in apparently pure laryngeal phthisis, with tubercle bacillary sputum, ought always, therefore, to be borne in mind. *Wm. Robertson.*

Harris, Thomas (Manchester).—*Neurosis of Larynx.* "Brit. Med. Journ.," Feb. 3, 1894.

THIS occurred in a man, aged fifty-five, who three months before had had shortness of breath, and in whom a deep expiration was accompanied by marked stridor, the inspiration being also slightly stridulous. The larynx was perfectly healthy, and presented no paralysis of the abductor or other muscles. The man presented well-marked tracheal tugging, also very slight pulsation over the manubrium sterni, which was only visible at the end of expiration, and a markedly accentuated second aortic sound. Dr. Harris mentioned two other cases of expiratory stridor ; in both cases a sacculated aneurism of the aorta was found, which markedly compressed the trachea. The present case was referred to the same cause—viz., the aneurism being so placed that greater pressure was exerted on the trachea and greater stenosis caused, during expiration, than during inspiration. *Wm. Robertson.*

Donilles.—*Foreign Body in the Respiratory Tract in a Child—Expulsion of the Body during Vomiting—Death from Exhaustion.* "Dauphiné Méd.," Feb., 1894.

THE title indicates the case. *A. Cartaz.*

EARS.

Lake (London). — *A Modified Aural Speculum.* "Brit. Med. Journ.," Feb. 3, 1894.

THIS is a speculum for the ear made of the same materials used in the manufacture of Fergusson's vaginal speculum. Increased reflective power, ability to use caustics innocuously (to speculum), and a good direct light to do away with the use of a reflector, are the advantages claimed.

Wm. Robertson.

Lund (Manchester). — *An Ear Syringe Guard.* "Brit. Med. Journ.," Feb. 3, 1894.

THE principal feature of this is a guard mounted on the nozzle of the syringe. This guard rests on the temple in front and behind on the mastoid. Through an aperture in the guard the front of the nozzle is passed to the distance required by screw action. The guard is fixed by the finger and thumb during use. [The only drawback is that the guard obscures the view of the meatus and the direction of its axis.—REP.]

Wm. Robertson.

Bissell, E. J. — *Aural Massage.* "Journ. Ophthal., Otol., and Laryngol.," Jan., 1894.

THE author uses a telephone-receiver attached to a Gœtel-battery, which gives a large range of vibrations by means of a ribbon rheotome, which can vary from sixty to twenty thousand per minute. *R. Lake.*

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Stewart (Nottingham). — *Eustachian Obstruction.* "Brit. Med. Journ.," Feb. 3, 1894.

THE most prominent symptom was deafness, temporary or permanent. The chief causes were catarrh of the middle ear, dry, mucous or purulent, vegetations in the naso-pharynx, or polypoid or other obstruction of the nose. For vegetations, Dr. Stewart proposed to have the patient lightly anæsthetized, and to remove the growths by the curette. *Wm. Robertson.*

Ménière (Paris). —*A Case of Revolver-shot in the* ***Ear.*** "Gaz. des Hôp.," Feb. 1, 1894.

THE writer communicates his observations on a young man who received a revolver-shot in the right ear, the muzzle being introduced into the concha. The bullet was of the diameter of nine millimètres. The medical man who was called arrived twenty minutes after the accident, and found a flow of blood from the ear and the mouth. The bullet was found in the middle of the sanguinolent matters vomited into the bed. There was facial paralysis. The ear was not examined, and the subsequent course was favourable. Thirteen days after the accident Dr. Ménière saw the patient. He noticed that the orifice of the meatus presented no trace of tearing and that it was simply blackened ; the meatus itself was also blackened, and a portion of it had burst under the pressure of the gases. Some rags of membrane were all that remained of the tympanum. In front and below the tissues were torn, and there was a loss of tissue. Injections into the ear passed in part into the throat. The projectile had found its way out by the nasal pharynx, and had been spat out by the patient.

