Examination showed complete destruction of the membrane and ossicles, and the inner wall of the middle ear covered with granulations. There was slight tenderness over the mastoid. Hearing had deteriorated rapidly after the discharge appeared, and the ear is now quite useless : AC –, BC –, Rinne –.

He was leaving Northumberland to live on the South Coast in a few days and he did not come to see me again.

The following instruments were shown by W. S. Thacker Neville, F.R.C.S.Ed.

(I) Wells' Electric Iodine Vaporizer.

Thirty grains of powder, consisting of iodine, boric acid, camphor, menthol, powdered cubebs, each 4 per cent., with thymol 1 per cent., are placed in the electric heater. The current is turned on. As soon as the heat reaches a sufficient degree, a cloud of smoke emerges from the outlet tip and this can be pumped through a catheter into the middle ear.

(II) Fowler's Auto-insufflator.

To inflate the ear, insert into one nostril, close the other and blow up the balloon.

(III) Lester's Pneumo-tympanic Masseur.

Insert into the ear. Squeeze rubber ball. If this is attached to a Siegle's speculum, the tympanic membrane will be seen to move in and out.

ABSTRACTS

EAR

The Pressure of the Cerebrospinal Fluid in Complications of Otitis Clinically Extradural. D. Van Caneghem. (*Les Annales d'Oto-Laryngologie*, Dec., 1933.)

After an exhaustive study of this question the author draws the following conclusions :

Extradural complications of otitis cause a hypertension of the cerebrospinal fluid in half the number of cases.

In cases of acute mastoiditis the extradural abscess almost always causes a fairly large hypertension (more than 30 cm.). If, therefore, in the case of a mastoiditis one finds a hypertension greater than 30 cm., it is probable that one will find an extradural abscess. A normal tension, however, does not exclude the possibility of an extradural abscess. The hypertension of the liquid does not

increase the gravity of the post-operative prognosis. There exist in a certain number of patients with complications which are clinically purely extradural, alterations of the cerebrospinal fluid which bear witness to meningitic alterations, although the clinical symptoms of such a complication are altogether absent. These are cases of latent meningitis. They denote a stage towards the inception of generalized meningitis. They do not denote the syndrome of serous meningitis.

The hypertension of the fluid cannot be explained by the phenomena of collateral œdema, nor by the toxic phenomena of general infection ; they are better explained by the variations in the calibre of the endocranial vessels.

Since acute serous meningitis is, above all, characterized by a meningeal reaction, and as the latter may be absent even when the alterations of the dura mater are profound, it seems probable that this clinical expression of meningitis—greatly increased tension—must be determined by alterations other than toxic or collateral phenomena.

L. GRAHAM BROWN.

Labyrinthitis and Post-operative Meningeal Manifestations. J. PIQUER and P. DELOBEL. (*Les Annales d'Oto-Laryngologie*, Jan., 1934.)

The writers give their opinion that in cases of complete post-operative labyrinthitis complicated by meningeal disturbances, the method of procedure will depend upon whether the onset of labyrinthitis is early or late. In the early cases one may wait for twenty-four hours and carefully watch the progress of the meningeal symptoms. If these have a tendency to increase it will be necessary to trephine the labyrinth without delay. Nevertheless it should be remembered that there is nothing to lose and everything to gain by early trephining. In the late cases of labyrinthitis, however, opening of the labyrinth is an absolute necessity and this procedure has numerous successes to its credit.

Four cases of post-operative labyrinthitis are described in detail in support of the conclusions expressed above.

L. GRAHAM BROWN.

The results in the first twenty cases of "Wittmaack's operation" for Otosclerosis. H. ROLLIN. (*Arch. Ohr-, u.s.w., Heilk.*, 1934, cxxxviii., 6-19.)

Professor Wittmaack's theory of the etiology of otosclerosis depends on venous stasis. The operation which he has suggested for the arrest of the otosclerotic process and possible amelioration of the symptoms consists in exposing the dura over the tegmen

tympani. The dura is then raised by blunt dissection from the underlying bone until the foramen of the superficial petrosal nerve and the accompanying vein is reached. These structures are divided and the dura is replaced. The *eminentia arcuata* is an important anatomical guide in this operation ; special elevators are used on which the average distance of the foramen from the surface is indicated.

