

## Abstracts.

### NOSE.

**Carter, W. W.**—**The Dynamics of Nasal Development: Its Bearing on Resection of the Nasal Septum.** "Annals of Otology," xxiii, p. 779.

Carter discusses the importance of the septum as a factor in the development of the nose, and concludes that the normal position of the upper edge of the septum, which constitutes the keystone, is necessary in order to maintain the integrity of the nasal arch. In removing the septum, therefore, no instrument should be used that necessitates tugging, for if this upper edge of the septum is removed or displaced a depressed deformity will result. A punch instrument is the best. The lifting force exerted by the septum is indispensable to the development of a symmetrical nose, and therefore it cannot be extensively removed with safety during the years of active nasal development. Fourteen years Carter regards as the limit of safety. On the other hand, the framework of the nose, conforming as it does to the definition of the arch, does not require any external support other than at its two extremities.

*Macleod Yearsley.*

**Wales, E. de Wolfe.**—**Cauterisation of Mucous Membranes, particularly of the Nasal Mucosa. A Protest.** "Annals of Otology," xxiii, p. 563.

This paper should be read by every rhinologist, and especially those on the threshold of their professional career. Wales calls attention to a fact too often overlooked: that the function of the nose is the matter of greatest importance in the treatment of all nasal diseases, and the reprehensible destruction of the nasal mucosa is so common that a vigorous protest is necessary against this practice. He ridicules the rhinology that suggests the cure of most ills by destroying some part of the nasal mucosa, with its genital and bladder spots, and its hæmorrhoidal, intestinal, hepatopancreatic, gastric, and cesophageal portions of the inferior turbinate. Cauterisation of any kind, except to save life, should never be used in the nose; and the strongest argument against it is that it increases a slight pathological condition to a graver one. The commonest result of cauterisation is cystic degeneration. Synechiæ, atrophic areas of scar tissue, crusting, purulent meningitis are other results. The author concludes: That many pathological conditions of the nose are caused by cauterisation; the application of cautery or caustics to the nasal mucosa often destroys the function of the nose. Cauterisation is a method of getting results without thought of final consequences. It is irrational and lessens the efficiency of the nose by destroying the integrity of the ciliated columnar epithelium, leaving in its place tissue which cannot carry on a single function of the nose.

*Macleod Yearsley.*

**Arkwright, J. A.**—**Portal of Entry of Meningococcus Intra-cellularis.** "Proceedings of Royal Society of Medicine, Section of Epidemiology and State Medicine," p. 71.

The author states that the meningococcus is present in the nasopharynx of cases of meningitis in the early stages of the disease. Goodwin examined the nasopharynx of fifty-two cases of meningitis and

isolated the meningococcus from twelve out of twenty-two examined in the first week, five out of fifteen examined in second week, none out of fifteen examined in third to ninth week, and one case on sixty-seventh day of disease, showing that the meningococcus may persist a long time.

Among convalescents recently under the author's observation, one man yielded a culture on the thirty-fifth day from onset. V. Lingelsheim examined the naso-pharynx of forty-nine patients in the first two or three days of the disease, and found that 93 per cent. gave positive results.

The detection of meningococci in the blood of patients affords an intelligible explanation of the route from the naso-pharynx to the meninges.

Elsner made positive cultures from the blood of ten cases out of forty-one examined.  
*Archer Ryland.*

**Pegler, L. Hemington.**—On Headache Associated with Intra-nasal Disorders. "Lancet," February 27, 1915, p. 435.

Pegler considers that the term "nasal," as applied to headache, should not be too rigidly employed. He classifies such headaches in three groups: simple non-inflammatory, chronic inflammatory, and a group in which inflammation or congestion is present more or less actively. In the first group headache is due to pressure.

The paper, which is a good exposition of the subject, requires reading in its entirety.  
*Macleod Yearsley.*

### LARYNX AND TRACHEA.

**Johnstone, F. M.**—Primary Diphtheria of the Trachea. "Medical Journal of Australia," May 22, 1915.

The notes concern a young woman, aged eighteen. At no time did she show any sign of diphtheria in the pharynx, nor was she ill beyond having a few severe suffocative attacks, often bringing up great masses of membrane. For a month she continued to bring up casts, latterly apparently of the finer bronchi. The voice continued husky for some time longer. A pure culture of the Klebs-Loeffler bacillus was found. Antitoxin used.  
*A. J. Brady.*

**Keith, John R.**—Vaso-Dilators in the Treatment of Hysterical Aphonia. "Brit. Med. Journ.," May 15, 1915, p. 847.

On the assumption that functional paralysis may be due to spasmodic vaso-constriction in the cerebral vessels, the author has been treating functional aphonia with nitroglycerin (gr.  $\frac{1}{100}$  by the mouth) and amyl nitrite (both as an inhalation and by the mouth).

