Sobetky, Irving.—Infiltration Anæsthesia in the Submucous Resection of the Nasal Septum. "Boston Med. and Surg. Journ.," February 1, 1912.

The author advocates the application of a 2–4 per cent. solution of cocaine to the septum, followed by the injection of 10 c.cm. of sterile normal saline with 4 minims of 1 : 1000 adrenalin. The injections are made (1) just posterior to the junction of the skin and mucous membrane on the septum, (2) at the junction of the septum and nasal floor, (3) opposite the anterior end of the middle turbinate, (4) septum opposite beginning of superior meatus. About 1 c.cm. is injected at each spot, and the needle must be introduced *through* the perichondrium. The case is ready for incision in five minutes. *Macleod Yearsley.*

Ritter, G., (Berlin).—The Separation of the Mucous Membrane in the Submucous Resection of the Septum. "Zeitschr. f. Laryngol.," Bd. iv, Heft 5.

The writer recommends a new form of elevator with a curved shaft and a bulbous extremity. The ordinary elevator is used at first to separate the perichondrium anteriorly, and thereafter the new elevator is used to get round the corner of the deviation, and also to fit into the concavity on the concave side of the septum. The instrument is, however, not suited to separate the mucous membrane from sharp prominences. *J. S. Fraser.*

Glogan, Otto (New York).—Removal of the Bony Septum. Zeitschr. f. Laryngol., Bd. iv, Heft 5.

Existing instruments may be divided into two groups, (1) biting and (2) breaking. To (1) belongs those of Freer, Middleton, Hajek, Jansen and Struyken. To (2) the forceps of Krause. Glogan considers that the biting instruments are the best, but objects that they only bite off a small piece at a time; further, the maxillary crest cannot be removed with biting instruments. Glogan has therefore invented two bayonet-shaped double saws, the one horizontal and the other vertical. The bony part of the septum is received between the blades and is first sawn through above, then below and finally behind. The bony deviation can then be removed in one piece. The mucous membrane is not injured as it does not come in contact with the edges of the saw. *J. S. Fraser.*

EAR.

Fridenberg, P.—The Ear and Social Hygiene. "Annals of Otol., Rhin. and Laryngol.," vol. xx, p. 784.

A short, thoughtful paper, worth reading, which pleads for a better recognition of the importance of the ear and its function. The eye has come in for a full share of attention and its "comfort" by proper illumination, legibility of type, etc., has been provided for. The ear needs similar assistance from the point of view of "ear strain," by noise, etc. It is pointed out that the aim of conservative otology is to preserve and develop normal hearing and speech, and to prevent aural disease, inferiority or abuse. *Macleod Yearsley.*

Lynch, R. C.—The Rôle of the Ear as a Complication to General Manifestation of Disease. "New Orleans Med. and Surg. Journ.," July, 1912.

The article draws attention to many of the aural lesions found in the course of general disorders. Otitis media of mild degree, which fre-

quently escapes notice during the progress of acute infectious diseases, often causes changes resulting in permanent functional incapacity of the organ.

Toxic neuritis can be recognised by its sudden onset and progressive course; it most frequently occurs during mumps.

Early in cases of nephritis hæmorrhagic infiltration into the tympanum, combined with vertigo and high-tone deafness, form a chain of symptoms almost as characteristic as albuminuric retinitis. Early aural symptoms in myxœdema are progressive loss of hearing with marked tinnitus, vertigo, and nervous irritability. The tympanic cavity may also be filled with serous effusion.

Diabetes is associated frequently with crops of furuncles in the auditory meatus and with severe itching of the same part.

Gout and rheumatism are responsible for deposits in the nerve, middle ear or external auditory canal, and occasionally for sudden hæmorrhage into the labyrinth owing to arterial degenerative changes.

Enteric fever causes toxic neuritis and occasionally an active and persistent otitis media during convalescence.

Aural tuberculosis should be suspected whenever an otorrhœa is persistent in a debilitated patient. *Knowles Renshaw.*

Murray, R. W. (Liverpool).—The Explosion at Bibby's Oil Works: How the Surgical Emergency was dealt with. (Abstract of portion of the above paper relating to burns of pinna.) "Liverpool Med.-Chir. Journ.," July, 1912.

