

The condition appears to be a general absence of moisture from the mouth, with perhaps a slighter similar affection of the nose. One feels inclined either to attribute it to causes resident within the nervous system, or else to regard it as allied to those granular atrophic phases of deficient secretion met with in the nose, fauces, pharynx, and conjunctiva. Prof. Fraser's paper in the *Edinburgh Hospital Reports for 1893* contains a table of the nineteen cases recorded up to that time. *StClair Thomson.*

Von Engelen.—*Adeno-Phlegmon of the Pharyngo-Maxillary Triangle. Drainage.* *Cure.* Cercle Méd. de Brux., April 6, 1898; "Journ. Méd. de Brux.," May 19, 1898.

THERE had been tonsillitis of three weeks' duration; the tonsil was swollen and appeared to fluctuate. Incision of the tonsil reached no pus, but on cutting deeply behind the posterior border of the sterno-mastoid it was evacuated, and cure rapidly followed. *B. J. Baron.*

NOSE, &C.

De Greift.—*Ozæna.* "Annales et Bulletin de la Soc. de Méd. d'Anvers," Nov. and Dec., 1898.

FIVE forms of ozæna are to be distinguished:—(1) Due to adenoids. (2) Due to sinusitis, with degeneration of the pituitary mucous membrane. (3) The necrosing form, the ethmoid being affected. Curetting is here the treatment. (4) Purulent form, with hypertrophy of the mucous membrane in children, and passing on to the next form—the (5) atrophic or true ozæna.

Treatment must be according to the cause, *e.g.*, ablation of the mucous membrane, application of powders, antiseptic and irritant, spraying with solutions of nitrate of silver. Vibratory massage, electrolysis, antidiphtheritic serum, injections of iodine. *B. J. Baron.*

Guye (Amsterdam).—*The Plica Vestibuli and Indrawing of the Alæ Nasi.* "Münchener Med. Woch.," June 28, 1898.

THE plica vestibuli is prevented from lying on the septum by the tension of the alæ nasi. This may be lessened in sleep or by paralysis; so that stenosis—which may be assisted by irregularities of the septum—is produced. This stenosis, owing to abnormalities of the septum, is usually more marked on one side, and is a frequent cause of disturbed sleep.

If the patient lies on the right side the right nostril closes; if on the left, then the left closes. He is compelled to lie on the side of the narrower nostril. If this closes, enough air is obtained through the other; if the wider nostril closes, nasal respiration is obstructed. The patient cannot fall asleep, or else he speedily wakes up again. If the right side is obstructed sleep must be obtained on the left side, which is usually more difficult, as the heart movements are more obstructed in this position. Tossing about from side to side then occurs, usually with interrupted sleep. Some overcome the difficulty by sleeping on their backs; but few can sleep comfortably in this position.

The author recommends a rubber ring with a diameter of ten to fourteen millimètres, a lumen of six to eight millimètres, and a breadth of two to six millimètres. It should be cut to fit irregularities of the septum. A thread may be attached to it to prevent its passing into the nostril during sleep. *Guild.*

Hammond, L. J. (Philadelphia).—*Surgical Treatment of the Sinuses accessory to the Nose.* "Philadelphia Polyclinic," June 11, 1898.

In a paper read before the Philadelphia County Medical Society the author deals at length with the treatment of chronic atrophic disease of these passages. He points out that disease in almost every case originates in the ethmoidal sinuses, spreading from thence into the sphenoidal and frontal. He does not consider the maxillary sinuses important factors in chronic atrophic disease, except in a secondary manner; they, are, however, more likely to be involved in acute inflammatory conditions. "Two forms of atrophic change take place within the mucous membrane of the nasal cavities that call for surgical interference: first, primary atrophy, the result of a depraved condition of the tissues as seen in strumous diathesis; second, that following hypertrophy, the latter less likely to at least primarily involve the accessory sinuses than the first mentioned, and is therefore more amenable to local treatment." In all cases which have passed the early stage he prefers to treat in a surgical manner. The patient is placed on his back and drawn to the edge of the table, so that the head can be dropped to an angle of forty-five to fifty degrees. The ethmoids are thoroughly explored by means of the blunt probe, and, after the carious area is located, all bare bone and granulation tissue is removed by means of a notch-shaped curette, the broken down necrotic tissue being syringed out at intervals with a warm boracic acid solution, the curetting being carried back as far as may be necessary. The author states that he has repeatedly removed the entire ethmoidal cell, and extended the curetting far back into the sphenoidal region with the happiest results. The after treatment consists in excluding the air from the nostrils by closing them with pledgets of sterilized cotton, and washing out the cavities twice in twenty-four hours for about six days.

St George Reid.

Henderson.—*Notes on an Interesting Case of Naso-Pharyngeal Polypus, Successfully Removed.* "The Indian Lancet," June 1, 1898.