Before deciding on this operation one must make as certain as possible of the correct diagnosis, and cases of adhesive catarrh must be rigidly excluded. One does not expect an improvement in the hearing, only an arrest of the progressive element in the deafness. Therefore cases with advanced deafness are unsuitable for "Wittmaack's operation". If one ear is better than the other the operation is done on the better hearing side. If both ears are fairly equally affected one operates on the side where the tinnitus is most marked, because this almost invariably disappears after " Wittmaack's operation ".

The case histories are given with the hearing tests (conversation voice and whisper) and the tuning fork tests. These were recorded in each case a month or two before operation and again about twelve months after the operation. The end-results of seventeen cases are considered, because two cases were of too recent date to be included ; another one was excluded because it was probably a case of chronic adhesive catarrh and not of otosclerosis.

No patient in the series suffered any aggravation of his symptoms as a result of the operation. Seven patients thought that the hearing had remained stationary, five thought that there was a slight improvement in the hearing on the operated side. Others expressed the wish to undergo operation on the opposite side as well.

The author estimates that the operation has arrested the progress of the disease in 90 per cent. of the cases. He admits, however, that it is impossible to come to a final conclusion after a year to one and a half years. The end-results should be judged at the earliest after five to six years.

J. A. KEEN.

On calcareous deposits in the *stria vascularis* of the cochlea. H. ROLLIN. (*Arch. Ohr-, u.s.w., Heilk.*, 1934, cxxxviii., 1-5.)

When examining serial sections of a collection of temporal bones, the author discovered calcareous deposits in the *stria vascularis* in three specimens. Two specimens came from children, aged 2½ and 6 and one from an adult, aged 59.

The deposits varied from small localized collections to elongated bands which occupied almost the whole extent of the *stria vascularis*. A high power illustration in the text shows that the calcareous

deposits were situated in the deeper layers of the *stria vascularis*, and that the surface epithelium was intact.

The author is unable to give any explanation of the clinical significance of this rare pathological finding. The patients had not complained of any ear symptoms and the hearing had not been tested *ante mortem*.

There is also a general discussion on the pathology of calcareous deposits in epithelial tissues. The first stage is a hyaline degeneration in the interstitial tissue cells. It appears that the meninges and choroid plexuses are especially liable to these changes.

J. A. KEEN.

Contribution to the Knowledge of the Genesis of certain symptoms of Apicitis. A. A. SJÖBERG. (*Acta Oto-Laryngologica*, xix., fasc. 4, 1934.)

Innumerable theories have been advanced to explain the anatomical basis of the chief symptoms of Gradenigo's syndrome.

Vogel's view, which ascribes the abducens palsy to a mild otogenous meningitis and which suggests that there is no proof that the process is localized at the apex of the pyramid, is untenable in view of the frequency with which radiograms demonstrate changes in cases of apicitis. Boonacker and Huizinga believe that abducens palsy may at times be due to influenzal neuritis apart from otitis. Nowadays the symptom of trigeminal pain has received more and more attention and is believed to be of greater significance than the abducens palsy, whereas X-ray technique has so far advanced as to show the development and regression of an apicitis in cases which have not been operated upon at all, as well as in those which have submitted to drainage of an apical abscess or to a radical or a simple mastoid operation alone.

Nowadays at the Sabbatsberg Clinic advantage is taken of greatly improved methods of X-ray photography of the skull; most cases of mastoiditis are Röntgen photographed, and views of the pyramids are included. Several pictures of this kind are reproduced in this article.

The author describes in detail four cases which include examples of well-developed and also of abortive apicitis, each case history is also considered in a résumé. Explanations are offered of the method of development of infection at the petrous apex and the path which may be followed from the middle-ear cleft. The pathology of the changes taking place in the cells in mastoiditis is discussed, but particular attention is taken to explain the orbital pain believed to be associated with the size of Dorello's (or more correctly Gruber's) canal. The abducens passes through this canal and the pain is thought to be brought about by pressure on nerve filaments which are given off to the abducens from the ophthalmic nerve (Rauber).

