which the author now adds a fourth. His case was that of a man, aged thirty-eight, who came into hospital for advanced pulmonary tuberculosis. A few days after admission he complained of slight dysphagia. Examination of the throat revealed several small, gray, slightly-raised spots on the left anterior pillar and left half of the soft palate. The spots spread slowly, and united so as to form false membranes covering the left tonsil, left anterior pillar, soft palate, and uvula, then the right anterior pillar and right tonsil, finally involving the whole faucial isthmus and posterior parts of the gums. In spite of its wide distribution the lesion gave rise practically to no pain, and the interference with deglutition was purely mechanical. It was impossible to say what influence the throat lesion had on the pulmonary condition, or *vice versâ*. The patient died of pulmonary tuberculosis at the end of two months.

The membranes were extremely tenacious; only the superficial parts could be removed with a swab: to remove the deeper parts a curette had to be used; the subjacent mucosa was then left swollen and bleeding. These membranes were submitted to bacteriological examination. The deep layers were found swarming with Friedländer's pneumo-bacillus, whilst the superficial layers were poor in microbes, but contained besides the pneumo-bacilli also a few cocci and some filaments and spirilla; but there was no diphtheria bacillus or tubercle bacillus in any of the specimens.

The author gives a detailed account of the culture experiments to which the bacilli were submitted. *Arthur J. Hutchison.*

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## NOSE AND NASO-PHARYNX.

**Clark, J. Payson** (Boston). — *Report of Two Cases operated on for Deformity of the Nose.* "Boston Medical and Surgical Journal," March 6, 1902.

In the first case the deformity might have been termed an exaggerated snub-nose, due to an overgrowth forward of the triangular cartilage of the septum, drawing up the tip of the nose and giving it an irregular, knob-like appearance. Through an incision in the mucous membrane of the left nostril, the skin was freed from the prominent portion of the nose, and the required amount of the redundant cartilage removed with a pair of curved scissors, and the nose dressed with a gauze plug and pad to keep it in position.

The second case was due to two falls on the nose, driving it laterally to the left, with considerable thickening of the right nasal bone. The blade of a narrow-bladed pair of scissors was pushed through the cartilaginous septum to its anterior border, $2\frac{1}{2}$ centimetres from the tip of the nose, and the cartilaginous and osseous septum divided, keeping to the line of the deformity. The nasal bones were sawn away from their articulation with the upper maxilla and broken away from their attachment to the frontal bone. After the operation the nose was kept in the desired position by means of strapping and pads of gauze.

Both operations were successful. *StGeorge Reid.*

**Collet, F. J.**—*Vertigo of Nasal Origin.* "Annales des Maladies de l'Oreille, du Larynx," etc., February, 1902.

Dr. Collet reports a case as follows: "The patient, a young man (thirty-two), complained of a tickling in his nose and a violent attack

of sneezing, following which he had a sharp pain in the back of his neck, and vertigo. The attack left him in a drowsy state. Fifteen days later he had a somewhat similar experience, but the tickling was in his throat. Twelve days later he had a slight attack, with no loss of consciousness, but with convulsive movements of arms, congestion of face; finally, fifteen minutes later, abundant perspiration."

Dr. Collet attributes these symptoms to excitation of the trigeminal nerve, and considers the case one of masked epilepsy.

*Anthony McCall.*

**Courtade, A.** — *Method of Registering the Permeability of the Nasal Fossæ.* "Archives Internat. de Laryngologie," etc., January-February, 1902.

In a paper read before the Society on January 17 Dr. Courtade describes an instrument (the "pneumodographe") he has invented, by means of which the breath from the mouth and nose can be condensed, and the amount exhaled recorded.

The apparatus is simple, consisting of three pieces of glass, held in position by metal clips, each piece of glass being removable. The glasses are placed in such a manner that the smallest blade of glass rests against the upper lip of the patient, who then breathes regularly ten to fifteen times; the vapour will condense on the respective glasses. A record of the amount of moisture can be secured by removing the smallest glass and applying a strip of chemically prepared paper. (Dr. Courtade recommends a little aniline dye in powder or a preparation of tannin.) *Anthony McCall.*

**Denker, Hagen.**—*On the Technique of Intranasal Operations.* "Zeitschr. für. Ohrenheilk.," Bd. XXXIX, Heft 3.

Denker, like Ostmann, uses the galvano-cautery to obliterate blood-vessels in intranasal operations. The cautery point is allowed to penetrate to the bone or deep in the cartilage at the commencement of the operation. Through this preliminary, repeated plugging is avoided, the operation field remains clear, and the duration of the operation is greatly shortened. *Guild.*