A YOUTH, aged nineteen. Patient was very anæmic, pulse weak and intermittent. The breathing was very laboured. The right half of the nose was completely blocked by the growth, which was about the size of an orange. On examination the growth was found to be protruding through the right posterior nares, occluding both the nares to such an extent as to seriously interfere with the respiration, occupying the superior aspect of the pharynx, and pushing the soft palate downwards and forwards. On digital examination the tumour was found to be soft to the feel in the front, but hard and ulcerated posteriorly. Some attempt at removal had already been made, and as the patient had lost a good deal of blood, he was put upon appropriate treatment and watched. Henderson considered two alternatives—(1) either to expose and remove the growth by performing an osteoplastic section of the superior maxilla after preliminary tracheotomy, or (2) to lay open the anterior nares by incising the upper lip in the median line, carrying it from the alæ of the nose upwards a little away from the median line, with an osteoplastic section of the nasal bone if necessary. It was decided to adopt the second and less extensive operation. The amount of space proved quite sufficient, and the tumour was removed with scissors, osteoplastic section of the nasal bone being dispensed with. The tumour was found to be firmly attached to the osseous surfaces surrounding the posterior nares, viz., the basilar process, the inferior surface of the sphenoid, the posterior part of the hard palate below the pterygoid process on the outer side, and part of the inner on the inner side. These extensive attachments were dealt with with ease.

No mention is made as to the nature of the growth. *Macleod Yearsley.*

Lenzmann.—*Septicæmia following a Furuncle of the Nasal Orifice.* “Münchener Med. Woch., June 21, 1898.

LENZMANN reported a fatal case of septicæmia which occurred in his practice. Woman, thirty-six, healthy constitution, developed a furuncle at the nasal orifice, where a small hair might have been removed. The next day the furuncle was redder and larger. An incision was made, when an opaque non-purulent fluid exuded. Fever increased, the frontal region became œdematous, and was incised on the fourth day. Patient became unconscious and weaker, and died on the fifth day. Numerous staphylococci were found in the furuncle and in the infiltrated soft parts on the forehead. *Guild.*

Leyser (Darmstadt).—*Hypertrophy of the Pharyngeal Tonsil in Connection with the Hypothesis that its Radical Removal requires an Anæsthetic.* “Therapeutische Monatshefte,” Dec., 1897.

IN this paper the author points out that we must reckon with the general risk attending chloroform administration, and in addition the special danger of aspiration. The duration of anæsthesia has no effect on the mortality. It cannot be denied that if repeated introduction of an instrument is necessary, the operation is sufficiently painful and prolonged to warrant anæsthesia. There are certainly children with whom one cannot accomplish this without force, but these also resist violently the administration of chloroform. Digital examination after three years of age is very seldom required by rhinologists who will use a little patience. The operator should not be like dentists and leave the question of anæsthesia to be decided by patients. He does not agree with Lenzmann that it is easy to arrive at that stage in narcosis where there is muscular relaxation and insensibility with retention of the pharyngeal and laryngeal reflexes. With the head hanging over there is greater safety, although the technique is more difficult and the hæmorrhage greater. A skilful operator can obtain good results with or without anæsthesia; the unskilful is not helped with anæsthesia, and the danger to the patient is increased. The radical removal does not depend on anæsthesia, but on a thorough knowledge of the anatomical conditions of the naso-pharynx and of the situation of the hypertrophy. For this knowledge of the anatomical and pathological conditions of the naso-pharyngeal tonsil we are indebted to Trautmann, who in 1886, from numerous *post-mortems*, which he confirmed in 1893 by a large series of new *post-mortems*, disproved the idea that hypertrophies develop on the lateral wall of the naso-pharynx, tube mouth, tubal prominence, and Rosenmüller fossa, and that those discovered there by posterior rhinoscopy or digital examination without exception are situated in the fornix. From this observation the possibility is deduced of removing the whole hypertrophy with one cut. Beckmann deserves the merit of having introduced a suitable instrument—a modification and improvement of Gottstein’s—and of having proved its practical worth (“Transactions of the German Otological Society in Jena, 1895”). This method reduces the necessity of anæsthesia to a minimum, as only one introduction is necessary. The short duration of the pain does not require an anæsthetic; it is only required where otherwise direct force would be necessary. Failure is due to want of dexterity, not to want of an anæsthetic. *Guild.*

O’Kinealy.—*Post-Nasal Growths—an Analysis of One Hundred Cases.* “The Indian Lancet,” June 1, 1898.