Van Voorthuysen, however, considers that the pain is due to stimulation of the meningeal branches of the ophthalmic nerve, the largest branch being the recurrent ophthalmic nerve which passes backwards over the apex of the pyramid.

H. V. FORSTER.

An aid to Interpretation of Intracranial Complications resulting from Venous Circulatory Disturbance of the Temporal Bone, offered by X-ray of the Lateral Sinus and Jugular Foramen. MATTHEW S. ERSNER and DAVID MYERS. (*Laryngoscope*, 1933, xliii., 800.)

The writers believe that circulatory anomalies causing a difference between the venous drainage of the two sides play an important part in some of the intracranial complications of mastoiditis, such as sinus thrombosis, Gradenigo's syndrome, serous meningitis, the otitic hydrocephalus of Symonds, and some cases of petrositis.

Their conclusions are summarized thus :—

1. X-ray examination of the mastoid process alone is not sufficient.

2. The examination should consist of a complete study of the temporal bone, including the mastoid process, the petrous, the vascular structures and the jugular foramina.

3. Three per cent. of skulls show an extremely small jugular foramen on one side. The lateral sinus of the same side is always smaller or may be completely absent.

4. In 89 per cent. of the skulls the right lateral sinus is usually larger than the left.

5. The left lateral sinus is frequently larger than the right.

6. The right lateral sinus is involved more frequently than the left, in a ratio of 3 : 2.

7. The lateral sinus may be completely absent. This finding has been substantiated by the X-ray before operation.

8. The presence of a large emissary vein may indicate the following : absence of lateral sinus; a small lateral sinus, or a thrombus obstructing the lateral sinus.

9. Anomalies of the sinuses and jugular foramen occur frequently. During health the circulation is adequate and therefore there are no symptoms.

10. Symptoms appear when there is circulatory disturbance.

11. Changes in venous pressure directly influence intracranial pressure, and this may be either increased or decreased.

12. Vasostasis as the result of pathology of the temporal bone, *plus* inadequate venous structures, will produce increased intracranial pressure and secondary meningeal symptoms.

13. We have carefully correlated the X-ray, clinical and operative findings, and we have found that the knowledge gained

from the X-ray, disclosing the size of the venous structures, has helped us in the prognosis and treatment of otitic complications.

14. We may suspect a stormy course when there is a demonstrable marked difference in the size of the lateral sinuses and when the larger side is involved.

15. When the infection occurs on the smaller side, the prognosis is more favourable and resolution is more apt to occur.

16. In sinus thrombosis, papillitis is present in 10 to 25 per cent. of the cases. Should a papillitis be absent, then we may assume that there is adequate circulation.

17. The presence of inadequate venous circulation, *plus* a papillitis and choked disc, indicates increased intracranial pressure, and measures to reduce it should immediately be instituted.

18. The Queckenstedt test, as utilized in the diagnosis of sinus thrombosis, is only of value when there is a rise of spinal pressure following jugular compression (a negative Tobey-Ayer). A positive Tobey-Ayer test must be carefully evaluated for the reasons mentioned in the text. F. W. WATKYN-THOMAS.

Intra-carotid Treatment of Meningitis; and changes noted in the Carotids following Intra-carotid Therapy. Measures to prevent these changes. MATTHEW S. ERSNER and DAVID MYERS. (*Laryngoscope*, 1933, xliii., 630.)

The writers agree with Kolmer that intra-carotid injections are valuable in meningitis, and believe that they can be continued over a long period, as the carotids "can stand a reasonable amount of abuse without injury to the artery or untoward signs systemically". Occasionally, however, the artery is injured by the repeated manipulation, and such a case is described:

The patient had a suppurative otitic meningitis with hæmolytic streptococcus on film and culture of the cerebrospinal fluid. This was treated by operative exposure of the middle and posterior fossae and by bilateral intra-carotid injections of 10 c.cm. of 0·5 per cent. acriflavine base and colloidal iodine twice daily; each artery was used in turn. She recovered, but there was temporary paralysis of the left sixth, seventh and twelfth nerves, probably due to thrombosis of the right common carotid. (It is possible that the seventh and twelfth nerve palsies, which were incomplete, were due to slight direct injury to the nerves at operation. Such an accident is not uncommon. At one time during the course of the case both sixth nerves were affected, which can hardly have been due to ischæmia.—F. W. W-T.)

