was followed by no unusual disturbance. The author concludes by referring to cases of a similar nature observed by Ziem, Lermoyez, Rethi, and others.

StGeorge Reid.

Pynchon, Edwin.—*Nasal Bougies and Drainage Tubes.* "New York Med. Journ.," Oct. 23, 1897.

THE writer finds fault with the several varieties of nasal drainage tubes at present used, inasmuch as the great majority of them on cross section resemble a flattened O, and therefore not properly adapted to the shape of the cavity they are designed for. As the septal surface of the nose is approximately plane, and the turbinal surface corrugated and convex, a device to meet the requirements of a proper drainage tube should have its inner side partly plane and partly convex, and its outer side concave. And on this principle he has constructed tubes which he holds possess great advantages over the others. *Sandford.*

Sachs, Richard (Hamburg).—*Primary Tubercular Tumour in Nose.* "Münchener Med. Woch.," Oct. 19, 1897.

PATIENT, A. C., twenty, had nasal obstruction for four years, with frontal headache and intermittent epistaxis.

Both nares were filled with growths; lungs normal; sputum free from bacilli. Tumours were removed—two from right, one from left—largest was six centimètres by two and a half centimètres. Removal left a cherry-sized perforation in septum nasi. Microscopic examination showed tubercle. Headache disappeared; respiration was free. He considers there was primary perichondritis, followed by perforation and tumour formation. Four months later there was nothing to be seen but the perforation.

Turnbull, Laurence (Philadelphia).—*The Anæsthetic to be Employed in the Various Operations on the Nose, Throat, and Ear.* "Med. and Surg. Rep.," Sept. 18, 1897.

THE author treats principally of the relative value of eucaine and cocaine solutions in these operations, applied either with a cotton wool swab or fine spray. He also speaks well of a solution composed of a 5 per cent. solution of cocaine and 2½ per cent. solution of eucaine. He points out that solutions of eucaine are more stable than those of cocaine, that it is possible to sterilize the former by boiling, and that it is also less poisonous, but on the other hand the anæsthesia in some cases is not so satisfactory. He concludes by referring to their relative value in ophthalmic operations. *StGeorge Reid.*

Wright, Jonathan.—*Papillary Œdematous Nasal Polypi and their Relation to Adenomata.* "New York Med. Journ.," Nov. 13, 1897.

THE writer traces the gradations in development from the ordinary mucous polypus through a benign adenomatous growth to a malignant one. He quotes a few very interesting cases, and has reproduced some instructive illustrations.

Sandford.

LARYNX.

Annandale, Thomas.—*Administration of Anæsthetics through a Tracheal Wound.* "The Lancet," Nov. 6, 1897.

IN operations which have necessitated a previous tracheotomy, the patient can be kept under chloroform by leading a rubber tube from the mouth of the tracheal

canula into a tumbler in which there is a sponge or cotton wool moistened with the anæsthetic. The advantages of this are :—(1) It is simple and effectual ; (2) the rubber tube can be easily disconnected from the tracheotomy tube, so as to clear the latter ; (3) it allows the anæsthetic to be administered at some distance from the patient, and so does not interfere with the operative procedure ; (4) the anæsthetic is not likely to be so irritating to the air passages as when it is more directly inhaled through the tracheotomy tube itself. The mechanism is illustrated.

StClair Thomson.

Fleming, C.—*A Personal Experience of Malignant Disease of the Larynx.* "Lancet," Oct. 16, 1897.

THE author in this case was also the patient ! He is forty-nine years of age, and there is no history of malignant disease in his family. The first thing he noticed was huskiness or weakness of his voice—about two years ago. Except for the muffled voice he had no other discomfort whatsoever ; no pain, tenderness, swelling, dysphagia—and, in fact, he remained to the last in perfect health. In November, 1895, he consulted Sir Felix Semon, who discovered a small growth on the left vocal cord ; but it was not till July, 1896, that the symptoms were sufficiently marked to warrant a diagnosis. An exploratory operation was then advised, and the advice confirmed by Mr. Butlin. A most important feature in this interesting history is the opposition the patient had to undergo from his friends—professional as well as lay—when the operation was decided on. However, on the 21st July, 1896, tracheotomy, laryngo-fissure, and complete removal of the left vocal cord was performed. He made a good recovery, and his voice has improved wonderfully in tone and character. Under the microscope the growth proved to be a typical squamous-celled carcinoma. *StClair Thomson.*

Friedrich (Leipzig).—*The Changes in the Affected Muscles in Paralysis of the Inferior Recurrent Laryngeal Nerve.* "Fortsch. der Medizin," Oct. 15, 1897.

AFTER reviewing the work that has been done in these cases, the author goes on to describe the histological appearances of the laryngeal muscles in the case of a man forty-eight years old, who had been under treatment for aortic aneurysm for four years, during which time there had been paralysis of the muscles supplied by the left recurrent laryngeal nerve.

