movements are (1) pulsatile from the large basal cerebral vessels; (2) respiratory; (3) vascular elevations and depressions, which alternate and are due to periodic dilatation and contraction of the blood-vessels, regulated by the vaso-motor centre. The exceedingly interesting pulsatory brain movements undoubtedly give rise to intra-cranial murmurs, and during the former the cerebro-spinal fluid is subjected to doubly compensatory movement. Any excess of cerebro spinal fluid is always compensatory, and it is to be noted that excess of this fluid within the cranium is not, as a rule, attended by tinnitus. In one case of dementia under Hyslop's notice, an intra-cranial murmur described by the patient as "deep down" in his brain, the tinnitus was probably due to the to-and-fro movement of the fluid over the roughened middle cerebral fossa, and was of respiratory rhythm. In great expansion of cerebral volume, owing to arterial pressure, brain may come in contact with the rigid bone, giving rise to a pulsatile murmur. Anæmia and hyperæmia are powerful agents in modifying pressure equilibrium. Undue pressure on peri- and endo-lymph attends the high arterial pressure of Bright's disease, giving rise to tinnitus. In plethora culminating in apoplexy, in which tinnitus is an early symptom, the brain may be forced against the inner table of the skull, thereby rendering it possibly for the pulsatile waves to come into almost direct contact with it. In anæmia and chlorosis, where tinnitus is often a prominent symptom, the murmurs originate possibly from the jugular bulb. Venous murmurs may be pulsatile or respiratory in rhythm, and the blood in the brain sinuses may undergo a pulsatile movement owing to the fact that during cardiac diastole much blood flows into the veins, and this movement may be propagated into the veins of the retina and auditory organs. Hyslop finally discusses crackling noises in the region of the longitudinal and lateral sinuses and the torcular. They are of uncertain origin.

Tinnitus due to cerebral aneurysm is only referred to, the paper being designed rather to open up a distinct line of investigation.

Macleod Yearsley.

PHARYNX.

Hays, Harold.—Pneumococcus Infections of the Throat.—"Annals of Otol., Rhinol., and Laryngol.," vol. xx, p. 835.

The author describes three cases and refers to the literature. The condition usually comes on suddenly with moderate temperature, intense congestion and œdema of the throat and inflammation of the anterior cervical glands. Prostration is considerable, swallowing painful, with thick tenacious mucus. Superficial circumscribed ulceration may occur. The course is short, terminating by lysis. Diagnosis must be made from diphtheria, Vincent's angina, tuberculosis, influenza and rheumatism.

Macleod Yearsley.

Spencer, W. G., M.S.—Congenital Specific Stenosis of the Fauces and Pharynx.—"Proc. Roy. Soc." (Clinical Section), January, 1912.

Female, aged nineteen, shows persistent nodes and gummatous scar on scalp. In June severe ulceration of fauces and pharynx; tracheotomy was performed. *Salvarsan injected and ulceration rapidly healed, but stenosis resulted.* Mr. Evans performed plastic operation in August, but in October patient re-admitted with dyspnœa and dysphagia; second tracheotomy, naso-pharynx only admitted small catheter and oropharynx

only number 10. Strictures dilated gradually, and patient taught to pass œsophageal tube herself; the tracheotomy tube will be required permanently. *J. S. Fraser.*

Berry, Gordon.—Sarcoma of the Tonsil. "Boston Med. and Surg. Journ.," vol. clxvi, p. 276.

The patient was a woman, aged eighty-five years and eleven months, with a lympho-sarcoma of the right tonsil and a nodular mass under the sterno-mastoid. The latter was dissected away and the external carotid ligatured. The tonsil tumour was removed through the mouth by dissection and a cold wire snare. Recovery was rapid and uneventful and no recurrence had taken place two months later. The neck began to be brawny three weeks later. A discussion of the literature is given.

Macleod Yearsley.

ŒSOPHAGUS.

Myers, H. L.—Report on Three Cases of Removal of Coins from the Œsophagus of Infants by a Simple Procedure. "Annals of Otol., Rhinol., and Laryngol.," vol. xx, p. 460.

The simple procedure was the passage of an olive-pointed, flexible bougie beyond the coin, followed by traction when the olive end engaged the lower edge of the coin. *Macleod Yearsley.*

Yankauer, Sidney.—Four Cases of Foreign Body in the Œsophagus removed with the aid of the Œsophagoscope. "Annals of Otology, Rhinology and Laryngology," vol. xx, p. 414.

Case 1, child, aged three; penny just above sternal notch, removed with ease. *Case* 2, child, aged fourteen months; small, irregular leaden toy at level of sternal notch, easily removed. *Case* 3, boy, aged two and a half; penny just below cricoid, easily removed. Previous attempts, by forceps introduced blindly, failed owing to seizure of the mucous membrane instead of the penny. *Case* 4, boy, aged four; piece of brass just above sternal notch. Truncated cone, smaller end very sharp. Extensive wound of posterior œsophageal wall at level of cricoid leading into fistulous track behind œsophagus. Foreign body removed with difficulty owing to torn œsophagus. Patient died next day.

Macleod Yearsley.

MISCELLANEOUS.

Caldera, C. (Turin).—Researches on Bacteræmia in Oto-rhino-laryngoiatry. "Archiv. Ital. distologia," January, 1912, p. 1.

The author, considering the demonstrated presence of bacteria in the blood in many diseases without the occurrence of grave septicæmia, has endeavoured to ascertain in what diseases of the throat and ear bacteræmia may take place.

It is well known that the tonsil is the gate of entrance for many grave blood diseases resulting, for instance, in endocarditis of which fatal cases have followed various forms of angina. Recent cases of Prof. C. Fedell [1] and of Prof. Egedi [2] are quoted. In three of these a fatal termination

[1] "Boletino mal. Orrecchio," February, 1911.
[2] *Ibid.*, October, 1910.