The carotids of three fatal cases were examined, and the authors' conclusions are summarized thus:

1. We believe that intra-carotid therapy offers a ray of hope in the treatment of an almost fatal complication.

2. We believe we have developed a technique which will minimize extra- and intra- vascular changes, especially thrombosis of the vessel, atheromatous changes and aneurysm.

3. We are of the opinion that the intima suffered less injury than any other portion of the artery; the media revealed areas of necrosis, hyalinization and infiltration with various cells.

4. The adventitia seemed to bear the brunt of pathological changes, showing necrosis, infiltration, and almost approaching abscess formation.

5. Both carotid vessels should be utilized in order to bring the medicaments in contact with both sides of the brain.

6. The arteries can stand a reasonable amount of trauma, provided considerable care and caution are exercised.

7. There is no doubt that a certain amount of damage is done to the carotids following intra-carotid therapy; this, however, should not deter anyone from employing this method in the treatment of meningitis.

Several important points in operative technique are mentioned:

1. The injection should be made into the common carotid, as the internal carotid is difficult to reach. Circulation by the external carotid must not be interfered with, but during the actual injection the external carotid must be temporarily occluded to prevent wastage of injection fluid into it. This is done by passing under it an oiled tape, which is released as soon as the injection is finished.

2. The fascial covering of the vessel must not be stripped, or the *vasa vasorum* will be damaged, and an unintended periarterial sympathectomy will be performed as well.

3. The wound must be kept filled with sterile oil between the injections.

4. In cases of otitic meningitis it might be well to use the vertebral arteries. The anatomical difficulties are considerable.

F. W. WATKYN-THOMAS.

NOSE AND ACCESSORY SINUSES

Lasting Dilatation of the Fronto-Nasal Duct by transplantation of blood vessel. DR. TETSUJI KAKINUMA. (*Oto-Rhino-Laryngologia*, Band vii., Heft 5, May, 1934, 421.)

The author performed the external frontal sinus operation in a boy of fifteen years old. He enlarged the fronto-nasal duct, but this closed again through the development of granulations. The author then transplanted a portion of the *saphena magna* vein into the duct and obtained lasting patency of the canal.

JAMES DUNDAS-GRANT.

Nose and Accessory Sinuses

Paradental Cysts. RUPPE, ARDOIN, LEMAÎTRE, MOREL-KAHN and ZHA. (*Les Annales d'Oto-Laryngologie*, March, 1934.)

The above authors have combined forces to give us a comprehensive survey of this subject. We are first introduced to the simple " apical granuloma ". The series of events which produces these granulomata (nearly always in connection with the permanent teeth) is as follows: dental caries, pulp necrosis, periapical granuloma, or cyst. The pathology and morbid anatomy of these simple granulomata are described, together with that of the " epithelial granuloma ", which differs from the former only in the presence of an epithelial lining, which is due to a proliferation of paradental epithelial remains caused by peri-apical irritation.

The remaining and larger section of the article deals with dental cysts. Particular stress is laid on the relationship of the cyst to the maxillary sinus. When the cyst develops in an upward direction it is often found that it completely replaces the antrum. It must not be supposed that there is a definite rupture into the antrum. What actually happens is that the thin layer of bone between the antral mucous membrane and the cyst lining is gradually expanded and absorbed so that a time arrives when the two lining membranes become adherent and the antral cavity disappears. The liquid in a dental cyst is at first pale and slightly mucoid, but hæmorrhages may occur which alter it to a dark chocolate colour. The tendency for the liquid to become infected is well known, and in such cases the lining membrane becomes thickened and is very adherent. Antral infection (when the antrum is present) is an unusual complication of dental cyst. Dental cysts are nearly always confined to the upper jaw, and an analysis is given of the various teeth which are liable to be the seat of affection. The last part of this work deals with the clinical aspect of dental cysts, the diagnostic assistance to be obtained from radiography, and their treatment. The ideal form of treatment is to remove the cyst wall in its entirety. This, however, is seldom practicable, particularly when suppuration has occurred and the cyst wall has become very adherent to the bone. In such cases it will be necessary to curette that part of the cyst wall which cannot be removed by decapsulation. One must be careful to use the curette very sparingly, otherwise osteitis and necrosis may occur.

