Abstracts.

PHARYNX.

Clinical Problems Relating to the Faucial Tonsils in Adults.—G. E. Shambaugh. "Annals of Otology," xxvi, p. 135.

The removal of tonsils in adults is by no means a minor operation, and, while the indications for it have been greatly increased by a better appreciation of the menace existing in tonsils as a seat of chronic infection, still it is quite evident that the indiscriminate removal of tonsils in adults is to be discouraged. The decision to remove the tonsil can be reached in a great many cases only after a useful investigation, which, to be complete, requires the co-operation of the internist.

Macleod Yearsley.

The Tonsil Question in Children.—G. W. Boot. "Annals of Otology," xxv, p. 129.

The author's advice is thus given: (1) Operate only for definite disease. (2) Be sure the tonsil condition is the cause of the disease. (3) Always do a urinalysis before operating. (4) Always inquire for a possible history of bleeding. (5) If not certain, test the blood coagulability. (6) Don't push the anæsthetic to the abolition of the laryngeal reflex. (7) Don't be slow in operating. (8) Don't destroy a functionating organ unless the gain more than offsets the loss. (9) The younger the patient the more carefully must the need of tonsillectomy be established.

Macleod Yearsley.

Concerning the Indications for and Dangers of Tonsillectomy.—G. B. Wood (Philadelphia). "Amer. Journ. Med. Sci.," August, 1917.

The operation of tonsillectomy is not free from danger, and while the percentage of fatal results is exceedingly small, serious complications are not very infrequent, so that although the benefit that accrues from the removal of an infecting tonsil often outweighs the risk of the operation, it is essential to have a clear understanding of the indications for the operation. The cases may be divided into two groups, namely: (1) Those in which the tonsils are responsible for local disturbances, and (2) those in which they act as a gateway of entrance for a systemic infection. It is sometimes very difficult to come to a decision in the second class of case, and in these a culture taken from the tonsillar crypts may be of assistance. Occasionally, such a culture when tested with the patient's blood will give some biological reaction indicative of an ætiological relation to an existing systemic infection. The principal dangers are those due to the anæsthetic, hæmorrhage, and septic infection, including abscess of lung. The use of chloroform in these operations, even when given by a skilled anæsthetist, is absolutely unjustifiable. Ether given by the open method is the safest anæsthetic, but the writer has seen one case in which serious acidosis followed a comparatively short and light ether narcosis. To guard against this, bicarbonate of soda in large doses should be given

as a routine measure for twenty-four hours before the operation. It has the additional advantage of reducing the vomiting to a minimum, and apparently making the post-operative sore throat less distressing. In spite of many suggestions to the contrary it is very rare for a permanent vocal or other loss of function to occur as the result of a tonsil operation.

Thomas Guthrie.

The Tonsils as an Atrium of Infection in Poliomyelitis.—E. M. Seydell. "Annals of Otology," xxvi, p. 98.

In the 203 cases studied, tonsils were present in 200. In three cases there was a partial absence of these structures, and in these cases the paralyses were slight and recovery rapid. Dr. Rosenow, in a communication to the author, stated: "I know of two cases that have developed poliomyelitis in whom tonsils and adenoids were presumably properly removed. In one there was only a slight weakness of the shoulder muscles, which disappeared promptly. In the other case the paralysis was slight, even though a brother of the patient, whose tonsils had not been removed, was severely paralysed. I have seen these two cases and have heard of others, and I believe in all cases the paralysis was not marked."

Macleod Yearsley.

Œdema of the Glottis (?) following Tonsillectomy.—E. Lee Myers. "The Laryngoscope," February, 1917, p. 98.

Myers' patient was a physician who complained of fulness in both ears. The tonsils were buried, the right one having been clipped a few years previously. Upon manipulation some caseous matter was pressed out. The patient was a powerful man of the plethoric type. The left tonsil was removed by dissection with the aid of quinine and urea hydrochloride infiltration. No attempt was made to control the hæmorrhage as the patient wished to lose some blood. The right tonsil was removed according to the same method, but there was slight difficulty in separating it from the posterior pillar, and two or three tags had to be removed with the tonsil punch. Slight arterial bleeding was stopped by torsion. Myers was hurriedly called at midnight on account of the patient's dyspnœa and found him presenting a puffy and anxious appearance. Laryngoscopy showed a turban-shaped epiglottis with infiltration of the glosso-epiglottidean folds. The vocal cords were not involved. The patient was given ice to suck, and an ice pack was applied to the throat externally. A local spray of adrenalin was used, but in spite of this the patient presented the characteristic apprehension met with in largyngeal obstruction. Recovery took place. Myers has noted that after enucleation of buried tonsils with adhesions there is considerable œdema of the uvula and posterior pillars, especially when the patient is full-blooded. He believes that the œdema was due to injury of the soft parts.