Two cases are reported in which benefit was obtained, but the narratives are insufficiently detailed.  
*Dan McKenzie.*

### EAR.

**Sharpe, N. (New York).**—Herpes Zoster of the Cephalic Extremity, with a special reference to the Geniculate, Auditory, Glosso-pharyngeal and Vagal Syndromes.<sup>1</sup> "Amer. Journ. Sci.," May, 1915.

While herpetic eruptions due to inflammation of the Gasserian ganglion have long been recognised, it has only comparatively recently

<sup>1</sup> See also p. 339, 355.

become known that a like condition may result from an affection of other sensory ganglia of the cranial nerves.

The syndrome of geniculate ganglion involvement is herpes zoster oticus alone, or with facial paralysis and auditory complications, due to spread of inflammation to the contiguous eighth nerve.

Herpetic inflammations of the ninth and tenth nerve ganglia occur, with herpes zoster oticus, herpes zoster pharyngis and laryngis, with pharyngeal and laryngeal palsies, occasionally with nausea and vomiting, bradycardia, hiccoughing, and other symptoms of vagal irritation.

Herpetic inflammations of the eighth nerve ganglia are indicated by symptoms referable to the vestibular and cochlear nerves, such as deafness, tinnitus aurium, nystagmus, nausea and vomiting, and disturbances of equilibrium, the fully developed picture resembling a severe type of Ménière's disease.

The neural symptoms may be very slight, often clearing up in a few days or weeks, or they might be quite severe, leaving permanent disturbances of function.

The writer reports two cases of herpes oticus with facial palsy, and one of herpes occipitocolaris with facial palsy.

Emphasis is laid on the fact that the clinical picture is by no means always limited to involvement of a single ganglion, and that multiple involvement of these ganglia is not infrequent, producing a great variety of clinical combinations, which are readily interpreted if the fundamental pathological conceptions are borne in mind. *Thomas Guthrie.*

**Sheppard, J. E.—The Importance of Disturbed Metabolism in the Ætiology of Secretory Middle-Ear Conditions.** "Annals of Otology," xxiii, p. 574.

A short but useful paper. The author considers that all cases of secretory middle-ear conditions are attributable to vasomotor disturbance, usually a paralysis or paresis, the expression of some general toxæmia due to disturbed metabolism and insufficient elimination. He points out how easily metabolism is disturbed by over-eating, even when the food taken is suitable. As to drinking, he sums it up in one sentence: "As little as possible at meals, and as much as possible between meals."

*Macleod Yearsley.*

**Ewing, S. A.—Difficulties in Diagnosis of Intracranial Extension of Suppurative Otitis.** "Medical Journal of Australia," March 27, 1915.

The presence of acute suppurative otitis does not necessarily imply that cerebral symptoms are due to it. A child with history of earache followed by discharge three days before admission to hospital. History of vomiting. Internal squint. Temperature 105.2° F. Cerebrospinal fluid clear. Mastoid antrum contained pneumococcal pus. It was not till the fifth day that the cause of the disease was evident by the presence of signs of apical pneumonia. In a suspected case of sinus thrombosis following an acute otitis, the tenderness over the external jugular vein and mastoid was explained by the presence of acute rheumatism.

On the other hand the absence of perforation of the membrana tympani, or of pus in the ear, does not exclude suppuration in the antrum and cerebral complications therefrom. Symptoms indicating intracranial complications are described. *A. J. Brady.*

**Shuter, R. E.—Intracranial Extensions of Middle-ear Disease.** "Medical Journal of Australia," March 27, 1915.

Shuter enters pretty fully into the study on this subject, his observations being mainly founded on personal experience. It is impossible to embody the matter in an abstract. He mentions a class of case where the ear disease is mild and prolonged, in which apparently the ear has got well, but in which the patient after some weeks manifests severe intracranial complications. In these cases the infecting organism is found to be an encapsuled *Diplococcus mucosus*, which is Gram-positive.

A. J. Brady.

**Perkins, Chas. E.—Report of Cases of Aural Infection with the Streptococcus Capsulatus.** "Annals of Otology," xxiii, p. 784.

Eight cases are reported, and the author concludes: (1) That the *S. capsulatus* has a special affinity for bone tissue; (2) that in these aural infections, if the passage between the middle ear and the mastoid is large, drainage through the ear may effect a cure, so the importance of early and free incision of the drum membrane cannot be over-estimated; (3) that X-ray examination is of great help in these cases; (4) that an early and free operation is indicated as soon as irreparable mastoid involvement is certain; (5) that, whether operated upon or not, these cases should be watched closely throughout, as late complications are more frequent, perhaps, than in other infections; (6) patients advanced in life and diabetics are more liable to this infection than to other forms.

Macleod Yearstey.