The authors do not advise suture. The cavity is lightly packed for twenty-four hours and applications of methylene blue or zinc chloride may be of assistance. Later on the cavity becomes filled with fibrous tissue which eventually becomes ossified. In cases in which the antrum communicates with the cyst cavity the authors prefer not to establish drainage through the nose, although a persistent suppuration may necessitate this practice.

M. VLASTO.

Abstracts

LARYNX

On the course of Restoration of the Voice in Acute Laryngeal Catarrh. DR. YOSHIO HAYASHI. (*Oto-Rhino-Laryngologia*, Band vii., Heft 5, May, 1934, 442.)

A nurse was almost aphonic at the end of a cold; she could phonate only on the note "f" [*sic*]. The larynx was red and swollen; after fifteen days the tone improved with the laryngeal condition, until she had completely recovered, with a vocal range of 28 semitones and voice duration of 18 seconds.

A man, aged 39, was hoarse after a cold. The voice was almost aphonic in the upper range, as the ventricular bands came together and hid the vocal cords. After sixteen days the voice was almost free from hoarseness and could be maintained for 13 seconds.

The author suggests that the disturbance of voice was probably due to diminished tension of the muscles of the vocal cords in acute inflammation.

JAMES DUNDAS-GRANT.

Radiological Examination of Tumours of the Larynx and Pharynx. DOTT. CARLO PICCHIO. (*Archivo Italiano di Otologia*, November, 1933.)

The author describes his method of X-raying the pharynx, larynx, and cervical trachea. He makes exposures, first, in an absolutely lateral plane, and then makes stereoscopic exposures, the first lateral and the second slightly oblique. He uses films 18 × 24 centimetres and the distance from the antikathode for the single exposure is one and a half metres, and for the stereoscopic exposures one metre. His exposures occupy from one to two-tenths of a second and in his stereoscopic technique he uses one-tenth second exposure and, by using automatic apparatus, only one-third of a second elapses between the two exposures. The exposures are all made during a period of apnœa.

The paper contains a large number of radiograms illustrating the appearance of the normal anatomy and of tumours in the upper respiratory tract. The lumen of the pharynx and trachea is very well shown; that of the larynx is obscured by the thyroid cartilage, especially when the latter is calcified. The ventricle of Morgagni of the side nearest the film shows up very clearly. The epiglottis and the arytenoid eminences are very clearly displayed and the aryepiglottic folds are also plainly indicated on most films. The narrowing of the air passage at the level of the vocal cords is well shown, and its relatively great width at the upper end of the trachea is obvious.

Examples are shown of tumours of the base of the tongue, the lateral wall of the pharynx, of the aryepiglottic fold, of the

ventricular band, and of almost every region in the upper air passages. The value of these exposures is that the extent of the tumour can be accurately determined; when, by ordinary inspection, only the upper surface of the tumour can be seen.

The author does not describe any method of utilizing opaque media to outline the tumours—he relies entirely on the relative opacities of the tumours and the surrounding tissues.

F. C. ORMEROD.

Tuberculosis in Macroscopically Healthy Larynxes in Phthisical Patients. DOTT. ETTORE GIUFFRIDA. (*L'Oto-rino-laringologia Italiana*, May, 1933.)

The author has been able to make histological examinations of what appeared to be clinically healthy larynxes in eighteen cases of pulmonary phthisis.

In every case he found a lesion in the larynx. In 90 per cent. of cases the lesion was proved to be tuberculous; in 10 per cent. the lesion was catarrhal. In practically all these cases the lesion was situated in the aggregations of lymphoid tissue which are normally found around the ventricle of Morgagni and the sacculus laryngis.