J. S. Fraser.

Gumma in Fossa of Rosenmüller, causing Deafness.—Isaac M. Heller. "Annals of Otology," xxvi, p. 70.

Married woman, aged forty-one. The growth prevented inflation by catheter. Diagnosis lay between malignancy and syphilis. Wassermann was positive. Three injections of 0·45 and 0·60 grm. of neo-salvarsan

were given with intervals of seven days. Sodium iodide and mercury were also given. Reaction was prompt, and after the third injection the fossa was free and hearing equal to that of the opposite ear.

Macleod Yearsley.

NOSE.

Antral Abscess Treated with Salicylic Acid.—P. R. Wilde. "Lancet," 1917, vol. i, p. 998.

An elderly lady with an antral abscess which had lasted fourteen years. Daily washed out through permanent tube. Treated by plugging antrum loosely with gauze impregnated by powder of acid. salicyl. 1 pt., sach. alb. 4 pts. Discharge ceased in four days. No further trouble.

Macleod Yearsley.

LARYNX.

Leeches in the Larynx.—Navarro. "Revue de Laryng., d'Otol., et de Rhinol.," June 30, 1917.

These occur very frequently in Andalusia, chiefly from June to October, and in field-labourers.

The pathognomonic symptom is hæmoptysis without any interference with the general health. Such symptoms as are especially referable to the larynx vary widely in intensity, from complete absence to a state of imminent asphyxia. In the latter case the unattached end of the animal acts as a valve, lying pendulous in the long axis of the larynx during inspiration, but flapping upwards so as to occlude the glottis during the expiratory blast. There is one sign which is only found occasionally, but which, when it exists, is characteristic; a coarse bruit, caused by the free end of the leech knocking against the glottic walls during expiration.

Treatment.—In the removal of a leech, cocaine is dangerous; on the contact of cocaine the leech relaxes its hold and falls into the trachea or bronchi.

Patients acquire a tolorance to leeches in the larynx.

H. Lawson Whale.

EAR.

Wounds of the External Auditory Meatus.—Rozier. "Rev. de Laryng., d'Otol., et de Rhinol.," August 15, 1917.

The fissures of Santorini, which normally contribute to the elasticity of the cartilaginous meatus, after an injury become filled by fibrous tissue continuous with the neighbouring perichondrium. And this plays an important part in stenoses of the cartilaginous meatus.

As regards treatment, the results of the author's full analysis of stenoses into annular and tubular, cartilaginous and bony, may be summarised as follows: A crescentic incision is made to encircle the posterior half of the meatus, and, from the centre of this, another is carried horizontally backwards. The resulting flaps are turned up and down, and as much cartilage, or bone, or both, removed as is necessary.

The flaps are stitched into place, and the enlarged canal dressed with gauze plugs. The prognosis is invalidated by a coexistent chronic otitis media. *H. Lawson Whale.*

Early Operative Treatment of Chronic Discharge from the Middle Ear.—R. Graham Brown. "Medical Journal of Australia," July 21, 1917.

Brown begins by stating that the orthodox treatment of suppurative conditions of the middle ear is hopeless. His paper is mainly an exposition of the theories and opinions of Charles Heath, with whom he is in close agreement. He gives a description of the Heath operation and methods of after-treatment. One paragraph leads to the question, is it an exact description of Heath's method? "After controlling all hæmorrhage, a careful dissection is made through the deep fascia. The lower border of the sheath of the temporal muscle is defined and left uninjured." Why dissect through the deep fascia when the parts can be separated downwards to the upper margin of the bony meatus without dissecting through the fascia? *A. J. Brady.*

Labyrinthine Fistula with Complete Loss of Cochlear Function and Persistence of Normal Vestibular Function.—J. Auerbach. "Annals of Otology," xxvi, p. 117.