**Guthrie, Leonard, and Fearnside, E. G.—Tumour of Right Cerebello-Pontine Angle. Posterior Decompression. Great Improvement.** "Proceedings of Royal Society of Medicine, Section of Neurology," p. 28.

In addition to all the typical cerebellar inco-ordination symptoms, the following symptoms were associated in this case: Failure of hearing on right side; intense headache, giddiness, vomiting; nystagmus to right and left. The headache was most marked in the occipital region and accompanied by tenderness of the skull above the mastoid processes.

The nystagmus was of intense vertical and lateral character; difficulty in opening mouth; the right half of face, both in its upper and lower portions, was paretic.

A large, bilateral, subtentorial, posterior decompression was performed.

The tumour could not be removed. After the operation all the manifestations began to improve.

Archer Ryland.

**Shuter, R. E.—Notes on a Case of Tumour of the Auditory Nerve.** "Medical Journal of Australia," February 27, 1915.

The author describes a most interesting case of tumour of the auditory nerve.

The patient was a farmer, aged forty-three, and gave the following history: Three years ago he gradually became deaf in the right ear, this was followed by attacks of giddiness, which increased in severity; he had no tendency to fall, but used a stick to assist in walking. No headache, vomiting, or loss of weight, no pain or discharge from the ear, nor history of injury or syphilis. When he was seen by Shuter, on April 14 last, he had a tendency to fall to the right and backwards; this was more

marked when the head was turned to that side. No spontaneous error in either elbow or wrist-joints. Horizontal spontaneous nystagmus present in first degree both to right and left. Pupils active to light and accommodation. Discs blurred. Right side of face slightly mask-like, but no sensory disturbance. Dr. Shuter lays great stress upon the fact that "when the conjunctiva of the right eye was gently stroked with cotton-wool the contraction of the orbicularis was not as active as that of the left," and points to this as an important factor in the diagnosis between conjunctival anæsthesia and commencing facial paralysis.

Examination of the ears showed the right ear to be absolutely deaf, nor did this ear respond to either caloric or tuning-fork tests. Left ear normal.

The operation consisted in exposing the cerebellum in the usual way by removal of the back part of the occipital bone. On lifting the right lobe the tumour was seen but could not be defined, owing to the patient's condition; he gradually got worse and died in a few hours, "apparently from disturbance of the centres in the medulla."

The *post-mortem* examination—which was very limited—showed a tumour adherent to the pars petrosa posterior to the internal meatus. The facial nerve was torn during removal of the growth, which appeared to be arising from the sheath of the auditory nerve, and was a glioma about the size of a walnut.

It is to be regretted that the patient's friends permitted only a very partial *post-mortem* examination through the operation wound.

A. J. Brady.

### MISCELLANEOUS.

**Choronshitzky, B. (Warsaw).—Percanalicular Perforation of the Lacrymal Sac as a Preliminary to Intra-nasal Dacryo-cysto-rhinostomy and as a Complete Operation.** "Archiv. für Laryngol.," vol. xxviii, part 3.

Under normal conditions access to the lacrymal sac from the nose is easily obtained by removal of that part of the lacrymal bone which is uncovered by other structures in the outer nasal wall. Very frequently, however, changes are present in the anterior part of the middle meatus which render the operation exceedingly difficult. Among such conditions are enlargement of the anterior end of the middle turbinal or of the cells of the uncinatè process, and these may, in a narrow nose, render it almost impossible to localise and open the sac. Under conditions of this kind the author has found the operation greatly facilitated by what he calls percanalicular perforation of the sac. A fine but stiff sound is passed along the lower canaliculus, without the latter being split up, and is made to enter the lacrymal sac, and then to perforate the inner wall of the sac and lacrymal bone, and so enter the nose. The sound, during this manœuvre, lies in the frontal plane and passes downwards and inwards at an angle of from thirty to forty degrees to the horizontal. The end of the sound projecting into the nose indicates the exact relation of the lacrymal sac to intranasal structures, and the exposure and opening of the sac can be easily and rapidly effected without unnecessary removal of bone.

Percanalicular perforation can also be successfully employed as a means of establishing drainage without further operation. Through the perforation made by the sound a fine cannula is inserted, and one end of a

strand of catgut is passed through the sound into the nose; to the other end is fixed a double silk thread, which is drawn through and knotted over the cheek.

*Thomas Guthrie.*

**Thomson, G. S.—Nasal Flap and Modified Langenbeck Operation for Cleft Palate.** "Medical Journal of Australia," May 22, 1915.

