

the line of junction with the soft palate being sharply defined. The uvula was oedematous, and the inferior surface of the palate pale.

An incision evacuated some clear serum, and the mass rapidly disappeared. The author states that the nose and pharynx were healthy, but the vault of the pharynx was covered with muco-purulent secretion. *StGorge Reid.*

N O S E, & c.

Barth (Danzig). — *Operative Treatment of Emphyema of the Frontal Sinus.* "Deutschen Medicinischen Wochenschrift," April 28, 1898. Congress of the German Surgical Society, Berlin, April, 1898.

THE osteoplastic operation (Kusber and Czerny) has overcome most of the disadvantages of the other methods. The drainage into the nose is, however, apt to be blocked, so that many operators do not rely on it. Barth thinks that, if possible, a wider exit should be made. He splits the nasal bone and the nasal process of the frontal bone, and forms a wider communication between the nose and the frontal sinus by removing the ethmoid cells. The wound is sutured after thorough removal of the frontal sinus mucous membrane. The method gives a good cosmetic result, disease of the ethmoid cells is not overlooked, and protection against relapses is obtained. *Guild.*

Guder.—*The Effect of Irritation of the Nasal Mucosa upon the Movements of the Heart and Pulse.* "Ann. des Mal. de l'Oreille," Jan., 1898.

IN view of the numerous reports—many of which are quoted in this paper—of cases in which nasal disease has been associated with affections of the heart's action, cardiac pains, etc., the author has undertaken a number of experiments in order to gain some definite knowledge on the subject. His method has been to take a sphygmographic tracing from the radial artery with Dudgeon's instrument, and then, leaving the arm and instrument in position, to irritate the surface of the turbinates and septum while a second sphygmographic tracing is obtained. A variety of irritants have been used—the probe, galvano-cautery, irritating in-sufflations, etc.—and the area submitted to irritation has been both limited and extensive. In all forty-three subjects have been tested—thirteen without and thirty with nasal disease—and the experiments have been repeated on several occasions.

The author has been impressed with the importance of this repetition; for the emotional element has a great influence in the variety of tracings obtained. Among the normal cases, where the turbinates and septum have been subjected to irritation, a certain proportion showed some increase in the pulse rate and some changes in the form of the dirotic wave. Slowing of the pulse and cardiac oppression were never observed. Where nasal disease was present a similar result was obtained, about half the cases showing a slight increase of frequency (eight to ten per minute), but nothing which produced subjective palpitation. In only one instance was slowing observed.

The result of the series of experiments is, then, entirely negative: though the author admits that, where a marked neurotic taint is present, some cardiac disturbance may occur from nasal disease.

He sums up as follows:—

1. The research proves that no special relationship exists between the nasal mucosa and the innervation of the heart.
2. The cases of cardiac disturbance dependent on nasal disease which have

been described by various authors, must have occurred in neurotic subjects predisposed to excessive reaction to irritation of any sensory nerve.

3. The sensory nerves of the nasal mucosa possess no special quality with regard to cardiac reflexes.

4. The trigeminal plays no other rôle in respect to these reflexes than that of any sensory nerve whatever submitted to any irritation. One should, however, bear in mind the high degree of sensibility developed in this nerve, as well as the character of the organ which it supplies. *Ernest Waggett.*

Kummell (Hamburg).—*The Treatment of Lupus with X Rays and Concentrated Light.* "Deutschen Medicinischen Wochenschrift," April 28, 1898. Congress of the German Surgical Society, Berlin, April, 1898.

THE speaker demonstrated several cases with lupus of the face which had been cured by the X rays. The danger of burning by too strong application of the rays is to be avoided by having the source of light to begin with at least forty centimètres from the skin, and then gradually bringing it nearer. By the first appearance of burning, which is characterized by a yellow tinge in the skin, the treatment must be stopped. The surrounding skin should be protected by tinfoil. Syphilitic ulceration was not influenced by the X rays. Kummell has also obtained good results from the use of concentrated light. *Guild.*

Lack, H. Lambert.—*Adenoid Vegetations and Laryngeal Stridor.* "Lancet," March 26, 1898.

IN criticising the above views it is pointed out that the author and Dr. G. A. Sutherland recently² claimed to prove that an affection commonly known as congenital laryngeal stridor depended upon a congenital deformity of the superior laryngeal aperture aided by the flaccidity of the parts in infancy (not in the latter factor alone, as Dr. Smith erroneously interprets the views). If adenoids are the exciting cause of the affection, as Dr. Smith asserts, it is a little surprising that Dr. P. McBride (who examined six cases for Dr. Thomson of Edinourgh) and the writer in some twelve consecutive cases have been unable to find them in a single instance. Dr. Smith's contention is weakened and his bias shown by his statement that he always believed these cases were due to adenoids, but that until this one case came under observation he had no substantial evidence of it. The typical class of cases described by Dr. Thomson, Dr. Sutherland, and the writer form a group *per se*, and must be carefully distinguished, as they pointed out, from cases of laryngeal spasm due to adenoids or other form of nasal obstruction. Many details of Dr. Smith's case, apart from the result of treatment, point to its belonging to the latter class. Thus the stridor ceased under chloroform, was much increased in sleep or by closing the mouth as in feeding, and the patient was subject to severe suffocative attacks, these symptoms being characteristic of the adenoid cases and very rare in the affection Drs. Sutherland and Lack called congenital laryngeal obstruction. Thus Dr. Smith's case in no way controverts their views as to the pathology of the latter affection. Finally, when Dr. Smith states that he believes the affection to be due to spasmodic contraction of the aryepiglottic folds, and that this is due to irritation set up by the adenoids in the naso-pharynx, the writer replies that the spasm in his patient was possibly due to irritation set up by the examiner's finger and laryngeal mirror in the infant's pharynx—a not uncommon reflex. *St. Clair Thomson.*

