Leipsic, 1891-92, xxxii., p. 421. Tricomi: Riforma Medica, Napoli, 1891, iii., p. 541. Cavazzani: Riforma Medica, Napoli, 1891, iv., p. 31. *Paci: Sperimentale, 1891, xlv., p. 425. *Lejars: Progrès Médical, Paris, 1892, xv., pp. 113-117. Berger and Fevrier: Bulletin de la Société de Chirurgie, Paris, 1892, xviii., pp. 75-80. *Gussenbauer: Beiträge zur Chirurgie, von Billroth, 1892, pp. 250-286. Arndt: Berliner Klinische Wochenschrift, 1892, p. 532. Shattock: Transactions of the Pathological Society of London, 1892, xliv., p. 62. Schlange: Archiv für Klinische Chirurgie, Berlin, 1893, xlvi., pp. 390-392. *Karewski: Archiv für Pathologische Anatomie, Berlin, 1893, cxxxiii., pp. 237-249. Buscarlet: Revue Médicale de la Suisse, 1893, xiii., p. 1. Sulicka: Thèse doc., Paris, 1893-94, No. 492. Parker: Bristol Medico-Chirurgical Journal, 1893, xi., p. 1. Hamann: Cleveland Medical Gazette, 1893-94, ix., pp. 110-112. *Giordano: Riforma Medica, Napoli, 1895, xi., pp. 530-544. Kopfstein: Wiener Klinische Rundschau, 1895, ix., p. 41. Lichtwitz: Gazette Hebdomadaire de la Société de Médecine, Bordeaux, 1895, xvi., p. 471. König: Archiv für Klinische Chirurgie, Berlin, 1896, li., pp. 578-618. Kontnik: Gazette Hebdomadaire, Paris, 1896, xliii., pp. 1216-1218. Binnie: Kansas City Medical Index, 1897, xviii., pp. 49-53. Von Hacker: Centralblatt für Chirurgie, Leipsic, 1897, xxiv., pp. 1073-1076. De Stella: Annales de la Société de Médecine de Gand, 1898, lxxviii., pp. 174-181. *Sultan: Deutsche Zeitschrift für Chirurgie, Leipsic, 1898, xlviii., pp. 113-155. Vaughan: Brit. Med. Jour., 1899, i., p. 148. *Nieny: Beiträge zur Klinischen Chirurgie, Tübingen, 1899, xxiii., pp. 89-108. Pouches similar in many ways to the one forming the subject of this paper are described by Watson, Pertick, Zuckerkandl, Kirchner, Schmidt, Kostanecki, and Kopfstein. The references of the first six will be found in Kostanecki's paper mentioned above.

StClair Thomson.

Lapeyre.—*Medical Treatment of Adenoid Growths.* "La Médecine Moderne." No. 42, October 16, 1901.

Lapeyre reports twenty-eight cases of adenoids in which he gave tincture of iodine internally in doses varying from 18 to 60 minims per day, the patients' ages ranging between five and nine years. Iodism was rarely produced. The adenoid symptoms disappeared rapidly. Lapeyre has used this treatment for three years, and highly recommends it. *Anthony McCall.*

LARYNX, Etc.

Milton, H.—*Removal of a Foreign Body from the Bronchus by Intrathoracic Tracheotomy.* "Lancet," January 26, 1901.

The patient was a Fellah, aged about forty years, on whom tracheotomy had been performed some years previously for syphilitic stenosis of the larynx. A short time previous to his readmission to hospital the tubular portion of the outer silver tube had become detached from the shield and had fallen into the trachea. On admission, the patient seemed in no ways incommoded, except for a slight fixed pain behind the sternum. No signs could be detected by external examination, and the laryngoscope showed nothing beyond the stenosis of the larynx. A long silver probe passed through the tracheotomy wound into the trachea as far as its bifurcation gave at first no indication; eventually, however, after bending its tip to the right, so as to facilitate its introduction into the right bronchus, a loud metallic click was produced, audible to the bystanders. During the following days many attempts were made to seize and withdraw the foreign body with various shaped forceps, blunt hooks, coin-catchers, slings, and mounted sponges without

success, the patient being frequently inverted. The patient was then left some days without further interference, but his temperature began to rise, and he was affected with a constant cough, accompanied by purulent expectoration, which gradually became fœtid. Examination of the chest showed that air entered both lungs freely, and that there were many moist rales and bronchitic sounds over the lower half of the right lung. The gravity of his condition was explained to the patient, as well as the serious nature of the operation proposed; he, however, expressed his anxiety to risk anything to obtain relief. It was evident that the tube could only be removed through a tracheal incision, and that this incision could be made in three positions, either in the neck, through the anterior or through the posterior mediastinum. The opening in the neck existed already, and all efforts to remove the tube through it had been unsuccessful. Of the two mediastinal routes, the posterior seemed to present more technical difficulties and to offer fewer chances of reaching the foreign body; it would at the same time afford better opportunities for drainage. It was decided ultimately to follow the anterior route.

