left, and finally of the legs and sphincters. The autopsy showed that both abscesses communicated with the occipito-atlantal articulation. The left lateral mass of the atlas and the corresponding occipital surface were eroded by tuberculous caries. *James Donelan.*

F. E. Hopkins (Springfield, Mass.).—*Neuroses of the Pharynx.* "Boston Med. and Surg. Journ.," September 8, 1904.

The author classifies pharyngeal neuroses as abnormalities of sensation, neuralgia, reflex neuroses, spasmodic disturbances, vascular neuroses. He considers all patients exhibiting these neuroses are neurasthenic, and thinks most reliance must be placed upon general treatment, although local treatment must not be forgotten. *Macleod Yearsley.*

G. A. Leland (Boston).—*Cicatricial Stricture of Pharyngeal Orifice relieved by Plastic Operation.* "Boston Med. and Surg. Journ.," September 15, 1904.

Male, aged thirty-five, the subject of very extensive scarring of face, fauces, and buccal pharynx, due to ulceration. The velum palati and tongue were firmly adherent to the posterior pharyngeal wall. Dilatation was tried, but the cicatrix continued to contract. Finally, tracheotomy was necessary. His condition in October, 1900, was such that the only entrance to the œsophagus from above the tongue was about sufficient to admit a small probe. The glosso-pharyngeal adhesion was about half an inch thick. The velum palati was completely adherent, the only opening being about 1 cm. by 1½ cm. near the hard palate.

Under cocain a suture was passed through the orifice, and as much of the cicatricial mass grasped as possible, the thread coming out near the right lateral wall of the pharynx. After breaking several needles, about 3 cm. were enclosed in a heavy double silk suture. The result was good, and he was dismissed on January 1st, 1901. He has been admitted to hospital to undergo a similar operation on the left side.

The salient process is the uselessness of dilating such cicatrices. An interesting point is that the patient was able to nourish himself for seven months *per rectum.* *Macleod Yearsley.*

NOSE.

Santalo (Madrid).—*Alveolo-Nasal Fistula.* "Boletin de Laringol., Otol., y. Rinol.," Madrid, 1904, p. 299.

The patient, a soldier, fell from his horse nine years previously, breaking his second left incisor. Later he broke the two next incisors and canine. He complained of an unpleasant smell and taste. A probe could be passed through the incisor socket. The fistula was treated by curette and galvano-cautery and cured. *James Donelan.*

H. L. Swain (New Haven, Conn.).—*Facial Asymmetry as a Cause of Deformities of the Nasal Septum.* "Boston Med. and Surg. Journ.," September 8, 1904.

This paper is a sequel to the same author's paper on "The Arch of the Palate," and is the result of work at the measurements of the vertical and horizontal diameters of the posterior choanæ, and observations on the

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asymmetry of the two sides of the face and head in certain races and individuals, chiefly Hawaiian and flathead Indian. His conclusions are: (1) Adenoid obstruction does not always and may never cause over-arching of the palate; (2) over-arching of the palate does not always produce bends of the septum; (3) over-arched palates and bent septa often occur together, and each is more frequent in leptoprosopic skulls; (4) leptoprosopic skulls and faces almost never exist in a marked degree without some distortion or over-arching of the palate and changes in the nasal cavity; (5) in a young child about to develop into marked leptoprosopia pronounced nasal stoppage by adenoids cannot fail to add to the degree of deformity; (6) if the first teeth are removed early and the dental arch disturbed, then the palate will more easily become narrowed and pointed in its own arch; (7) the whole tendency is more often inherited than acquired. *Macleod Yearsley.*

Gibb, J. S. (Philadelphia).—*Sepsis and Asepsis in Intra-nasal Surgery.* "The Therapeutic Gazette," September 15, 1904.

The author's conclusions are as follows:

1. In intra-nasal operations, other than careful cleansing of the mucous membrane to free it of crusts, pus, inspissated mucus, and foreign matters, no special antiseptic precautions are necessary.
2. Careful antiseptic preparation of the hands of the surgeon, the instruments, gauze, cotton, etc., is desirable.
3. Sepsis is not the rule after intra-nasal operations, and when it does occur is usually mild and transient; but it may be rapid, severe, and grave.
4. Nasal sepsis is manifested by follicular tonsillitis, inflammatory changes in the nasal chambers, and especially in the wound, and in some cases acute otitis media. *Macleod Yearsley.*

G. H. Makuen (Philadelphia).—*Neuroses of the Nose.* "Boston Med. and Surg. Journ.," September 8, 1904.

The author divided these manifestations into two classes, the sensory and the reflex. He expresses himself sceptical as regards the latter, although he admits that the following are reflex neuroses of undoubted nasal origin—sneezing, cough, glottic spasm, and asthma.

Macleod Yearsley.

ACCESSORY SINUSES.

Guizez.—*Maxillary Sinusitis, owing to a Misplaced Tooth.* "Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx," February, 1904.

A woman consulted the writer for a purulent discharge of the left nasal fossa. The history of the case was as follows: In June, 1902, she commenced to suffer in the region of the left upper molars. Dental inflammatory attacks occurred repeatedly, attended with very violent pains. On July 13, 1902, the first molar was extracted, but no relief followed; in fact, the pain was increased for some days. Cicatrisation of the alveolus did not proceed satisfactorily, and a dental fistula remained

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