that of the subcordial space is in the same condition with ecchymoses.

Histological examination showed that the ciliated epithelium of the false cords was, on the whole, well preserved, although here and there single superficial cells were somewhat swollen and desquamated. Between the epithelial cells are leucocytes, mostly mononuclear; they are also found between the irregular polygonal prickle cells, and more numerous amongst the cells of the lower stratum. The blood vessels are greatly enlarged and contain numerous leucocytes, many of the capillaries being almost filled with them. Foci of infiltration are seen round numerous vessels. These appearances are less marked in the deeper layers. These changes are quite as characteristic in the mucous glands and their surroundings. Around each group, both on the surface and deeper layers, are a large collection of leucocytes, which follow the course of the interglandular connective tissue and project between the individual acini. The glands are wide and contain mucus and degenerated leucocytes. The glandular epithelium is swollen; single cells here and there have vacuoles, or are reduced by discharge of their contents to short granular-hemmed half-moons, in which the nucleus remains preserved. At the junction of the mucous membrane of the false cord and upper laryngeal space, and downwards in the sinus Morgagni, the changes are still more developed. On the projecting edge of the vocal cords the changes are slightly marked; in the deeper parts there is slight infiltration in the transversely striated muscular fibres. Here, also, it follows at first the small vessels, breaks through in streaks the bands of connective tissue, and separates the single muscular fibres.

Epiglottis and aryepiglottidean folds show the same changes, the first only in a slight degree on the upper and lateral parts. Small hæmorrhages, irregularly distributed, occur also in the subepithelial connective tissue of the epiglottis, of the vocal cords, at their transition into the sinus Morgagni, and in the deep periglandular connective tissue of the subglottic region.

The second case showed, apart from diffuse collections of leucocytes, formation of small leukæmic nodes, *e.g.*, in the glosso-epiglottidean ligament, upper section of the sinus Morgagni, and in the submucous tissue of the anterior surface of the posterior laryngeal wall under the cartilage of Santorini. These, except the last, were visible macroscopically. They were limited in the epiglottis and sinus Morgagni to the subepithelial tissue. Their structure was similar to adenoid tissue; leucocytes were more numerous in the centre; towards the periphery there was a tolerably regular connective-tissue reticulum. On the summit of single nodes the

epithelium was diminished or wanting; in consequence, small superficial ulcers were formed.

The third case showed a pale, thickened, granular mucous membrane in the larynx, and about the middle of the right vocal cord a two to three millimètre large hæmorrhagic ulcer. The mucous membrane of the trachea exhibited nodes in some parts arranged in rows, in others single, the larger of which showed small openings on their summits. They were soft, white, and showed here and there in the recent state a dark areola. Of special interest were the pathological changes on the edge of the vocal cord. About the middle of the right vocal cord the proper pavement epithelium was wanting to the extent of two millimètres. The covering layer was sharply defined with incurved edges. This defect was situated on the top of a round node, which consisted of well-preserved—only in part in the superficial layer—degenerated leucocytes. This small lymphoid tubercle was surrounded on all sides by hæmorrhagic tissue, which perpendicularly reached to the muscle layer. The lengthy duration of this hæmorrhagic infiltration is shown by the state of the fibrinous part of the extravasation, which is in the form of a regular network of hyaline-looking trabeculæ. In the meshes lie red blood corpuscles, mostly degenerated, some remains of leucocytes, and, in addition, cut vessels filled with freshly coagulated fibrin. This hæmorrhagic areola extends to a considerable distance between the subepithelial and elastic tissue layer. The tracheal ciliated epithelium is mostly exfoliated, the basal membrane preserved. The nodules extend on one side to the free surface, bulging the basal membrane convexly and thinning it externally; on the other side they extend to the intertracheal tissue.

With regard to these changes, the most interesting is the leucocythæmic infiltration of the laryngeal mucous membrane. The formation of nodules is important clinically, either from their size or from ulceration with formation of pus. Extensive inflammation in the soft parts or cartilaginous framework may be a source of danger. If the nodules are on exposed parts they readily break down and form ulcers. Hæmorrhages are to be frequently expected from the ulcers. More important clinically is the diffuse infiltration of the larynx and subcordial space. The more developed laryngeal changes seem usually to develop a few weeks before death; infiltration of the larynx may be very rapid. Under what conditions there is more tendency to formation of nodes or infiltration, and in what percentage of cases laryngeal changes occur, has not been settled. *Guild.*

E A R.

Alt, F. (Vienna).—*A Contribution to the Pathology of the Auditory Cortical Centre.* "Monats. für Ohrenheilk.," Jan., 1898.

ALT describes an interesting case of crossed cortical deafness. Few cases have been observed. In the majority of recorded cases no exact examination of the ear was undertaken; the methods were inefficient, and conditions really physiological attributed to anatomical lesion in the cortex. Thus Wernicke quotes a case of Hutin's of supposed cross deafness in a man of seventy-six, who heard the watch on the right side at twenty-five centimètres, and on the left side only close to the ear. *Post mortem* a patch of red softening was found in the cortex, involving the lower parietal lobule, and the adjoining parts of the occipital and temporal lobes, and to these lesions the deafness was ascribed. Further, in