# Abstracts.

## NOSE.

**P. Stenger.—On the Technique of the Intra-nasal Operations on the Ethmoidal Labyrinth.** "Zeitschr. f. Ohrenheilk.," vol. lxiv, Part I.

The anterior end of the middle turbinate is removed in the usual way with scissors and snare, and the bulla ethmoidalis localised and opened through with a Heymann's forceps. It is pointed out that the ethmoidal cell system is bordered by flat, more or less even bony surfaces, the lamina papyracea and the bony boundary of the anterior and middle fossæ, and that the walls of the cells are set roughly at right angles to one of these surfaces, and are of such a consistence that they can be nipped through with a cutting instrument. The cell walls afford a suitable hold for a cutting forceps, and if this appears to fail and a smooth bony surface is encountered, the boundary line has probably been reached. No hooks or sharp spoons should ever be employed on account of the danger of fracturing the lamina papyracea or wall of the anterior fossa by tearing and pulling. An illustration of the forceps recommended would have made the paper more useful. *Lindley Sewell.*

**Coleman, Frank.—Fistula of the Antrum closed by Sliding Bone-Flaps.** "Proc. Roy. Soc. Med.," December, 1911 (Odontological Section).

The patient was a male, aged twenty-nine. Mr. Coleman ascertained that he had a tooth removed in February, 1911. The extraction had been a difficult one and the root had come away encased in a layer of bone. A watery discharge from the tooth-socket followed and was not relieved by irrigation of the antrum. On September 28 Coleman found an opening into the antrum about the size of a goose-quill in the region of the left second upper molar, and on probing the antral cavity proved to be small. The normal opening was patent and there was no foreign body present in the cavity; fluid syringed through the antrum returned clear. Under general anæsthesia the edges of the fistula were freshened with an antrum perforator, and two chisel-cuts were made into the bone in front of and behind the fistula, while similar cuts were made with bone forceps on the inner and outer sides. The incisions were made sufficiently deep to weaken without detaching the bone. In this way the opening was surrounded by four movable or hinged bone-flaps, which were crushed together by means of the thumb and fingers. The operation was completed by uniting the mucous membrane with silk stitches. One month later the condition was satisfactory. *J. S. Fraser.*

**Herxheimer, Professor.—The So-called "Hard Papilloma" of the Nose, with Notes of a Case Affecting the Frontal Sinus.** "Zeitschr. f. Laryngol.," Bd. iv, Heft 3, p. 249.

Nasal papillomata have been divided into two classes—hard and soft. The latter are more common and are covered by cylindrical epithelium; they are really inflammatory hyperplasias. The hard papillomata are cauliflower-like growths covered with squamous epithelium; they are real tumours, and show both connective-tissue and epithelial proliferation. The squamous epithelium covering the tumour is probably due to metaplasia, although the formation of keratin and prickle-cells may occur. Similar metaplasia of cylindrical into squamous epithelium is, of course, observed in ozæna and also in the genital organs in certain conditions.

Herxheimer considers that the cells of this region have the power to develop in either direction, *i. e.* into squamous or into cylindrical cells. From a clinical point of view the hard papillomata appear to be somewhat malignant, though microscopically they seem to be simple tumours; they really occupy a middle place between innocent and malignant growths. Billroth recorded a case in which the tumour existed for eleven years without causing glandular involvement, but out of twenty-four cases collected by Blumenthal seven were malignant. Herxheimer himself has collected thirty-eight cases up to date in almost all of which the tumour was situated on the septum. There are only four cases hitherto described of malignant tumour of the frontal sinus, and in all but one instance the growth has been a sarcoma. The present patient was a woman, aged sixty, who suffered from myxœdema and had to take thyroid tablets. For two years she had suffered from a swelling on the forehead over the right eye, and later from symptoms of brain pressure along with double vision and exophthalmos; nasal examination was negative. At the operation a greyish cauliflower-like tumour was exposed protruding from the right frontal sinus. The tumour had destroyed the posterior wall of the sinus completely and a part of the anterior and inferior walls, and had thus broken through into the orbit and displaced the eyeball; it had also invaded the left frontal sinus. Suppuration followed in the wound cavity, and continued till bismuth paste (33 per cent.) was injected. Herxheimer calls the tumour, no doubt with justice, a "cylindrical-celled papillary fibro-epithelioma." *J. S. Fraser.*

**Karbowski. B. (Munich).—Bilateral Dilatation of the Frontal Sinus.** "Zeitschr. f. Larngol.," Bd. iv, Heft 5.

In rare cases dilatation of the frontal sinus may be due to new growths, traumatism, syphilis, etc., but it is usually caused by inflammatory changes in the mucosa with consequent narrowing (or even closure) of the frontal duct; the contents of the dilated sinus may be purulent (pyocele) or mucoid (mucocele). The process of dilatation is often slow, and may take twenty years; the ethmoidal, and even the sphenoidal sinuses may be involved. Karbowski records a case of symmetrical dilatation of the frontal sinuses with perforation of the floor. The patient had suffered from nasal discharge for about a year, but for several months the flow had ceased, and the patient had complained of supra-orbital headache. The case was first seen by an oculist, and later by a surgeon, who punctured the swelling and evacuated thick fluid. When observed by Karbowski the case presented the well-known features of frontal mucocele. At the operation the fluid proved to be thick, greenish, odourless pus; the ethmoidal regions were not involved. The fluid was sterile. Microscopical examination of the polypoid mucosa showed that in places the epithelium was absent, while in others it was reduced to a layer of flat cells; the submucous tissue was thickened and infiltrated; osteoclasts were not observed in the bone removed. *J. S. Fraser.*

## LARYNX.

**Barach, J. H. (Pittsburg).—Observations on Sound Production and Sound Conduction along the Respiratory Tract.** "Amer. Journ. Med. Sci.," October, 1911.

The author called attention in a previous paper to the fact that, owing to the properties of sound transmission possessed by the framework of