In the majority of the cases the rest of the larynx was found to be histologically healthy, but lesions were described on the epiglottis and in the interarytenoid region, and in these situations the deposit of tubercle was in an area of lymphoid tissue. The lymphoid tissue is normally present in these regions of the larynx, and the author considers that these cases show a latent tuberculosis and may explain the mild catarrhal appearances of the vocal cords and other structures in which a more definitely tuberculous lesion might be expected.

The author divides larynxes into the "long" type in which the vertical diameter is greater than the transverse and the "wide" type in which the transverse is greater than the vertical. The author does not think that either of these types is more liable to tuberculosis than the other but he concludes from examination of these cases that in the wide type the tuberculous lesion is more definitely localized to the lymphoid masses and appears to be of a more chronic character.

In the long type there is a greater extension of the lesion and a greater likelihood of ulcerative processes. In other organs morphological variations in the dimensions and shape effect some control over the gravity of tuberculous lesions, and he considers that in the larynx the morphology exercises some control over the disposition of the lymphoid tissue and, at the same time, over the progress of a tuberculous infection.

F. C. ORMEROD.

Abstracts

Microscopical Tuberculous Lesions of the Intrinsic Muscles of the Larynx. DOTT. GIUSEPPE CANTELE. (*Archivo Italiano di Otologia*, October, 1933.)

The intrinsic muscles of the larynx were examined microscopically in twenty-six cases of tuberculosis. The cases were divided into three groups. In the first there was no obvious clinical lesion, in the second there had been periods of hoarseness, with apparently catarrhal changes, flaccidity of the cords, etc., and in the third there were typical tuberculous lesions.

In the first group there were no changes in the muscular fibres, but occasionally there was some atrophy of the vascular elements and of the connective tissue.

In the second group, there was a parenchymatous degeneration of the muscle fibres and a tendency to hyperplasia of the connective tissue. In one case in this group there was a small-celled infiltration of one of the vocal muscles.

In the third group the parenchymatous degeneration was more marked. There was a loss of the transverse striation of the fibres, irregular appearance of the sarcolemma, and a fragmentation of the fibres.

There were also changes in the nuclei of the muscle fibres and in the fibrous tissue. In some cases there were typical tubercles in the muscles.

There was no typical change which could be associated with any particular type of lesion on the surface of the larynx. The lesions did, however, appear to conform geographically, to some extent, to the site of the surface lesions. They were most commonly found in the interarytenoid space and in the muscle fibres immediately underlying the vocal cords. This corresponds with the commonest site for the surface tuberculous lesion, and also with the points of greatest muscular activity. This latter factor may account for the occurrence of the lesions in this region by determining a sensitivity to toxins.

F. C. ORMEROD.

A Case of Non-suppurative Perichondritis of the Thyroid Cartilage. G. BOENNINGHAUS. (*Z. Laryng.*, 1934, XXV., 18-28.)

The case of perichondritis which is described followed mumps in a man, aged 41, and the inflammation affected the ala of the thyroid cartilage on the right side. The first complication was a superficial abscess over the arytenoid. The infection then spread to the corresponding thyroid cartilage, where it caused a considerable swelling both on the inner and outer surfaces without going on to suppuration.

This form of perichondritis is admittedly rare, and the diagnosis and pathology are fully discussed. One of the most important

diagnostic signs of perichondritis on the inner surface of the thyroid ala is a widening and flattening-out of the corresponding sinus pyriformis without any swelling of the epiglottis or of the ary-epiglottic fold.

J. A. KEEN.

Measurements of the Subglottic Pressure in Patients with Tracheotomy Tubes. W. BERGER. (*Z. Laryng.*, 1934, XXV., 28-38.)

After reviewing the literature of the subject with full reference the author describes his investigations into this problem in three of his own patients.

