

MOUTH, Etc.

Walsham, Hugh.—*Latent Tuberculosis of the Tonsil.* "Lancet," June 18, 1898.

Out of the thirty-four consecutive post-mortems, the author found the tonsils to be more or less tuberculous in twenty. Presumably this conclusion was based on the discovery of giant cells, as there is no mention of tubercle bacilli being found. It is also to be concluded that all the post-mortems were on patients who had died of pulmonary tuberculosis. Microscopical examination of tonsils and adenoid vegetations removed from living subjects proved entirely negative. Reference is made to the well-known observations of Lermoyez.

StClair Thomson.

NOSE.

Bereus.—*The Rebuilding of a Nose without the Use of an Artificial Bridge.* "The Laryngoscope," March, 1899.

The author having treated a number of nasal deformities due to injury, almost all recent, has been impressed with the ease and the subsequent slight shock and pain with which the bones are reset. The lack of pain is probably due to lack of muscular contraction.

The author describes and gives photographs of a case due to severe injury in early childhood, treated by himself. The nasal bones were pushed apart and flattened, producing an almost flat and very broad bridge. The alæ were broad and prominent. The columna occluded the right naris, while the body of the septum was deflected to the left, and its upper half was adherent to the wall of the vestibule.

Under ether anæsthesia this adhesion was divided. With a modified Adam's forceps the nasal bones were in turn grasped and broken from their attachment. The right nasal bone not having broken satisfactorily, was rendered pliable by heavy blows with a bull's hide mallet on a rectangular bar of steel guarded by rubber tubing laid upon it. The nasal processes of the superior maxillæ were broken at the same time. The perpendicular plate of the ethmoid and the rest of the septum, when deflected, and the nasal spine of the superior maxilla, were broken. The nose was then quite pliable. One of the author's perforated cork splints was then put in each nostril. A plaster cast of the normal nose was bandaged firmly as an external splint. There was very slight reaction and no complaint of pain after operation. The plaster cast was removed in three days, and a Fox glass clip, with the ends longer and broader than usual, was substituted. This was mounted later with plain glasses, and worn for three weeks.

R. M. Fenn.

Kenny, A. L.—*Golovine's Osteoplastic Operation on the Frontal Sinus.* "The Australian Medical Gazette," January 20, 1899.

This is a description of a successful operation for chronic frontal sinus suppuration. The peculiarities of the operation were the turning down of a hinged flap consisting of the anterior wall of the sinus and the overlying periosteum only, and its subsequent replacement, and the use, instead of a trephine or chisel, of an instrument modified from a circular metal-cutter.

Kenny claims for this instrument the following advantages: 1. The bone incision is as narrow as possible, and there is a minimum loss of substance. 2. It is more effective and more manageable on a curving surface than is a trephine. 3. The length of the cutting arm can be changed in a moment, and by taking different centres and different lengths of arm, a regular incision of parabolic shape or half curve, with nearly straight sides, can readily be made. 4. It acts more quickly than a trephine.

Atwood Thorne.

Lack, H. L.—*Fibrinous or Membranous Rhinitis, and its relation to Diphtheria.* "Proc. Royal Med. Chir. Soc., Lond.," October 25, 1898.

Fibrinous rhinitis, first described by Schuller in 1871, is defined as a subacute or chronic affection of the nose, characterized by a fibrinous or membranous exudation on the nasal mucous membrane. The great interest of the affection lies in its connection with diphtheria, the older observers considering the diseases quite distinct, while the more recent observers, relying on the results of bacteriological examination, claim that fibrinous rhinitis is merely a mild manifestation of diphtheria. Cases of the disease are shown to be very common, forming no less than $2\frac{1}{2}$ per cent. of all the children attending the author's hospital practice. A brief analysis is then given of the symptoms presented by thirty-six cases of the affection. The disease is shown to be essentially one of children, and to occur most frequently in the autumn months.

The chief symptoms are seen to be purely local, such as nasal obstruction and discharge, excoriation of the nostrils and upper lip, occasional epistaxis, etc.; sometimes sore throat is seen, presenting peculiar characteristics, which are described.