As a result of the explosion 123 cases of burn were treated at the Northern Hospital, Liverpool, of whom 75 were admitted as in-patients. In the author's opinion the most interesting and remarkable complication was that affecting the ears. In 15 of the cases in which burns of the face and pinnæ had occurred, complete healing was followed about four weeks after the accident by sudden and apparently spontaneous swelling. "A man's ears would have a normal appearance one night, and the following morning they were swollen beyond recognition." The swelling involved the whole of the pinna and was not very painful. The burns had been of the second or third degree, and received the same treatment as those of the face, *i. e.* boric acid ointment. In most cases both ears were affected, and in no case could traumatism be accepted as an explanation. A day or two before the swelling appeared the patients experienced a burning or tingling sensation in the ears, and the author is inclined to regard the trouble as of nervous origin. The effusion was in all cases of a serous nature, and in none of them did suppuration occur. The swelling gradually subsided, the cartilage being absorbed, not exfoliated, and very marked deformity was the result. The writer has found no account of a similar condition following upon burns.

Thomas Guthrie.

Frey, Hugo.—A New Method for the Estimation of the Bone-conduction of Sound. "Monats. f. Ohrenheilk.," Jahrg. 45, Heft v.

There can be no doubt that Schwabach's, Weber's and Rinne's tests are all dependent upon the same clinical fact, viz. the increase or diminution of bone-conduction. The divergent results obtained when testing bone-conduction even in normal cases by Schwabach, Emmerson, Siebenmann and others were due to their placing the end-piece of the fork on the crown of the head, and then measuring the time in seconds which elapsed between the striking of the fork and the disappearance of

sound-perception. A marked advance was made in the method now employed, by which the fork is placed over the base of the mastoid process, and a measurement is taken of the time in seconds during which the normal ear hears the fork above or below that time during which it was heard by the patient.

The following modification of Schwabach's test has been advanced with the object of enabling us to compare the relationship which exists between air- and bone-conduction, and thereby avoiding at least one of the many sources of error which this method entails. As the test is usually employed this relationship is greatly upset by reason of the fact that the period of vibration of a tuning-fork which is suspended free in air or held lightly between the fingers is much longer than that of the same fork when its stem is firmly planted upon a hard substance. Our measurements are further adversely influenced by the fact that whilst we are transferring the fork from one mastoid process to the other it must for a time swing freely in the air, which still further interferes with the character of its vibrations. These difficulties may be overcome by comparing the pathologically altered bone-conduction with the normal air-conduction in the following manner. The examiner must in the first place determine the constant difference in time between his own bone- and air-conduction for a given tuning-fork: this is known as normal Rinne (*n.r.*). In the second place he must determine the difference between the air-conduction of the patient and his own; this is designated as air-figure (*l.*). He must in the third place estimate the difference between the bone-conduction of the patient and his own air-conduction; this is known as the examiner's differing number (*f.d.*). In estimating bone-conduction the author uses the tuning-fork e (Bezold) and g_2 (Reiner). By the first of these the normal rinne is in his own case 40 sec. and by the second 21 sec.

Example.—A case of unilateral interference with conduction, confirmed by otoscopical examination. Tuning-fork e; *n.r.* = 40, *l.* = 36, *f.d.* = 16. This interpretated means, the air-conduction is diminished by 36 sec., and the bone-conduction is lengthened by 24 sec. (air seconds) compared with the normal. The Rinne test may be reckoned from the above figures If the patient's air-conduction were normal the Rinne would work out + 16 (40–24), but we know from *l.* that air-conduction is diminished by 36 sec. Therefore in this case the Rinne would be − 20. The opinion is held that the estimation of bone-conduction if carried out in this manner will give more accurate results, and lead to a truer interpretation of the variations in bone-conduction which occur with different tones and in different diseases. *J. B. Horgan.*

MISCELLANEOUS.

Thost, A. (Eppendorf).—Gout in the Upper Air-passages. "Archiv für Laryngol.," vol. xxvi, Part II.

After some reference to the nature of gout and to the relation of diseases of metabolism in general to the mucous membranes, the writer considers the diagnosis of gout of the upper air-passages. In his opinion we are justified in arriving at a diagnosis of gout of these regions—(1) when there is a family tendency to the disease; (2) when gout has been proved to be present by examination of the purin metabolism, or when the upper air-passages are affected during acute attacks of gout elsewhere;