1. A man, aged 47, who required an urgent tracheotomy for a severe angina with œdema of the glottis. The measurements of the subglottic pressures were made before removal of the cannula when the larynx had become normal again. 2. A man, aged 64, who had a tracheotomy done prior to complete laryngectomy for carcinoma. The subglottic pressures were determined before the operation at a time when the patient could still breathe comfortably through the glottis, and no stridor was present when the tracheotomy tube was closed with the finger. 3. A woman, aged 37, who had worn a tracheotomy tube for five years on account of a fibrous stricture of the glottis, due to the effects of deep X-ray treatment for tuberculous glands in the neck nine years before. At the time when the pressure measurements were made this patient, also, could breathe through the mouth without experiencing dyspnœa.

The subglottic pressures are given in terms of millimetres of a water column. The manometric curves are reproduced in the text and they show how the pressures varied with quiet respiration, the whisper, phonation, and coughing.

Even when the glottis could be closed by forcible action of the adductors the subglottic pressure showed very appreciable rises when the patient phonated, whispered, or made a forcible expiratory effort. Previous observers have suggested that the subglottic pressure is to some extent under the control of the musculature which closes the glottis. Dr. Berger shows that the air pressure in the subglottic space is less dependent on the closure of the glottis than had been supposed.

J. A. KEEN.

Methods of Treatment by Endoscopy in Croup and Tracheo-Bronchial Diphtheria. A. LEMARIEY and L. HAMAN. (*Les Annales d'Oto-Laryngologie*, February, 1934.)

The article begins with a description of direct laryngoscopy in its application to the aspiration of membranes from the larynx and the tracheo-bronchial tract. The time necessary for the identification of the larynx and the aspiration should not exceed 30 seconds.

Abstracts

The tracheal cannulas should have their opening at the side, and not at the end of the tube, and there should be two or three spare cannulas in reserve in case of obstruction of the lumen by membrane. The author contrasts the safety of freeing the larynx by endoscopy with the dangers which attend blind intubation. Many children have been the victims of an attack of syncope during intubation which has necessitated an urgent tracheotomy with, frequently, fatal results. Whereas, on the contrary, it is an easy matter to pass oxygen through a tracheal cannula and restore to life an asphyxiated child. Although treatment by aspiration has no contra-indications so far as the patient is concerned, one should point out that the medical man is dangerously exposed to infection, and we are given instructions as to how some of these dangers can be avoided. The failures and successes of this method of treatment are impartially analysed, and we are given the clinical details of seven cases, although the article itself is based on an experience from twenty-eight cases. A further point in favour of treatment by direct laryngoscopy is the possibility of making a differential diagnosis in cases of laryngeal obstruction when the clinical picture of a diphtheritic infection is not quite complete.

M. VLASTO.

MISCELLANEOUS

Total Tonsillectomy in the " sub-acute " stage after a wide incision of a Peritonsillar Abscess. GEORGES CANUYT. (*Annales d'Oto-Laryngologie*, February, 1934.)

The author first recapitulates details of the method which he has advocated for opening peritonsillar phlegmons. At the termination of the operation, the upper pole of the tonsil is partially dislocated so that the first stage of a tonsillectomy has already been achieved. Tonsillectomy is carried out in one of three stages. (1) During acute inflammation. (2) In the sub-acute stage. (3) In the quiescent stage. Although the author has carried out many tonsillectomies during the acute stage and, indeed, his knowledge of the pathological anatomy of peritonsillar phlegmons has largely been derived from such treatment, he does not recommend this method, which he considers unnecessarily painful, dangerous, and often incomplete. On the other hand, if the affected tonsil is allowed to settle down for a period of weeks or months, as is the usual custom, the tonsil will reattach itself to the tonsillar fossa and the fibrous adhesions will render the operation very difficult. Moreover, one runs the risk of the patient putting off the evil day and this is one of the reasons why so many recurrent quinsies are seen. The author advocates operating in the " warm " stage as opposed to the " hot "

and " cold " stages. The removal of the tonsil is carried out four or five days after the evacuation of the phlegmon by his method, that is to say when the temperature has dropped to nearly normal. At about this time, the œdema has disappeared, the infiltrated tissues have regained their mobility, the fossa is widely open, the walls of the abscess cavity are well-defined and a substantial portion of the tonsil is freed. The operation is easy, painless, and safe. As usual, local anæsthesia is advocated.