Man, aged forty-three, with left otorrhœa from childhood. Dry for pus five to six years. Seven months before consultation, violent attack of vertigo with vomiting. A full account of the examination is given. The interesting features of the case are: (1) Practically normal vestibular reaction, showing neither an increased nor a diminished static activity. (2) Complete loss of cochlear function, indicating a widespread invasion of the labyrinth at some past period. (3) Question of treatment. The patient was seen by several otologists, who advised a radical mastoid operation. Was this advice justified in the light of the findings? (4) A dry ear with no spontaneous nystagmus, no dizziness, no loss of hearing seems to call for no operative interference. (5) With a recurrent acute infection of the middle ear, causing retention, dizziness, spontaneous nystagmus, and disturbance of equilibrium, a radical mastoid would be in order. In no case should a labyrinth operation be considered, unless intra-cranial complications were threatening or manifest.

Macleod Yearsley.

Salivary Fistula following a Simple Mastoidectomy with Cervical Abscess.—F. C. Schreiber. "Annals of Otology," xxvi, p. 113.

A rare post-operative sequel. The case, a girl, aged seven, show it in conjunction with facial paralysis, a double catastrophe, regarded by the recorder as unique. She was operated upon for acute mastoid abscess with cervical abscess at the age of two. *Macleod Yearsley.*

MISCELLANEOUS.

Mental Hygiene and Shell-shock during and after the War.—F. W. Mott. "Brit. Med. Journ.," July 14, 1917.

In his Chadwick Lecture Major Mott defines shell-shock as a term applied to a group of varying signs and symptoms, indicative of loss of

functions and disorder of functions of the central nervous system, arising from sudden and prolonged exposure to forces generated by high explosives.

It is obvious that in modern trench warfare the brain of the soldier is exposed to a constant stream of exciting and terrifying sensory impressions, and that the shell bursting near him merely acts as the last straw on an utterly exhausted nervous system.

The extrinsic conditions of warfare—the unceasing din, the exposure to cold and wet, the gruesome spectacles, the dreads and fears—all undoubedly predispose to shell-shock: whilst of even greater importance as a predisposing factor are intrinsic conditions, such as a neurotic disposition or an inborn or acquired neuropathic taint.

Aphonia is a frequent symptom, and it differs in no way from hysterical aphonia. Those patients often shout during sleep, and this may be a prelude to the recovery of speech. One man, on being told that he had been talking in his sleep, was so surprised that he said, "I don't believe it." In some such cases the fear effect on the conscious mind inhibits the respiratory movements necessary for phonation, and X-ray examination shows that the diaphragm is hardly moving at all. Under such circumstances, breathing exercises may be usefully employed.

Aphonia is often accompanied by deafness, and the patient may recover his speech and yet remain deaf. In only about 17 per cent. of the cases is the deafness really due to ear diseases; in the majority of cases it is purely functional.

The treatment of shell-shock varies according to the symptoms. Insomnia is frequent, and for this the writer has found the continuous warm bath (up to an hour or more) of great value.

Severe cases require quiet repose in single rooms, but the patient should be kept occupied and amused by knitting, basket-making, etc.

Discipline is very essential during convalescence, and diversion of the mind by useful occupation in workshop or garden has been most successful in restoring to health and strength these disabled men.

Douglas Guthrie.

REVIEW.

Injuries of the Face and Jaw and their Repair, and the Treatment of Fractured Jaws. By P. MARTINIER, Professor of the Dental School of Paris, and Dr. G. LEMERLE, Professor of the Dental School of Paris; translated by H. LAWSON WHALE, M.D., F.R.C.S., Capt., R.A.M.C. Published by Baillière, Tindall & Cox. Price, 5*s.* net.

This is a small book of 345 pages, by two French dentists, chiefly devoted to consideration of various prosthetic apparatus. There are numberless mechanical devices described, with minute attention to detail, and this alone makes the book a valuable one to surgeons and dental surgeons interested in modern plastic work. The translator, Capt. H. Lawson Whale, has done his work sympathetically in producing a book pleasant to read and easily understood, whilst maintaining the spirit of the original.