The affection is very chronic, lasting on an average six to eight weeks or more.

General symptoms are seen to be very mild, and sometimes altogether absent. Many cases are not seen until very late in the disease, others probably are often overlooked even by competent observers, and some probably are never seen at all; the children, not being in any way ill, continue to attend school, etc., as usual. There is complete absence of all paralytic sequelæ.

A brief sketch is then given of nasal diphtheria, and special attention is drawn to cases in which a purulent nasal discharge persists often for many weeks after an attack of true faucial diphtheria. The symptoms of the two diseases, fibrinous rhinitis and true nasal diphtheria, are then briefly contrasted.

The results of bacteriological examination, carried out in thirty-three cases, are then reported. The true Klebs-Löffler bacillus is constantly present, generally in pure culture, sometimes mixed with pyogenic cocci, sarcinæ, etc. It is usually of the large variety, and its identity is proved by its morphology, by its growth on various culture media, etc. It is further shown to be of full virulence on animals, to produce virulent toxins, and to be neutralized by antitoxins. Further, it is shown to be capable of living for several months on culture media, and by its vigorous growth to crowd out other organisms if present.

Finally, the surroundings of the patients were examined, all sources of diphtheria sought for, and, as far as possible, all persons with whom the patients came into contact were seen and examined both clinically and bacteriologically. A previous history of diphtheria is found in connection with one case only. The disease is found to be very

infectious, however; often it gives rise to itself (nine cases occurred in four families), and often to mild sore throat, twenty-five instances of which occurred in eleven families. The Klebs-Löffler bacillus was also found in healthy throats in association with these cases. A comparative investigation showing the frequency with which the bacilli were found in healthy noses is then described, and statistics of similar investigations on both healthy noses and throats and on cases of non-diphtheritic sore throat are quoted.

The conclusion is arrived at that fibrinous rhinitis is a mild variety of diphtheria, the difference in the clinical manifestations apparently depending on some differences in the organisms associated with the Klebs-Löffler bacillus. The diagnostic value of the presence of the bacillus in sore throats which do not clinically appear to be diphtheria is also discussed, and is considered to be very slight.

Meyjes, Posthumus (Amsterdam).—(1) *A Case of Inverted Tooth in the Nasal Cavity.*

(2) *A Case of Probable Pneumatocele of the Frontal Sinus.* "Monatsschrift für Ohrenheilkunde," October, 1898.

See Report of Laryngological and Otological Society of the Netherlands in January number. *William Lamb.*

LARYNX.

Betti, Ugo Arturo (Genoa).—*The Relations of the Larynx with the Vertebral Column in Man.* "Bollettino," Florence, January, 1899.

The author reviews the statements of various anatomists on this point. Luschka and Hoffinan make the larynx correspond with the fourth or fifth cervical vertebra. Symington, from the middle of the body of the fourth to the upper margin of the sixth. Krause, without fixing the level, says it is lower in men than in women. Drobnik, that the lower limit of the larynx is generally at the level of the body of the sixth vertebra. Quain, that the thyroid cartilage corresponds with the fifth cervical vertebra, the cricoid with the sixth. Taguecki (from sixty dissections), that it extends exactly from the upper border of the fifth to the lower border of the seventh vertebra in the male, and that it is a little higher in the female, *i.e.*, between the upper margin of the third intervertebral disc, and that of the body of the seventh vertebra.

Dr. Arturo gives tabular details of his dissections of 100 bodies in which the larynxes had been fixed by the insertion of needles, and draws the following conclusions:

The level of the thyroid notch corresponds most frequently with the body of the fourth cervical vertebra, often with that of the fifth and the third intervertebral disc, rarely with the body of the third vertebra or the second or fourth disc.

The level of the crico-thyroid space is most often at that of the seventh vertebra, often at the sixth disc, sometimes at the body of the eighth and seventh, rarely at the fifth disc. These levels are higher in the female and in long necks.

The differences in level of the individual parts of the larynx do not allow any conclusions to be drawn as to its symmetry, or from the