Loud voice was heard at four mètres. Antiseptic treatment was carried out, the meatus cicatrized and contracted till soon there remained nothing but a fistula of scarcely one millimètre in diameter ; the purulent discharge diminished more and more, but loud voice was not heard further than two metres. Finally the passage contracted until it was completely closed.

The author calls attention to the little disorganization produced by a bullet which destroyed the facial nerve, which glanced over the vascular cord in the neck without wounding it, and found its way out by the pharynx. It is equally important to bear in mind the absence of concussion of the internal ear. *Lacoarret.*

Thorner, Max.—*Pathological Conditions following Piercing of the Lobules of the Ears.* "Journ. Amer. Med. Assoc.," Jan. 27, 1894.

A SHORT *resumé* of the most important literature on the subject, and a short detailed account of three cases of erysipelas, two of cleft lobule, a paragraph on eczema, one of fibroma, one fibro-chondroma, and one keloid. *R. Lake.*

Helfich, C. H.—*A Case of Otitis Interna Traumatica.* "Journ. Ophthal., Otol., and Laryngol.," Jan., 1894.

THE patient, a child aged five, became deaf after an attack of meningitis, due to a fall ; there was also partial aphasia and lateral vertigo ; the original injury was a fall on the back of the head. *R. Lake.*

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Linnell, E. H.—*Chronic Suppurative Inflammation of the Left Middle Ear; Acute Suppurative Inflammation of the Right Middle Ear; Death from Purulent Meningitis.* "Journ. Ophthal., Otol., and Laryngol.," Jan., 1894.

No operation was undertaken for the intra-cranial trouble, though it existed for twelve days; otherwise the title describes the case. *R. Lake.*

Barker, A. (London).—*Suppuration in the Sulcus Lateralis.* "Clin. Journ.," Feb. 28, 1894.

This may lead to many dangers, especially meningitis, cerebral or cerebellar abscess, phlebitis of the lateral sinus, and septicæmia or pyæmia. It generally arises from suppurative disease of the middle ear spreading along the smaller veins, or directly by caries and destruction of bone. Its tendency to occur in chronic rather than acute cases is due to the relatively intact condition of the mucous membrane in the latter. The history of old-standing ear disease should always be investigated. The chief symptoms are a rigor and rise of temperature which oscillates later on, œdema and tenderness of the mastoid region; the middle ear may be blocked or perfectly free. The middle ear should be disinfected and cleared, and leeches should be applied to the mastoid. If the symptoms increase, the mastoid antrum must be opened—in adults the cells also—and if no sufficient focus of pus is found, the opening must be extended into the lateral sulcus, and any pus allowed to escape freely. If the sinus is on pressure with a probe found to be thrombosed, it should be exposed above the thrombus and ligatured, then the internal jugular should be ligatured, the sinus incised, cleared of thrombus, cleansed and, if necessary, drained. It is most important to do nothing until the middle ear has been thoroughly cleansed out—by drying, mopping out with perchloride of iron and dusting with iodoform for a few days. Mr. Barker has seen "the most virulent conditions" induced "by meddling with the ear when it was in a septic condition." He protests against the routine practice of at once opening the mastoid in all cases of suppuration of the middle ear with high temperature. *Dundas Grant.*

Courtade.—*A New Treatment for Abscesses in the External Auditory Meatus by means of Intubation.* Société de Therapeutique, Feb. 4, 1894.

Intubation consists of the introduction into the external meatus of an india-rubber tube which is designed to play at the same time the part of drain and of permanent dilator. This treatment has been employed in a pretty considerable number of patients affected with follicular abscesses or with furuncles of the meatus, and has given remarkable results. Sleep, which had disappeared for from a week to a fortnight, owing to the frightful pain, returned as soon as intubation was practised. Recovery was effected, on an average, in from eight to ten days.