The larynx was hardened in formol and alcohol, and the microscope revealed the following changes in the muscles affected.

On transverse section the fibres are oval or round, and only a few completely fill out their sarcolemma. They are much atrophied, and in many instances look like small round pieces lying in the sarcolemma, which is much too large for them. In places they are completely destroyed, and what is left of them is represented by a faintly coloured substance, which *looks like* fat cells.

The longitudinal and transverse striæ are retained even in the much atrophied portions, but degenerative changes are evident from the fibrillæ being separated, and they do not take the stain readily.

The longitudinal section shows that they are not even in thickness, and that they do not stain equally. The paler fibres often present hazy contours, but the transverse striæ, and to a greater degree the longitudinal ones, are retained.

The interstitial connective tissue is increased very unequally ; *e.g.*, whilst in many places there is no trace of increase, in other places, notably in the m. vocalis and m. thyro-arytenoidœus, there are bands of it. Since this occurs mainly in the most degenerated muscles, it is possible that the fibres with their sarcolemma are changed into connective tissue.

Very few nuclei are present, which is probably explained by the length of time of the existence of the paralysis. On the sound side the nuclei are increased. May this be due to the increased functional activity of these muscles?

No fat cells were found as a result of the degenerative changes, though they were found where they normally exist in the vicinity of vessels and nerves.

The degenerative changes were much more marked in some muscles than in others, *e.g.*, none in the interarytenoid and crico-thyroid, and a varying amount in the other muscles.

In the m. crico-arytenoid lateralis, thyro-arytenoid, and vocalis there was a certain amount, most marked in the last; but it was deepest in the posticus, where it is difficult to make out muscular structure.

All this shows that the histological changes follow Semon's observations; but whether the fact that this muscle shows signs of greater atrophy proves that it was first attacked, and that paralysis of the ad luctors ensued later, is not certain from microscopic observation. *Barclay J. Baron.*

Laryngeal Stenosis and Intubation. Leading Article, "New York Med. Journ.," Oct. 16, 1897.

O'DWYER'S tube seems occasionally to be productive of laryngeal stenosis, and, on the other hand, in stenosis from other causes it has proved remedial. Bayeux, of Paris, called attention to the fact that the majority of cases of stenosis occurred in children who had expelled the tube frequently during the treatment of their laryngeal or other trouble. Some of these stenoses were seated below the glottis; others, and they were the gravest, were situated at the level of the cricoid cartilage, where the larynx is narrowest. And, according to the same authority, repeated expulsions of the tube are symptomatic of laryngeal ulceration of the cricoid portion of the larynx. This portion should serve as the gauge for the size of the tube to be used, which would vary according to the child's age. He considered that neither a prolonged course of intubations nor tracheotomy was sufficient in the treatment of stenosis: it was better to perform crico-tracheotomy at once, since it was the cricoid portion of the larynx that was injured, and offered an obstacle to catheterism. In this way he treated two cases, and with speedy success. *Sandford.*

Rosapelly.—*Further Researches on the Rôle of the Larynx in producing the Voiced and Voiceless Consonants* (*Speaking, Whispering, and Respiratory Voice*). "Arch. Intern. de Laryngol., Otol., et Rhinol.," Sept. and Oct., 1897.

THE author proves by tracings taken with a recording instrument that, whereas in producing a voiced consonant (such as *b* in *aba*) the vocal cords are in a state of vibration, no vibrations occur when a voiceless consonant (*e.g.*, *p* in *apa*) is produced. Secondly, by laryngoscopy, during the attempt to pronounce *apa* he finds that at the moment corresponding to the attempted production of *p* the vocal cords are abducted. When, on the other hand, *aba* is attempted, the vocal cords remain in apposition throughout the attempt. In whispering the vocal cords are responsible for an appreciable part of the sound produced. No apposition of the cords occurs, but the glottis is reduced to a triangular figure, with a very narrow base. Laryngoscopy during the attempt to whisper shows that the voiceless consonants are produced during momentary abduction of the cords. The laryngeal vibrations employed in whispering may be detected by placing a binaural stethoscope against the cricoid cartilage. No such vibrations are heard when the voiceless consonants are produced. The laryngeal sound of whispering is monotonous in

the strict sense of the word. By the term "respiratory voice" the author designates the voice produced with a widely open glottis. This phenomenon is observed after violent exertion which necessitates panting—*i.e.*, rapid, uninterrupted respiration. In the respiratory voice the mechanism of voiced and voiceless consonants does not differ; indeed, it may be said that all the phenomena of speech are mute, including even the vowels, so far as the larynx is concerned. *Ernest Waggett.*

Schmidt, Edmund.—*Cancer of the Larynx.* "Deutsche Med. Woch.," No. 5, Nov. 4, 1897.

EDMUND SCHMIDT, in Meissen, reports this case to show how the symptoms depend on the situation.

Patient was a woman fifty years old, and complained of slight difficulty in swallowing.