**Gaudier.**—*A Case of Mucocele of the Frontal Sinus.* "L'Écho Méd. du Nord," February 23, 1902.

The patient was a boy, aged sixteen. When he was nine years old, patient had a severe attack of scarlatina complicated with diphtheria, in the course of which double suppurative otitis media and right nasal suppuration appeared. These conditions persisted for a long time, but finally passed off, leaving some deafness and some blocking of the right side of nose. Four years later his father noted a slight, painless swelling in the boy's right naso-orbital angle, which did not cause any symptoms in either nose or eye. The swelling increased and began to produce epiphora. The right middle turbinal was then found to be adherent to the septum, apparently in its whole length; it was quite impossible to catheterize the frontal sinus. Three years later, after prolonged fatigue, the swelling increased considerably in a few days and became tender. On examination, this swelling was found to be situated in the upper and inner angle of the orbit, was about the size of a hazel-nut, and quite hard except at its lower part, where a soft spot was found. The eyes were widely separated by the hypertrophy of the nasal skeleton, and the right eye was protruded downwards and outwards,

but was normal as regards visual power. The swelling was punctured through the soft spot with a Pravaz's syringe; the needle passed into the frontal sinus, and a small drop of thick mucus was withdrawn. Thus, the diagnosis of mucocele of the frontal sinus was established.

*Operation.*—The sinus was freely opened from the front. It was very large, and communicated through a perforation in the septum with the left frontal sinus, which was likewise opened freely. Both sinuses were full of thick mucus, and lined with very vascular, thickened mucous membrane. The mucus having been removed and the membrane thoroughly curetted and cauterized, the wound was closed except for a drainage-tube at the lower angle. This was removed on the fourth day, and the stitches on the eighth day; healing was complete, and there was no deformity. It was not possible during the operation to pass a catheter or probe from the sinus into the nose; but in view of the complete removal of the lining membrane of the sinus, Gaudier did not consider this a matter of importance. Four months after the operation the eye had returned to its proper position; no exophthalmos, movements quite free; no deformity at the seat of operation.

The rest of this paper gives a summary of the views held with regard to the pathogenesis, pathological anatomy, etc., of mucocele of the frontal sinus. *Arthur J. Hutchison.*

**Genta, S.** (Genoa).—*Effects of Nasal Obstruction on the Blood Pressure.* "Annali di Laringologia," etc., Genoa, January, 1902.

The author undertook the investigation of this subject with a view to giving a further demonstration of the existence of an *adenoid cachexy*, which is claimed to have been first affirmed by Professor Massini and the author, who is his assistant, in a paper entitled "Effects of the Partial or Total Occlusion of the Nasal Fossæ on Respiration." The experiments were made on rabbits. Closure of one nostril by means of a plug of cotton-wool smeared with vaseline caused a sudden and irregular rise in pressure, which lasted about half an hour and then returned to normal. When both nostrils were closed, the pressure in the carotid rose to from 60 to 70 and even 90 milligrammes, causing very wide and irregular movements of the tracing, which disappear very slowly. The tracings given in the paper show, however, the eventual return to the normal, or almost normal, curve. In some cases this took eight days to accomplish, and the author thinks that the return to the normal pressure was probably due to the development of the habit of mouth-breathing, the rabbits having had to accustom themselves to the suppression of the natural channel, which at the moment of occlusion had caused the respiratory and circulatory disorders recorded in the tracings. He therefore considers as entirely devoid of foundation the theories based on occlusion of the nares, which have been put forward to explain the changes in the composition of the blood and the symptoms observed in hypertrophy of the pharyngeal tonsils.

*James Donelan.*

**Ingersoll, J. M.**—*Rhinoliths and Foreign Bodies in the Nose.* "New York Medical Record," April 12, 1902.

This is a short article based upon the author's own experience. The diversity of character of foreign bodies is well exemplified by the following list removed by the author: A shoe-button, a bean, a piece

of cardboard, a water-melon seed, a small cloak-button, a piece of bone from a pig's foot, and a pea.

In removing foreign bodies from children's noses, the author advises the use of chloroform anæsthesia. He has found also that adrenalin is of value, as giving increased room and a better field of view. Undue haste is never justifiable in removing foreign bodies. Details are given of a case of rhinolith, removed by crushing, in a man aged forty-six. The nucleus was a bean, and the whole mass weighed 2 grammes.