Intubation has several advantages which ought to be considered in carrying out treatment. In the first place, it restores to its normal diameter the canal, previously more or less obliterated by swelling. In addition, when the meatus is obstructed the pus has no sufficient means of exit; it stagnates in the canal, and thus becomes a constant source of

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infection. In this last condition, an injection forced into the meatus provokes new outbreaks, due, probably, to the driving in of the pus which cannot be eliminated. Intubation brings about the disappearance of this inconvenience and renders these injections useful as well as indispensable. In addition, the tube by the eccentric compression which it exercises upon the walls, causes the disappearance of the infiltration. Finally, it does away with the terrible pain which prevents the patient from sleeping. After some days of dilatation the tube can be removed, and a tampon of iodoform gauze put in its place to keep up the dilatation and to make certain of the antisepsis of the part. The intubation is useless when the abscess, being of considerable size, is visible from the exterior. This ought then to be opened by means of the bistoury, so that the pus may have an easy outflow. It is also useless in cases where the abscess commences deeply in the thickness of the soft walls of the meatus, a case in which it is often impossible in the earlier days to determine its exact site; but at a later period, when the inflammation is localized and produces pronounced bulging, intubation would be useful if the abscess cavity lies in the deeper parts of the narrowed meatus. Intubation is again indicated whenever the auditory meatus is swollen as it is in otitis externa, either primary, or secondary to acute suppuration of the middle ear, and when the narrowing of the canal prevents the injections from penetrating to the proper depth.

After the operation of separation of the auricle, a drainage-tube of the diameter of the meatus is inserted so as to prevent the displacement of the organ, and to offer opposition to the consecutive cicatricial contraction of the passage. *Lacoarret.*

Annandale, McBride, etc. (Edinburgh). — *Intra-Cranial Surgery.* "Brit. Med. Journ.," Feb. 17, 1894.

As regards middle-ear disease, Prof. Annandale remarks (1) that patients so suffering were liable to certain risks with which all were familiar; (2) these risks might involve suppuration, extending to the mastoid or even to the cerebral sinuses; (3) the temporo-sphenoidal lobe was most commonly first affected, then the rest of the cerebrum, and then the cerebellum; (4) localized ear symptoms were not usually present; (5) incision should be made at the point of suggestion. Dr. McBride, in alluding to the subject, stated that the cases most frequently grouped themselves round meningitis, sinus phlebitis or hæmorrhage. Evidence of past or present ear disease might not be obtained. Otitis media with bulged membrane was suggestive. Acute otitis media following influenza might give rise to symptoms of intra-cranial mischief, and yet all these passed off without interference. If the case were of a more serious type great pain existed, and there might be tenderness. On external examination perforation (membrana tympani) might be found, and it was supposed that a small perforation was more serious than a large one. The malleus might be largely exposed. When danger was threatened from an otorrhœa the discharge often lessened or ceased. If intra-cranial disease resulted from ear disease there might be local tenderness or external swelling. If deep-seated pain in the ear, with rigors, existed, then

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swelling outside was rather a favourable sign than otherwise. The pain might be followed by vomiting, etc. The question of meningitis *versus* local disease had then to be considered. *Wm. Robertson.*

McBride (Edinburgh). — *The Diagnosis and Prophylaxis o Intra-Cranial Complications from Ear Disease.* "Edinburgh Med. Journ.," April, 1894.

THIS paper forms a contribution from the aural point of view to a discussion introduced by Prof. Annandale "on intra-cranial surgery." Prefacing his remarks by alluding to the three intra-cranial dangers from ear disease—viz., meningitis, rachitis of the cerebral sinuses, especially the sigmoid, and abscess—the author has in a few paragraphs very clearly summarized the symptomology and diagnosis of those conditions within the ear likely to become propagated to neighbouring intra-cranial tissues. The remarks are so thoroughly practical and minute in detail that only those who are conversant with the subject will recognize their value. The importance of carefully analyzing the answers given by patients to the question "Have you had a 'running ear'?" is not overlooked, while the necessity of making a careful objective examination of the ear in a patient with head symptoms likely to proceed from ear disease is prominently noticed.