The steps of this operation are then described. The patient died two days later.

Necropsy.—A post-mortem examination made shortly after death showed an acutely septic condition of the anterior mediastinum and commencing pneumonia of both lungs. There was no lesion or affection of the pleura, pericardium, or great vessels of the chest. There were two ulcers in the right bronchus from the pressure of the tube, and extreme cicatrization of the larynx from old syphilitic changes. The fatal result of the operation must be attributed to one of two causes—(1) acute septicæmia, and (2) interference with the functions of the thoracic organs due directly to the operative lesions. The evidence is largely in favour of the first supposition. All the elements necessary for its occurrence were present, suppuration pre-existed, the drainage and occlusion of the wound were imperfect, and the cellular tissue, of extreme tenuity, occupying the anterior mediastinum probably presented very little resistance to microbic invasion, while affording a ready means of entry for the resulting toxins.

Before quitting the particular case now reported, it may be well to consider how its particular dangers might have been better averted. Had the author to perform the operation again, he would modify the procedure after the removal of the foreign body as follows: No attempt would be made to close the tracheal incision by suture, the difficulties of an effectual closure being, as already pointed out, very great. The greater part of the manubrium sterni would be removed subperiosteally, and through the large opening thus afforded a large gauze plug would be introduced down to the tracheal wound sufficiently firmly to occlude it. The two halves of the sternum would be firmly united below this opening by three or four strong silver sutures, leaving their ends projecting between the skin flaps, sutured to the same extent. He would suture the skin from the tracheotomy wound down to the opening in the manubrium, and occlude the whole of the sutured skin with collodion and gauze, thus rendering it very easy to maintain an effective dressing over the plug, which might be changed every three or four hours.

Apart from the difficulties and dangers of any particular case, it is necessary to make a careful analysis of the intrinsic dangers of anterior median thoracic section. They may be considered under four heads: hæmorrhage, shock, lesion to any vital function, and, lastly, sepsis.

The operation is not one to be performed without very evident indication or without due consideration being given to all other possible methods of relief. Until its technique is much more thoroughly worked out the operation is one that is only justifiable when life itself is in danger, when there is a good chance of being able to remove the *causus morbi*, and where no less dangerous route or method is available. Undoubtedly the splitting of the sternum affords the most perfect approach to the anterior and middle mediastina; it remains to be seen whether this approach is not too dangerous to be admissible except in the most desperate cases.

(NOTE BY ABSTRACTOR.—There is no mention of the Röntgen rays having been employed, not simply to diagnose the presence of the foreign body, but also to locate its exact position, and on the screen to direct the movement of instruments introduced through the tracheotomy wound for its removal.—*StC. T.*)

StClair Thomson.

Ross, George S. (Montreal).—*Congenital Stenosis of the Larynx.* "Montreal Medical Journal," September, 1901.

This is the history of a case occurring in a female child aged three years. She had never cried in her life. Phonation was impossible. When irritated she would give vent to a muffled sound, as if a gag were held over her mouth. Deglutition was perfect, and the nourishment of the body natural, so that when seen by the doctor she appeared to be a healthy, robust child.

After much effort a glimpse of the larynx was obtained by means of the laryngoscope, and a web or band was seen to be stretched across the glottis, binding the vocal cords together. The colour of the band was lighter than that of the surrounding mucous membrane. Respiration was carried on through an oval opening in the web, large enough to admit of aeration of the blood when the child was not excited; but when this occurred cyanosis was always induced. *Price-Brown.*

EAR.

Crouzillac.—*A Case of Secondo-Tertiary Syphilitic Labyrinthitis; Cure.* "Annales des Maladies de l'Oreille," etc., August, 1901.

This case occurred in a man of forty-three, and is interesting for the following reasons:

1. The rapidity with which the affection invaded the labyrinth.
2. The presence of concomitant cerebral troubles which seriously affected the prognosis.
3. The favourable result finally obtained by specific treatment.

Macleod Yearsley.

Felix, Eugene.—*Labyrinthitis in Acquired Syphilis.* "Annales des Maladies de l'Oreille," etc., December, 1901.

This is a very good review of the subject. Felix points out the rarity of labyrinthitis due to recent syphilis, but mentions cases observed by himself and other authorities. He distinguishes clinically three varieties of labyrinthine syphilis—that of slow onset, that of rapid onset, and apoplectiform. He believes, with Gradenigo, that the