*Macleod Yearsley.*

**Mackenzie, Hunter.**—*A Case of Intractable Nasal Hæmorrhage.* "Lancet," May 10, 1902.

In this case the patient, a male, aged forty-nine, an alcoholic and suffering from slight albuminuria, had repeated attacks of nasal hæmorrhage. When seen by the author the bleeding-point was located on the anterior third of the septum and 1 centimetre above the nasal floor. The point was cauterized with the galvano-cautery, and a plug soaked with solution of adrenalin-chloride inserted into the nasal passage. Recurring attacks of profuse hæmorrhage still took place. The author then had the patient put under chloroform, and, by means of a nasal scoop and curette, stripped off the whole of the mucosa covering the septum. This method of treatment had the desired result, the hæmorrhage completely ceasing. *W. Milligan.*

**Mantoux.**—*Methylene Blue in the Treatment of the "Angina of Vincent."* "La Presse Méd.," March 1, 1902.

The chronic membranous pharyngitis, due to a mixed growth of spirilla and fusiform bacilli, which French writers describe under the name of "l'angine de Vincent," is an extremely persistent disease, lasting for weeks or even months in spite of all treatment. Various authors have recently reported cases which resisted treatment with other topical applications, including peroxide of hydrogen and tincture of iodine, but yielded in a few days to local applications of methylene blue. The methylene blue used must be chemically pure, because ordinary commercial methylene blue contains considerable quantities of chloride of zinc and of arsenic. It is to be applied to the false membranes in the pharynx in powder, by means of small swabs of cotton-wool; the patient is then to gargle with boracic lotion or boiled water. This is done once or twice a day till the membranes have disappeared. Very little of the blue seems to be absorbed, though it does occasionally appear in the urine. The treatment is quite painless, the only disadvantage being that the whole of the mouth and the lips are stained a deep blue colour. The staining, however, passes off in from twelve to twenty-four hours. *Arthur J. Hutchison.*

**Thomas, W. Thelwall.**—*An Operation for the Cure of Frontal Sinus Suppuration.* "Liverpool Medico. Chirurg. Journal," September, 1901.

In order to secure successful results three things are essential:

1. To explore the sinus.
2. To make a good drain into the nose by breaking down the anterior ethmoidal cells.
3. To avoid all unnecessary interference with the lining membrane of the sinus.

The operation, as performed by the author, is as follows:

"The eyebrow having been shaved and the neighbourhood cleansed, a curved incision is made down to the brow from the supraorbital notch, along the margin of the orbit on to the side of the nose in the line of the naso-maxillary suture. A periosteal elevator is placed on the bone and the tissues raised from the front wall of the sinus. A strong retractor keeps an area of the bone exposed, generally sufficient for this purpose; if not, then a short vertical cut may be added at the inner end or the outer end of the first incision prolonged. A gouge is now carefully driven into the sinus, and a circular hole in the bone cut to the extent of half an inch or so.

"The muco-periosteal lining is incised and the interior of the sinus carefully examined. A forehead electric light on the operator's head is essential. Blood and pus are carefully mopped out with pieces of gauze, and growths or polypi (if any) removed; but exuberant granulations must not be mistaken for the latter. By means of a pair of forceps introduced through the sinus the anterior ethmoidal cells are broken up, so that a large communication is made with the nose. A large drainage-tube is inserted, and the upper end is left projecting from the inner end of the wound. The ends of the tube are anchored together by a silk thread. The forehead wound is now sutured, leaving only the inner extremity open for the tube.

"After treatment: For a week or nine days the tube is daily moved up and down and syringed through with a weak antiseptic lotion, at the end of which time the silk is cut out of the lower end of the tube, left attached to the upper end, and the tube drawn into the sinus, the silk only remaining outside, fixed to the forehead by plaster. The lower end of the tube is cut off until it only just projects through the anterior nares. Syringing now takes place from below until granulations almost close the upper aperture, when the tube is withdrawn downwards, the silk being cut. The wound heals soundly in a few days."

*W. Milligan.*

**Wells, Walter A.** (Washington).—*The After-treatment of Operations on the Nasal Accessory Sinuses.* "Boston Medical and Surgical Journal."

The author refers to the delay in the ultimate healing in these operations and to the frequent failure of complete success, and believes it to be due in many cases to the insufficiency of the treatment, the want of proper curetting, of removal of granulations, or the eradication of some pathological condition. He refers to what are termed the dry and wet methods of local treatment, and prefers effective irrigation.

*StGeorge Reid.*

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## LARYNX AND TRACHEA.

**Onodi.**—*Dead Bone wedged in below the Vocal Cords.* "Monatschrift für Ohrenheilkunde," December, 1901.

The patient, a man of thirty-two, contracted syphilis eight years ago. Three years ago he came into hospital with symptoms of laryngeal stenosis, supposed to be due to abductor paralysis, as the cords were in the median position. Sublimate injections cured his stenosis, but his voice remained hoarse. Two years ago he coughed