Due reference is made to the so-called "head symptoms" often observed in acute otitis media, which subside and disappear without operative interference, except in influenza, where acute otitis media may be followed by implication of the temporal bone, with all its attendant risks. Dr. McBride has never been able to convince himself that perforations of Shrapnell's membrane are more often causes of intra complications than other forms. The presence of granulations in a diseased ear is strongly suggestive of defective drainage, and the diagnosis of a dangerous ear lesion is furnished if the probe detects dead bone through a fistula in the posterior wall of the meatus. The same remark applies to the discovery of cholesteatomatous masses in a diseased middle ear. A large perforation in the membrana tympanum at its lower part is not so suggestive of intra trouble, but in any case where fœtor of the discharge is marked the probability of intra extension is increased. Pain in the ear or over the mastoid is considered an early manifestation of extension. Pain and swelling over the ear rather point to local trouble, while tenderness without any external evidence points to deep ostitis. Pain in the ear, diffuse headache and vomiting indicate drainage. It is impossible often to distinguish between commencing intra-cranial mischief and retention of pus in the middle ear. Both conditions give rise to pain, rigors and vomiting, in both giddiness may exist, and optic neuritis is present in cases that recover without operation, and absent in the graver condition.

The indication, and one that should be clearly understood, is to establish drainage from the middle ear, and if serious symptoms continue, then we may suspect that the intra-cranial structures have become implicated. Face to face with intra-cranial complications, it is difficult to say which of the three usual occurrences there is the shape. All three may coexist in a case, while two of these conditions still more frequently

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do so. If we find very marked fluctuations of temperature within short periods, and if rigors be severe and frequent, associated with perspirations, we may suspect septic thrombosis, which, in most cases, has involved the sigmoid sinus. The diagnosis of cerebral abscess rests on evidence from the pulse, temperature, and percussion tenderness. Pulse and temperature are the most important. If both be persistently subnormal, strong probability points to a localized collection of pus. The following complex of symptoms point to chronic abscess, viz., (1) pain in one ear, the seat of suppuration ; (2) optic neuritis ; (3) subnormal pulse and temperature and continuous headache. Is the pus in the cerebrum or cerebellum? Marked implication of the mastoid region indicates the cerebellum more than where the symptoms are confined to the tympanum. The author now refers to the prophylaxis of intra-cranial complications, due to suppurative middle ear diseases. Such prophylactic operations are—excision of drumhead and ossicles ; opening the mastoid antrum ; Stacke's operation and its modifications. *Wm. Robertson.*

REVIEW.

Squire.—*The Hygienic Prevention of Consumption.* By J. EDWARD SQUIRE, M.D. (London). Crown octavo, 193 pages. London : Charles Griffin. 1893.

AFTER adducing the now readily accepted proofs of the dependence of tuberculosis on the presence of the specific bacillus, the various channels of entrance of the micro-organism into the body are discussed, including injected food or air, inoculation, and the very rare congenital infection.

The moderate importance attached to hereditary transmission is indicated in the following extract :—"When we speak of heredity in "consumption, we can only refer to an inherited predisposition to take "the disease, if exposed to the determining cause—a diathesis which "may be modified or corrected by the mode of life of the individual" (p. 28). This is the keynote of the writer's acceptable doctrine, which is calculated to inspire comfort, hope, and courage where only despair was formerly possible. The various causes of acquisition of general and local predisposition are not discussed. The means of prevention are studied in relation to the various periods of life—infancy, childhood, school-life, manhood, and age, the circumstances of air, food, dress, occupation, exercise, and marriage receiving full consideration.

The very important subject of the prevention of consumption in the family, when one member of the household is consumptive, is treated under the heads of (1) *Hygienic Management of the House*—ventilation, lighting, dusting with a damp cloth, warming ; (2) *Special Precautions for the Invalid*—disposal of the sputa, avoidance of infection by the breath or the air of the sick-room ; (3) *Precautions for the Remainder of the Household*—contact with the patient, kissing, &c. Two chapters are devoted to State interference in the prevention of the spread of the

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