The principles of the operation are the elimination of the tension and the reduction of trauma and of interference with the blood supply. This is effected by the use of flaps obtained from the upper aspects of the hard and soft palates. The flaps are turned down into the mouth and united in a V-shaped manner, so that the raw surfaces of the flaps are opposed to one another. In the case of the hard palate the flaps are obtained from the nasal floor and from the septum, where the latter reaches the floor. The defects of the present operation for closing the cleft in the soft palate is the necessity of dividing the tensor and even levator palati, and the separation of the nasal portion of the soft from the hard palate. These two factors probably account for after-trouble in phonation. This defect is overcome in the present operation. The flaps to close the defective soft palate are obtained from the upper surface of same, using half the thickness of the palate.

For details see original.

*A. J. Brady.*

**Harris, Wilfred.—Pituitary Infantilism (Lorain Type), with Hydrocephalus and Optic Atrophy.** "Proceedings of Royal Society of Medicine, Neurological Section," p. 35.

The patient was aged twenty-one, height 3 ft. 8 in., weight 49 lb. Said to have had meningitis at age of two and to have ceased growing at age of six. Skiagrams show unossified epiphyses and a very large sella turcica. Vision had been failing for nearly twelve months.

Lumbar puncture showed normal cerebro-spinal fluid. Removal of 25 c.c. improved the vision decidedly.

*Archer Ryland.*

**Griffith, Stanley.—Cervical Gland Tuberculosis.** "Lancet," June 19, 1915.

An extremely interesting and valuable contribution to the subject from many points. It strongly supports the view that bovine tubercle bacilli are morphologically distinct from the human type and can be diagnosed as such, so contradicting the conclusions of the Rome Congress. Further, that in 68 cases of primary cervical glands, tuberculosis was proved by culture and inoculation. Thirty-five were of the human type and 33 were bovine. Under five years of age 9 were bovine and 1 human. Above twenty years of age 13 were human and 4 bovine. Of the last group (bovine) one patient was aged forty-one, and eleven months after removal of the examined gland wrote to say that his neck "was fuller than ever of glands." These figures confirm the accepted view that bovine is common in early life, but further they emphatically prove that adults are not exempt from that type of infection.

His experience also shows how difficult it often is to demonstrate bacilli in the gland substance, and that special measures are necessary—cultures and animal inoculation. In only 2 out of 33 "human" cases were tubercle bacilli found in moderate numbers.

One hundred and ten cases were examined. Ten of them were not tuberculous macroscopically and afforded negative results. Twenty-nine failed to produce tuberculosis in guinea-pigs, but in 15 of them tubercle

bacilli were demonstrated. These cases might be interpreted as spontaneous cures, since they were macroscopically tuberculous. The remaining 71 cases all proved positive.

The presence of short well-stained bacilli was held to be suggestive of bovine type and proved to be correct by cultures. Many cases (17) which presented but few bacilli microscopically, afforded abundant cultures.

The abstractor's experience is that tubercle bacilli of either type are rarely found in caseous tubercular glands. But they can be demonstrated by mincing and straining the gland pulp, then treating by hypochlorite and staining by the picro-fuchsin method. The characters usually accepted as bovine are short, plump, sausage-shaped bacilli, with deep and even staining, in striking contrast with the long, slender and beaded human type.

Wyatt Wingrave.

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## REVIEWS.

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*The Extra Pharmacopœia of Martindale and Westcott.* Sixteenth Edition. London: H. K. Lewis, 1915. Vol. I, 14s., and Vol. II, 7s. net.

The extraordinary demand for further editions of this work has resulted in the issue of the sixteenth edition. We have often commented on its great comprehensiveness and compactness. In regard to drugs and other agents in the treatment of disease it may almost be termed an "Enquire within upon everything." Many practitioners have found that after searching far and wide for information about some novel or strange drug they have found it in Martindale. The present edition is a peculiarly important one in view of the alterations in the strength of official solutions of one kind and another, and, further, of the substitution of chemical or English names for medicaments which have hitherto been known by artificial names of German manufacture. A very fair statement with regard to trade-marks is made by the writers, who realise the difficulties to be met with in the case of those held by alien enemies. They put in a strong plea, however, for trade-marks held by British manufacturers, recommending to the recognition of the medical profession those who take a pride in producing a pure chemical and who desire to protect it. Every progressive practitioner should read the preface to this edition from beginning to end, but at all events pages ix to xxii, in which attention is drawn to the newest remedies or the newest applications of old ones, as well as important reference to sources of further information. Such a perusal will not merely justify the expenditure of time, but will probably speedily compensate the practitioner for the cost of the new edition. Many excellent preparations for use in diseases of the throat, nose and ear are scattered through the pages, and the work will maintain its position as a therapeutic stand-by for the general practitioner as well as for the consultant.

Dundas Grant.

*The Diseases of Children.* Edited by Dr. M. PFAUNDLER and Dr. A. SCHLOSSMANN. (English Translation by Dr. H. N. K. SHAW and LINNEUS LA FÉTRA.) By ARTHUR J. BEDELL. Vol. VI.