IN this paper (read before the Indian Medical Congress) an attempt is made by an analysis of one hundred cases to ascertain the race distribution, age incidence, ratio for sexes, and the frequency and nature of the complications of post-nasal adenoids in reference to their occurrence in India. Such inferences drawn from

so small a number of cases can be but approximate in nature. The hundred cases occurred amongst a total of 461 patients of various nationalities treated during ten months for nose and throat affections in the Medical College Hospital, Calcutta. Post-nasal growths were thus 23·8 per cent. of all the patients, showing that they are not uncommon in Calcutta. The symptoms among the younger patients were those typical of "adenoids," in the older they were chiefly those of naso-pharyngeal catarrh. As regards *race*, for each native who suffered, the proportional number of Europeans with the same condition was over 2½. It is noteworthy that out of the 461 patients seen, 11 were Jews, and of these 6 had adenoids. *Age*:—Amongst the Europeans 52, and amongst the natives 21, of the cases were under 20 years of age—a total of 73 per cent. The remaining 27 per cent. were 20 years old or more. The youngest patient in each race was 3½ years old; the eldest was, among the Europeans, 31, and in the natives 35. The highest and lowest limits were: European males, 4 and 31 years. European females, 3½ and 21 years. Native males 3½ and 32 years. Native females, 8 and 35 years.

Sex.—In Europeans 41 out of 124, males; 20 out of 47 females; in natives, 30 out of 239 of the former, and 9 out of 51 of the latter sex. Relatively, however, it was found that among the Europeans half the females and one-third of the males suffered, while among the natives, approximately, a sixth of the former and an eighth of the latter sex were affected.

Under the head of complications the following troubles were included:—*Fauces* (enlarged tonsils, congestion and hypertrophy of the faucial pillars) found in 73 patients, 47 Europeans and 26 natives (32 males, 15 females of the former; 20 men, 6 women, of the latter). *Pharynx* (congestion or granular pharyngitis), 71 cases, 44 Europeans (28 men, 16 women), 27 natives (22 men, 5 women). *Nose* (hypertrophic rhinitis, septal deviations, crests, spurs, necrosis of the septum, nasal polypi, nasal papilloma), 60 cases, 32 Europeans (19 males, 13 females), 28 natives (22 males, 6 females). *Larynx*.—Although the larynx was not examined in every case, it was found to be in various stages of chronic congestion in 21 patients. Of these 8 were Europeans (males), 11 native men, 2 native women. One of the last had paralysis of the left vocal cord and left side of the soft palate. *Ears*.—Only examined when complained of. Ear trouble in 22 cases only (Europeans, 9 men, 5 women. Natives, 6 men, 2 women). Condition chiefly met with being "Eustachian catarrh."

[We cannot but regret that a more systematic examination of the ears was not made; probably a considerable number of ear troubles passed unrecognized.]

Tongue (hyperplasia of lingual tonsil, enlargement of superficial veins at root of tongue) 26 cases, Europeans, 9 males, 6 females. Natives, 9 males, 2 females.

Treatment.—The post-nasal growths were in most cases removed under chloroform by means of Lowenberg's forceps on Gottstein's curette.

The paper is illustrated by two tables, showing the proportion of cases affected to those examined, together with the race distribution, ratio for sexes and age incidence, and the number of patients affected with various complications.

MacLeod Yearsley.

Röpe (Solingen) — *Radical Operation in Chronic Obstruction by Mucus and Suppuration in the Upper Accessory Sinuses of the Nose.* *Vereinigung West Deutscher Hals- und Ohren-ärzte in Köln*, April, 1898; "*Münchener Med. Woch.*," June 21, 1898.

THE author thinks that in almost every case of chronic empyema of the frontal sinus the ethmoid is also affected; therefore he recommends subperiosteal removal of the anterior wall of the frontal sinus, removal of the mucous membrane (Kühnt's method), broad opening and enlargement from the frontal sinus of the

diseased ethmoid. In double frontal empyema a horizontal incision is made from the outer third of the margo supraorbitalis to the corresponding point on the other side, with a perpendicular incision in the middle line. Skin and periosteum are reflected together, anterior wall of both sinuses with the septum and pars nasalis of the frontal bone are removed. He showed eleven cases; the cosmetic result was good with the exception of one case, where the cavity was abnormally large and deep. The patients have neither headache nor secretion from the affected cavities. Healing lasted ten days to six weeks. *Guild.*

Schiff, Arthur. — *Ueber das Vorkommen des Meningococcus Intracellularis (Weichselbaum) in der Nasenhöhle nicht Meningitis kranker Individuen Aus der III. Medicinische Universitäts Klinik, Wien.* "Centralblatt für innere Medicin," No. 22, 1898.

THE meningococcus intracellularis has been frequently found in the nasal secretion of these affected with epidemic cerebro-spinal meningitis.

