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

second of these varieties is the most frequent. He enters into the question of treatment, and gives eight cases from his own clinic.

Macleod Yearsley.

Koenig, C. J.—*On a New Method of Massaging the Ossicles by means of Lucae's Probe.* "Archives Internationales de Laryngologie," etc. September-October, 1901.

The application of Lucae's spring-pressure probe is usually accompanied with considerable pain. Occasionally cases in which the manipulation is not felt are met with, but are very rare. Local anæsthesia by any method does not appear to have much influence.

Koenig claims that his method is less painful and more efficacious. He melts a little paraffin, and plunges the tip of the probe therein, and finds that by means of the soft drop of paraffin the massage can be effected with much less pain than usual. It does not cause any excoriations or irritation of the membrane, and the massage can therefore be more prolonged, whilst the pressure can be augmented to 60 or 100 grammes.

Macleod Yearsley.

Nadoleczny (Munich).—*Contribution to the Study of "Bleeding Polypi of the Nasal Septum."* "Annales des Maladies de l'Oreille," etc., October, 1901.

This interesting communication contains the report of a case which occurred in an anæmic girl of twenty-three years of age. The nose showed hypertrophy of the mucous membrane on the right side, with slight deviation of the septum, with the convexity to the right. The left nostril was obstructed by a grayish, rounded tumour of smooth surface, and about the size of a small nut. It was removed by the galvano-cautery snare with ease. On histological examination, it was found to be formed of connective tissue, so rich in dilated vessels as to warrant the title of *cavernous fibro-angioma.* The author gives a *résumé* of the literature of the subject, and enters at length upon its pathology, symptoms, prognosis, diagnosis, and treatment.

Macleod Yearsley.

McBride, P.—*Some Questions with regard to Acute Middle-Ear Inflammation.* "Lancet," May 18, 1901.

The author first narrates a case in which a small pouting perforation in the left drum, of recent origin, proved intractable until pus had been evacuated from the right maxillary sinus. Consideration of this case raises several important questions, which he treats seriatim:

1. *The Connection between Acute Otitis Media and Affections of the Nose and Naso-pharynx.*—It is, of course, perfectly well known that acute nasal or pharyngeal inflammation may lead to suppuration of the middle ear. It is also known that marked adenoids, and possibly much-enlarged inferior turbinals, may predispose to the affection. It is, however, not sufficiently recognised that there is a form of adenoids which practically produces no other trouble, but which may be responsible for recurrent attacks. In these cases the patient breathes perfectly; he may be subject to colds in the head, but they do not attract much attention. On examining with the rhinoscopic mirror, however, a layer of adenoid tissue is observed occupying the space between the Eustachian orifices, and apparently pressing upon their margins. On digital examination, the lymphoid tissue will be felt, but it will be observed that there is not any great quantity present. In

such cases, however, the recurrent acute ear attacks will usually cease after the adenoid tissue has been removed.

2. *What is the best Method of treating Middle-Ear Inflammation after Spontaneous or Artificial Perforation has occurred?*—The method of plugging the meatus with aseptic dressing after, so far as possible, sterilizing the canal is not at all suitable for all cases. In this instance the perforation certainly diminished in the two days during which such dressings were applied. In future the author will adopt this method with great caution, if at all, when the perforation is small and the membrane tends to bulge. It is, of course, now the custom to decry the use of Politzer's bag, and even the catheter, in all cases while suppuration is still going on. In the average patient, where there is no recognisable infective secretion in the nose or naso-pharynx, and where drainage is difficult owing to the small size of the perforation, he is still inclined to advocate both methods. If they seem actually beneficial, he is not disposed to be deterred from their use because they are hypothetically, or even theoretically, dangerous.

3. *When should the Question of Mastoid Operation be considered?*—There are two conditions which, after perforation has occurred, seem to the author to indicate that the case will be troublesome—to wit, (1) excessive discharge, and (2) a small perforation in a bulged membrane. When the discharge appears in such quantity that it is hardly conceivable that it can be all secreted by the lining membrane of the tympanum, it will usually be found that after a varying period some tenderness, or even spontaneous pain, arises in the mastoid region.

In the presence of a small pouting perforation and a bulged membrane, the surgeon is often in great difficulties as to how best to obtain drainage. A free incision is valuable for the moment, but, as every experienced aurist knows, it soon closes, and the condition is no better than before. The least indication of mastoid inflammation will give an excuse for operating. It is, indeed, an open question whether the occurrence of pain should be awaited.

One word more as to the method of operating in these recent cases. It is of the utmost importance that the middle-ear structures should be respected, and for this reason Schwartze's method should be adopted, associated, if necessary, with the removal of any softened bone which may be found in the lower part of the process. If these rules be adhered to, we commonly find that the discharge from the ear ceases, the membrane heals, and almost perfect hearing results.

StClair Thomson.

Simpson, J. Christian.—*Case of a Parasite—"Argas (or Ornithodorus) Méguini" (Dujès)—in each Ear.* "Lancet," April 27, 1901.

A patient brought the author a living specimen of this tick, which he said had come from his right ear of its own accord on the previous day. Nothing abnormal was found in that ear, but on removing some wax from the other a parasite similar to, but smaller than, the other specimen was plainly visible closely applied to the drum. As it is very important not to leave any portion of the suckers or hooks in the tissues, more especially in the drum, by soaking a small pledget of wadding with chloroform and inserting it into the canal for a few seconds, the tick was rapidly killed, and was easily removed by syringing. On examination, it was found to be entire, and no injury was visible to the drum of either ear.