M. VLASTO.

Syphilis of the Œsophagus. E. WATSON-WILLIAMS. (*The Practitioner*, September, 1933.)

Four cases of syphilis of the œsophagus are described, and two more in which that diagnosis appeared to be correct. Dysphagia was the symptom which first attracted notice in all : four of the six showed wasting ; and only one had real pain. The local appearances include :

(1) General œsophagitis tending to affect the middle two-fourths of the œsophagus, but in one case the whole.

(2) Maceration of the epithelium, with longitudinal desquamation going on to complete shedding of the epithelium.

(3) Formation of leucoplakic patches consisting of thickening of the epithelium only.

In 350 consecutive œsophagoscopies appearances (2) and (3) were not seen except in the six cases described. There were eleven cases of aneurysm causing dysphagia during the period covered by these œsophagoscopies.

R. R. SIMPSON.

Vallecular Dysphagia. JOHN E. G. MCGIBBON and J. H. MATHER. (*B.M.J.*, Dec. 2nd, 1933.)

Dysphagia, caused by filling and retention of food in the valleculae, is described. This type of dysphagia may be a distinct entity of clinical importance—of unknown pathology—and present as primary vallecular dysphagia. Alternatively, it may occur as a secondary phenomenon due to some manifest disturbance of the neuromuscular mechanism of swallowing, or to local disease in the pharynx or œsophagus. These cases are termed " secondary vallecular dysphagia ", and they are not clinically important, as their symptoms are overshadowed by the existence of a graver lesion. Treatment of primary vallecular dysphagia has, in most cases, resolved itself into explanation and reassurance, with disappearance of symptoms. In more severe cases, however, it might be necessary to amputate the free portion of the epiglottis.

R. R. SIMPSON.

OBITUARY

CHARLES JOSEPH HEATH, F.R.C.S.—(1856-1934)

MR. CHARLES HEATH had the talent of making friends among his colleagues, even if they differed from him in regard to the call for operative interference and its nature. His whole-hearted insistence on the correctness of his views on otology was part of his nature and he was just as insistent in his views on wild-fowl shooting and other forms of sport. His enthusiasm for inventing mastoid instruments was intense and perhaps exaggerated, but this, again, was Heath, and it extended to the implements for sport as well as to the gas-masks necessitated by the horrible methods of modern warfare. His essentially sanguine disposition explains the peculiarities of his personality and the attraction he had for his many friends, including those who declined to share his views. His manual dexterity was undeniable and a distinguished member of our Section stated that, if he were himself concerned, he would have another opinion as to the necessity for operation, but would confidently entrust Mr. Heath with its performance.

This is not the occasion for analysing views which have been freely praised and criticized in comparatively recent times. It suffices to say that Heath's name has a place in the history of otology: and the modified radical mastoid operation, though not unknown to other operators at home and abroad, was accepted as a stereotyped procedure, mainly through Charles Heath's advocacy.

Of the numerous instruments which he invented, some were undoubtedly modifications, sometimes slight, sometimes considerable, but always ingenious, and all operators have in their equipment something at least of Heath's, whether it be a gouge, a probe, a punch-forceps or some other instrument. Sportsmen will remember him for his gun, soldiers for his gas-mask, and many friends for his infectious animation and fundamental goodness of heart. Even those whose views differed most widely from his, entertained for him a warm and even affectionate regard.

JAMES DUNDAS-GRANT.

GENERAL NOTES

SCOTTISH OTOLOGICAL AND LARYNGOLOGICAL SOCIETY.

The Society offers a prize of £20 for the best piece of Clinical or Laboratory research work in Oto-Laryngology. The prize is open to Clinical Tutors, Clinical Assistants and House Surgeons attached to the Clinics of Ordinary and Corresponding Members of the Scottish Society, and to those Members of the Scottish Society of not more than ten years' standing as Specialists. Further particulars of the prize may be obtained from the Hon. Secretary, Dr. Chas. E. Scott, 33 Palmerston Place, Edinburgh, 12, and all papers embodying the research work must be sent to him not later than April 1st, 1935.