In a case of supposed acute epidemic cerebro-spinal meningitis the author found in the nose numerous meningococci intracellulares, which were proved by cultivation and animal experiment. Lumbar puncture, however, showed tubercle bacilli, which was confirmed by *post-mortem* examination. This induced him to examine the nasal cavities of patients and those in good health for the relative frequency of this organism. The examination showed that the meningococcus intracellularis was present not infrequently in those who had not epidemic meningitis, when this disease was sporadic.

He examined twenty-seven individuals, some of whose nostrils were normal while others had slight catarrh. In seven cases microscopically more or less numerous intracellular diplococci were seen, which had the appearance of Weichselbaum's; but only in three cases were they so numerous that their pure cultivation could be effected. It must be noted, however, that they are difficult to grow on the usual nutritive media, and that on agar glycerine plates they can hardly be differentiated microscopically from other short bacilli. *Guild.*

Vansant.—*A New and Successful Treatment of Certain Forms of Headache.* "The Philadelphia Med. Journ.," May 7, 1898.

THE author of this paper directs attention to the treatment of headache by forcible syringing of the nasal accessory sinuses with a stream of hot, dry air (medicated in some instances) or nitrous oxide gas. He has found that frontal headaches in particular are relieved from this treatment, although some of the patients also referred the pain to the temporal regions or to the vertex, and in some instances the statement was made that the pain went all through the head, but was worse in the frontal region.

Vansant asserts that the relief from headache of even many years' standing, given by this hot air treatment, has been so quick and complete as to be, in some instances, "positively startling." The relief was complete and permanent after one or two treatments in some instances; in other cases a more prolonged treatment was required. Notes are given of thirteen cases, of which the following are brief abstracts:—

Case 1—Constant frontal headache and tinnitus aurium of over twenty years' duration in the case of atrophic rhinitis; permanent relief from the headache and tinnitus from one treatment. Female, aged forty-two.

Case 2 (a Physician)—Acute frontal sinusitis, with intense frontal headache of three days' duration; immediate and complete relief from one treatment. In this case nasal obstruction (septal deviation) closed the outlet of the frontal sinus, and confined the secretions in that cavity.

Case 3—Male. Dull headache, with confused feeling in the head, for two years, relieved in one treatment. Septal exostosis, hypertrophic rhinitis, granular pharyngitis.

Case 4—Frequent severe headache for several years. Result of treatment, marked improvement after several hot air applications. Female. This case also had nasal stenosis.

Case 5—Female, aged fifteen. Constant frontal headache for three years; permanent relief from one treatment. The removal of a large nasal polypus did not relieve the headache.

Case 6—Severe frontal and vertical headache, with excessive tinnitus and deafness of two years' duration. Complete relief from headache and tinnitus, with restoration of hearing to normal in three treatments. Female, aged twenty-five.

Case 7—Headache of from four to five years' duration, principally frontal, and associated with very severe tinnitus aurium. Relief from one treatment. Male, aged seventy.

Case 8—Intense frontal headache and severe tinnitus of six weeks' duration. Relief after a number of treatments. Female, aged forty.

Case 9—Intense frontal headache of long duration, associated with occipital headache, uterine disease and general debility. Complete relief from the frontal headache with one treatment. Female, aged forty-two.

Case 10—Severe frontal and temporal headache, associated with nasal polypi. Relief with one treatment. Male, aged thirty-three.

Case 11—Acute frontal headache, following a coryza. Relief by hot-air treatment. Female, aged thirty.

Case 12—Almost constant headache for more than a year. Relief in a few treatments. Female, aged nineteen.

Case 13—Severe headache, with acute inflammation of the left frontal, ethmoidal, and sphenoidal sinuses. Relief after hot-air treatment. Female.

It is to be noted that in nearly all these cases there was nasal obstruction present in some form or another. The forcible syringing of hot-air into the accessory sinuses caused, in many instances, a free serous discharge from the nostrils, which, however, did not last very long. Vansant points out both these facts, and states that he combines his treatment with the removal of any nasal obstruction present. He thinks the explanation of the relief caused by the hot-air syringing to be as follows:—The condition causing the headache consists in a blocking and stoppage of the small outlets to the sinuses or the small cavities within the sinuses; that this stoppage is followed, in some instances, by a retention of gases or fluids in these cavities; in other instances by absorption and rarefaction of the confined air, thus lessening the support of the atmospheric pressure to the walls of the bloodvessels, and causing chronic congestion of the mucous membrane lining the sinuses. The effect of the forcible syringing of these cavities with hot air is to open up these outlets, allow retained gases or fluids to escape, and to restore the equilibrium of the atmospheric pressure. When the outlets are once freed of their obstructions, they do not easily become obstructed again; hence the relief from headache was not only obtained quickly, but the good results of the treatment were lasting.

It is regrettable that Vansant has given no description of the technique of his treatment.

Macleod Yearsley.