² The "Lancet," Sept. 11th, 1897, p. 653.

Mackenzie, G. Hunter.—*Nasal Polypi: their Diagnosis and Radical Treatment.* "The Lancet," Feb. 5, 1898.

THE presence of a mucous polypus in the posterior nares is sometimes overlooked if the following method is not adopted. The patient is instructed to close the opposite nostril, and firmly blow down the affected one; the polypus will then be distinctly observed to advance and recede with respiration.

The clinical characters are described. In treatment the forceps are condemned, and the cold snare, galvano-cautery point, and curette are recommended.

Hæmorrhage as a concomitant of mucous polypus of the nose is of bad significance with one exception. The exception is what is known as "bleeding polypus of the nose," a variety which usually affects women, and curiously enough is almost invariably located in the left nostril. It is of the nature of an angioma, and is attached to the anterior part of the septum.

Hæmorrhage in a mucous polypus almost invariably indicates a high degree of malignancy, and is one of the earliest and most persistent symptoms. The naked-eye appearances in the early stages in such cases may be very similar to ordinary mucous polypi, or more commonly the growths may be mottled and blood-stained. A characteristic feature of the hæmorrhage is the ease with which it may be induced, as, for instance, by simple and gentle probing. *StClair Thomson.*

Smith, Eustace.—*Adenoid Vegetations and Laryngeal Stridor.* "The Lancet," March 19, 1898.

SOME time ago the author expressed the opinion that laryngeal stridor, like many other nervous phenomena in early life, was sometimes due to the irritation of adenoid growths, and might be successfully treated by their removal. At that time he was unable to support this view with substantial evidence, but he is now able to quote an instance in which congenital crowing of a marked type ceased within a few days of the removal of the post-nasal growths.

An infant was admitted to hospital for laryngeal stridor at the age of one month. It was stated that the breathing had been noisy from birth, and that at times the crowing was so loud and the breathing so laboured and distressed as to raise fears for the child's life. The crowing was continuous. At times, however, especially after a meal or during the night, the breathing would become excessively loud and stridulous. In these attacks the face grew livid, the chest-wall was drawn in deeply, and the child showed every mark of suffering from want of air. After a time, varying from twenty minutes to an hour, the dyspnœa gradually subsided and the child returned to his ordinary state—crowing loudly with each breath, but giving no sign of discomfort. Still, even in these intervals of comparatively quiet breathing there was marked recession of the lower ribs and epigastrium, and all the intercostal spaces were drawn in. The stridor was a long-drawn croak, which was loud in inspiration, and less loud, although distinct, when the breath was expelled. It never ceased even during sleep. At times the child coughed, but the cough had no barking laryngeal quality, and the cry was natural and clear. Examination of the chest showed that the respiratory murmur was equal on the two sides. A few scattered rhonchi were noticed. During the suffocative attacks the lividity and distress were so great that it was thought advisable to keep instruments always ready at hand for the operation of tracheotomy. The temperature was normal throughout, and remained quite unaffected by the attacks of dyspnœa. Digital examination of the throat discovered a number of vegetations of small size in the naso-pharynx. No attempt was made at this time to remove the growths, but a two per cent. solution of resorcin was injected into the nostrils twice a day to control any post-nasal catarrh. The crowing, however, was not lessened by

this treatment, although the cough ceased, and after a few weeks the mother was told to remove the child, but to bring him back to the hospital if the symptom did not improve.

Three months later the child was re-admitted to the hospital. His general condition was less satisfactory than before. He was soft and flabby, and was said not to care for his food. The adenoid growths were scraped away under chloroform. While under the anæsthetic it was noted that the crowing ceased and the breathing was perfectly quiet and natural. A few days after the operation the following observation was made of the condition of the larynx :—The epiglottis was sharply folded on itself, so as to bring the posterior lateral surfaces into almost complete apposition. It was pale in colour, and somewhat thicker than usual. Throughout the examination the aryepiglottic folds were held tense. They were thinned and shortened, thus approximating the arytenoid cartilages and narrowing the upper aperture of the larynx. Only a small portion of the posterior ends of the vocal cords were visible; they were apparently healthy.

No suffocative attacks occurred after the operation, and stridor declined until it only became noticeable on deep inspiration or crying.