Nov., 1896. Examination showed a swelling on the posterior surface of the right arytenoid covered with normal membrane, circumscribed, and soft when felt by a probe. Slight impaired movement of the right cord, although they came together on phonation.

March, 1897. Intermittent pain on swallowing; in the middle of the swelling were two whitish grey nodes. Part removed, and showed simple flat-celled tumour. Another piece removed, four weeks later, showed cancer. Patient was operated on, and died from pneumonia.

Post-mortem showed cancer of œsophagus above the flat plate of the cricoid. Change in the arytenoid was a metastatic growth, which affected the crico-arytenoid joints and caused impaired movement of the cord. He points out, as an important and grave symptom, the impaired movement at the beginning and throughout the illness.

Uchermann, Prof. V. (Christiania).—*Laryngitis Acuta Rheumatica Circumscripta* (*Nodosa*).

RHEUMATIC affections of the larynx are not well known.

1. One form described is where, in acute rheumatism, the crico-arytenoid joint may be affected and eventually ankylosed.

2. Another form described by Ingalls (Ninth International Congress at Washington) under the name of "acute and chronic rheumatic sore throat," exhibited the following symptoms: slight fever; pain varying in intensity, especially on swallowing; strong injection in pharynx, and eventually in larynx, with no secretion.

3. Another form has been described as angina, or pharyngitis rheumatica.

4. There is another form, which is rare, well marked, and of great interest both for differential diagnosis and treatment.

This form is represented by definite, very sensitive, red or bluish red masses of hard infiltration, which may be as large as an almond; if near the crico-arytenoid joint, a false ankylosis, with fixation of the vocal cord, may be caused, and by improper treatment may be permanent. Many of the so-called rheumatic recurrent paralyses may be due to this peri-articular rheumatic inflammation; similar appearances are seen on the palate, septum nasi, inner part of meatus, and tympanum, analogous to erythema multiforme and nodosum.

The following cases are given:—

1. K. H. (nineteen years of age) six years ago had rheumatic fever for four days; he had pain in the neck, difficulty and pain on swallowing, with hoarseness. Present state: Patient is hoarse; pain on swallowing; no cough. Laryngeal mucous membrane injected; both false cords swollen. Pars arytenoidea sinistra and next part of the ary-epiglottic fold swollen and of a dark bluish red colour.

Left cord is fixed in cadaveric position—edge convex and swollen on the upper surface. Diagnosis was laryngitis acuta circumscripta rheumatica, with infiltration and false ankylosis of the crico-arytenoid joint.

He was treated with salicylate of soda. Four days afterwards pain ceased; eight days later swelling disappeared—only slight hyperæmia; vocal cord is movable. No history of syphilis or tubercle.

Case 2. T. P., forty-nine years of age. Four days pain in neck on swallowing; last night cough and hoarseness. Present state: Introitus laryngis injected—posterior part swollen. Partes arytenoideæ infiltrated, bluish, and œdematous. Vocal cords slightly injected—otherwise normal and movable. Recovery in two days, after use of salicylate of soda.

The author has also seen a third case, but gives no description.

Wallace, Alexander.—*Atonic Aphonia.* "Lancet," Oct. 30, 1897.

THE value of this report is, to a large extent, neutralized by the unfortunate absence of the report of any laryngoscopic examination. It appears to have been a case of hysterical mutism, and is interesting as occurring in an adult male.

StClair Thomson.

ŒSOPHAGUS.

Snyder, A. A.—*Œsophagotomy and Removal of Dental Plate with Upper Central Incisor Tooth.* "New York Med. Journ.," Sept. 18, 1897.

THE patient, a woman of twenty-two, had swallowed a broken dental plate, which had lodged in the œsophagus. She was seen the following day, when her voice was deficient, and she complained of much pain above the sterno-clavicular joint on the left side. Attempts at removal of the obstruction had failed owing to the extremely irritable condition of the mouth and pharynx, in spite of cocaine applications and ninety-grain doses of potassium bromide in three doses. After much difficulty a flexible bullet probe located the obstruction at five and a half inches from the incisor teeth, and an operation was advised and accepted. On the third day from the date of the accident the plate was removed. A two-inch incision was made along the inner edge of the sterno-mastoid muscle, the skin having first been drawn a little towards the median line so as to form a valvular opening. The jugular vein and common carotid artery were exposed. A long probe passed through the mouth into the œsophagus located the latter, which was then incised by a cut large enough to admit the little finger. The plate and tooth measured one and a half inches by one and a quarter inches. The patient made an excellent recovery. It may be added that the X rays failed to locate the foreign body in this case.

Sandford.

THYROID, &c.

Rodocanachi, A. J.—*Four Cases of Goitre treated by Operation, and Certain Dangerous Symptoms which may follow the Operation.* "Lancet," Oct. 9, 1897.

THE symptoms to which the author wishes to draw attention are essentially restlessness, a rapid pulse, rapid respiration, accompanied by a considerable