The previous history of the patient was that he had camped out in

Arizona in the month of June. He returned to his home in Massachusetts, U.S.A., at the end of that month, and then "had some curious sensations in the left ear, a sort of pain above the ear, and a rattling sound in the ear. These feelings decreased and had almost passed away, though the rattling was occasionally heard" up to August 25, when the live parasite came from the right ear, which apparently had not been the subject of any striking abnormal sensations.

The article is illustrated by drawings of the parasite. It is about three-sixteenths of an inch in length, and the magnification of the photograph is slightly over × 6. The larger living specimen was more than double this size, and broad and thick in proportion. In colour and general appearance its body resembled an unroasted coffee-bean.

StClair Thomson.

Stanculéanu and **Depoutre.**—*Anatomical and Pathological Study of the Posterior Cellules of the Mastoid Cells near the Lateral Sinus.* "Annales des Maladies de l'Oreille," etc., October, 1901.

This is a lengthy communication, interspersed with figures, which will be useful to the study of mastoid operations. The posterior group of mastoid cells are nearly as constant as those at the tip of the process, and their importance from the clinical point of view is scarcely less, on account of their close proximity to the lateral sinus and to the meninges.

The authors have made the following measurements in 100 temporal bones: 1. The size of the tympanum and of the aditus in children; the size of the antrum in temporals of all ages. 2. The distance which separates the antrum from the wall of the lateral sinus. 3. The distance which separates the antrum from the posterior cells. 4. The distance of the sigmoid groove from the posterior wall of the meatus.

Macleod Yearsley.

Toubert.—*A Rare Variety of Aberrant Mastoid Cellulitis.* "Revue Hebdom. de Laryngol.," etc., August 10, 1901.

A young man, twenty-two years old, who had suffered from repeated attacks of otitis in childhood, had subacute bronchitis and otalgia, then otorrhœa (right) in January, 1901. When seen, February 13, there was free discharge from the right ear, but no pain or tenderness over the mastoid, though the patient stated there had been pain in the posterior part of the mastoid. On March 11 diffuse retro-auricular swelling, pain on pressure not more marked than on pinching. The swelling was thought to be glandular. March 22: The swelling had become fluctuant; incised over its lower part; a teaspoonful of pus evacuated; no bare bone found; no fistula; the pus contained streptococcus. March 25-30: Cessation of discharge from the meatus, but persistent discharge from the retro-auricular wound.

March 31: A small piece of bare bone was found. Operation: A cavity found filled with soft granulation tissue. The curette brought away a scale of bone (cortex) about 1 centimetre square, then the soft diploë below till hard bone was reached. No opening in the floor of the cavity. This cavity was 3 centimetres behind and 2 centimetres above the posterior and superior borders respectively of the external auditory meatus. Healed completely by April 16.

A few similar cases have been reported, in all of which the position

of the suppurating centre has been constant. The author would group these together as retro-antral or mastoido-occipital cases. Examining 100 skulls, Stanculéanu and Depoutre found retro-antral cells in 40, all connected with the lateral sinus, and most, but not all, communicating with the antrum. Infection travels from the antrum to the retro-antral cells in most cases, probably viâ the blood or lymph stream, and not by a direct route. The pus may escape by three routes, viz: (1) Outwards, (2) into the antrum, or (3) inwards into the cranial cavity (Moure's fatal case), or by two of these routes at one time (case of Taptas). *Arthur J. Hutchison.*

Wilson, T. Stacey.—*Otitis Media and Pneumonia.* "The Birmingham Medical Review," July, 1901.

The author believes that otitis media is present in most fatal cases of pneumonia. He lays stress on the fact that, although this complication is a frequent occurrence, the classic symptoms usually associated with the disease may be absent. He recommends the "desirability of examining the ears in every case of severe acute pneumonia in children and young people."

Pain may be absent; the hearing in the healthy ear may be so good that the deafness in the affected one is either overlooked or attributed to the dulness which might be the natural result of the fever. Discharge is of little value as a symptom, as when this takes place the danger of pyæmia is usually over.

Some of the symptoms which should cause the observer to examine the ear for the source of pyæmic infection are the following: Slight pain, with or without tenderness in the limbs; abdominal pain or tenderness, often accompanied by distension; diarrhœa about the fifth or sixth day; skin eruptions; small boils, singly or in groups; meningitis, or signs of meningeal irritation.

An incision of the membrana tympani is usually followed by a subsidence of the symptoms. *Anthony McCall.*

THYROID, Etc.

Charlton, George A. (Montreal).—*Frequency and Distribution of Goitre in the Island of Montreal.* "Montreal Medical Journal," August, 1901.

In an exhaustive article the writer gives the methods and results of his investigation. The Island of Montreal covers an area of thirty miles by ten. It is situated in the mouth of the Ottawa River, at its juncture with the St. Lawrence. In general configuration the island is a plain, gently sloping from Mount Royal, a rocky elevation of 800 feet, down to the water's edge. The main body of the island is about 60 feet above sea-level.

The soil varies from a few inches to several feet in depth, lying mainly upon Silurian limestone, with here and there an outcrop of Lower Laurentian. Natural springs are few and marshes scarce, although the surface-water remains a long time in early spring, as well as after heavy rain.

Regarding water-supply, the citizens of Montreal and the villagers living near the shore use river-water, derived chiefly from the Ottawa, which is soft, and contains a low percentage of salts of lime. Those