In this interesting case the connexion between the respiratory croak and the state of the pharynx hardly admits of doubt. For three months the stridor had persisted day and night without improvement; indeed, the attacks of acute dyspnoea, instead of growing milder, had become more severe and distressing. Ordinary measures of relief had met with no success. Then the adenoids were removed and a change was apparent at once. The night attacks ceased to occur and the child slept undisturbed. In a few days the croaking had begun to be less noisy; in a fortnight it could not be heard in ordinary breathing; in another two days it could not be heard at all, and the child was dismissed as cured. The case was not one of congenital malformation such as has been described by Dr. Lees, for the larynx was of normal size and development. Nor can the croaking be attributed to any laxness or flabbiness of tissue, as suggested by Dr. Sutherland and Dr. Lambert Lack, for Dr. MacIlraith noted that the aryepiglottic folds were held tense during the whole of the laryngoscopic examination. Moreover, the fact that the stridor ceased while the patient was under the influence of the anæsthetic, points very decidedly to spasm as a cause of the croaking. Dr. John Thomson has argued in favour of respiratory spasm being common in these cases, and attributes it to imperfect co-ordination of the respiratory muscles. Dr. G. Smith was inclined at one time to accept Dr. Robertson's explanation that the trouble lay in a posticus paralysis consequent upon a depraved innervation of those muscles from over-stimulation of the accessory nucleus, but the present instance has convinced me that paralysis of muscle is not a necessary element in the derangement. It is quite possible that the mechanism of the noise may be different in different cases. In the subject of this note the stridor is attributed to a spasmodic contraction of the aryepiglottic folds, and it is believed that this was due to irritation set up by the adenoids in the naso-pharynx. The author thinks it probable from this and other examples of the affection which have come under his notice, that adenoid vegetations and the post-nasal catarrh which almost invariably accompanies them may be a cause of many of the cases of congenital croaking, as they are, undoubtedly, of many of the cases of laryngismus stridulus. That the number and size of the adenoids present in any particular case are insignificant ought not, in his judgment, to tell against this view. It is a common observation in the case of older children that the degree of distress and general interference with nutrition caused by the vegetations is often greatly out of all proportion to the actual amount of adenoid hypertrophy. The reason of this he believes to be that the nervous

irritation is not uncommonly the consequence not so much of the growths themselves as of the post-nasal catarrh, which rarely fails to be joined with them sooner or later; at any rate, by reducing the catarrh he has often succeeded in putting a stop to signs of nervous distress, although the adenoid overgrowth itself was in no way interfered with by the treatment. In the present case, however, treatment of the post-nasal catarrh did not affect the crowing, which only ceased after the post-nasal vegetations had been scraped away. *StClair Thomson.*

Taylor.—*A Case of Urticaria of the Pharynx producing Grave Œdema of the Glottis.* “Philadelphia Med. Journ.,” April 2, 1898.

THE patient, a young lady, was seized with urgent dyspnoea after dinner, followed very rapidly by urticaria over almost the whole body. Counter irritation by heat to the feet, ice to the neck, a spray of cocaine and antipyrin gave great relief; also hypodermically strychnia, atropin, and later pilocarpin, and internally stimulants were administered. *B. J. Baron.*

LARYNX.

Barnett, J. E. S.—*Case of Spasmodic Dyspnoea.* “The Lancet,” April 30, 1898.

THE patient was aged three and a half months, and had suffered from obstructed respiration since soon after birth. Tracheotomy was performed, but the child died cyanosed three weeks afterwards. At the *post-mortem* it was found that the thymus gland was enlarged. It is suggested that this irritated the recurrent laryngeal nerves, setting up spasm, and that this was relieved by the tracheotomy: but the gland still growing caused direct and fatal pressure on the trachea. There was neither ulceration of the trachea nor papilloma of the larynx. *StClair Thomson.*

Garre, Prof. (Rostock).—*Extirpation of Larynx and Œsophagus.* Rostocker Aerzte Verein. “Münchener Med. Woch.,” May 3, 1898.

1. THE author showed a man in good health after total excision of the larynx two years before. The specimen showed the larynx and attached muscles, as the growth had infiltrated through the thyroid cartilage.

Jan. 14th, 1896. High tracheotomy was done.

Feb. 10th, 1896. Total extirpation of the larynx.

2. He also showed a case of extirpation of the larynx, with part of the œsophagus. The specimen showed carcinoma of the œsophagus, which had infiltrated into the cricoid cartilage and extended to the arytenoids.

Dec. 6th, 1897. Low tracheotomy, with cocaine.

Dec. 18th. Thyrotomy for diagnosis. Piece of tissue between the arytenoids was removed and showed carcinoma of the œsophagus under an intact mucous membrane.

Jan. 7th, 1898. Total extirpation of larynx, with upper part of œsophagus. Part removed was five centimètres in length and included the whole lumen, except two centimètres of the posterior wall. The incision was carried half a centimètre from the tumour. The trachea was divided close to the cricoid and the upper ring removed. It was then closed by suture. Closure of the œsophagus was not possible. It was stitched to the surrounding soft parts, to be closed later by a plastic operation.

What is the danger of the operation, and what are the chances of recurrence? Statistics vary greatly. Sendziak has collected one hundred and eighty-eight cases of total extirpation, with a mortality of forty-four per cent. This does not give a