# ABSTRACTS

## EAR.

*The Frequency of Mastoiditis in Infants.* F. C. HELWIG and O. J. DIXON. (*Archives of Oto-Laryngology*, Vol. ii., No. 2, February 1930.)

There has been considerable controversy regarding the relationship between middle-ear infections and acute nutritional disturbances in infants. The majority of investigators have regarded the ear as an important primary focus of infection in cases of enteritis, and in consequence many mastoidectomies have been performed, and the mortality rate has increased in proportion. Helwig and Dixon, like many previous observers, have found pus in the middle ear and mastoid antra of a large number of infants at post-mortem examination. In a series of 173 consecutive post-mortems at a Children's Hospital, there appeared to be evidence of otitis media in 57 cases (32·8 per cent.). Only 17 of those cases had died of enteritis; in the remaining 40 the causes of death included every common disease of infancy. Apparently the incidence of ear and mastoid infection was greater in the "non-enteric" than in the enteric group. Histological examination of the ears in which pus was found revealed œdema and swelling of the mucous membrane, but no necrosis of bone. The ear infections were evidently of short duration, and only in 3 of the 57 cases could the mastoid infections have been the cause of death. The otitis which occasionally accompanies enteritis is a secondary and not a primary infection.

DOUGLAS GUTHRIE.

*A Special Type of Acute Mastoiditis.* H. CHATELLIER. (*Archives Internationales de Laryngologie*, September to October 1929.)

The onset of the mastoiditis is particularly sudden. In the most typical cases, and these are the rarest, no pus is found. The mastoid cells are filled with soft gelatinous pellets. The curette removes them with ease. These are not diffluent, and are of the size and shape of the cells from which they come. They vary in size from a grain of rice to that of a bean. Their colour is pearly grey, sometimes ruddy. They may be mistaken for the lateral sinus or the dura mater of the middle fossa. Under the microscope, these pellets are seen to consist of fibro-leucocytic collections. Most of the polymorphonuclear leucocytes occupy the centre of the mass, and are gradually replaced by fibrinous exudate as the periphery is reached. Gram-positive cocci are distributed throughout. The causative organism is nearly always the streptococcus.

MICHAEL VLASTO.

# Abstracts

*Dropsy of the Labyrinth.* ZAVISKA PAVEL (Czechoslovakia). (*Oto-Laryngologica Slavica*, Vol. i., Fasc. 2, p. 8.)

The process described by Wittmaack as dropsy of the labyrinth, as the basis of certain forms of labyrinthine deafness, may be of tympanic, of meningeal, or of hæmatogenous origin. Cases of each class are narrated. The tympanic forms are best treated with pilocarpine, the meningeal with pilocarpine and lumbar puncture. The hæmatogenous occur in the course of infectious diseases, *diabetes mellitus*, or osteomyelitis, which influence the secretion of the endolymph. Diminution is shown by collapse of the membrane of Reissner, and may be due to increase in the acidity of the blood. Pilocarpine, as shown by experiment, causes an increase in the endolymph with bulging of Reissner's membrane. It is useless in affections of the auditory nerve. JAMES DUNDAS-GRANT.

*Case of Cerebral Tumour (Gliosarcoma) with Chronic Suppuration of the Middle Ear.* Dr S. YOSHIDA, Kyushu. (*Oto-Rhino-Laryngologia*, Vol. iii., No. 2, p. 108.)

The patient, a girl aged 5, a month after an injury to the skull suffered from headache, vomiting and other cerebral symptoms, and paralysis of the extremities. Six months later she died and there was found a gliosarcoma in the temporo-sphenoidal lobe of the right hemisphere, quite unconnected with the suppuration in the middle ear. There was the slow nystagmus described by Borries (*Zeitschrift für Hals-, Nasen- und Ohrenheilkunde*, Bd. xiii., Heft 3, p. 318; *Journal of Laryngology and Otology*, Vol. xli., p. 770). The writer considers that there was a very close relation between the injury and the development of the tumour. JAMES DUNDAS-GRANT.

*Proposals with Regard to the Instruction of Deaf-mutes in Japan.* Dr KENKICHI ASSAI, Osaka. (*Oto-Rhino-Laryngologia*, Vol. iii., No. 2, p. 118.)

The author has taught the lip-reading method for twenty years. He lays stress upon the grouping of the pupils. Like Urbantschitsch and Bezold he insists on the treatment of the residual hearing-power by means of hearing exercises, with especial consideration of the endowments of the pupils. JAMES DUNDAS-GRANT.

*Studies on some Cutaneous and Subcutaneous Phenomena and their relation to the Labyrinthal Alterations in Morbus Ménièri.* S. H. MYGIND and DIDA DEDERING, Copenhagen. (*Acta Oto-Laryngologica*, Vol. xiii., Fasc. 4.)

In former papers an attempt has been made to prove that the aural phenomena in morbus Ménièri depend on alterations in the labyrinth, which, at least so far as the deafness is concerned, chiefly consist in

an increase of the fluid content as part of an abnormal deposition of water in the body. With the idea of attaining a more intimate conception of the etiology and pathogenesis of this disease a study was made of certain cutaneous and subcutaneous phenomena, not only because they frequently appear in these patients, but because, in contradistinction from the changes in the ear, they are directly visible and palpable.

Nearly all the patients exhibited pronounced symptoms of disturbances in the superficial circulation, although none of them suffered from any disease of the heart or kidneys—at least not to any serious degree. The phenomena indicate that these patients suffer from vasomotor disturbance.

They have cold hands and feet, broken chilblains, vasomotor hyperirritability to a remarkable degree, waves of flushing of the face, sometimes one-sided. Urticaria was found to be frequent in the patients themselves and their family histories. Vasomotor rhinitis occurred in no less than 22 per cent. of them. As these cutaneous disturbances are not only very frequent in these patients, but come and go in periods corresponding to the good and bad periods of the ear phenomena, it is tempting to try to explain the changing aural phenomena from a corresponding changing vasomotor state in the ear, but the auditory phenomena are not so fugitive as the vasomotor phenomena and yet, when they pass off, function is generally as well restored. On the other hand there is doubtless an intimate relation, and one may suppose that a secondary, more massive alteration, due to an abnormal vasomotor function, is the cause of the abnormal state of the ear. With this idea in view attention has been directed to the so-called subcutaneous infiltrations so frequently observed in the patients. They consist of a swelling of the ordinary subcutaneous tissue, as a rule disproportionate to the general development of fat in the individual to such an extent that pronounced infiltrations may be found in persons of underweight. The water in the infiltrated tissue cannot be displaced by pressure as in nephritis and cardiac failure. It is probably an intra- and not intercellular œdema, though the latter may also follow as a later stage in the lower parts of the body. The poor circulation is a peripheral phenomenon.

In seeking analogous alterations in the ear the submucous layer of the tube and the middle ear should be considered. The tubal stenosis so frequently appearing in Ménière patients, particularly in bad periods, would correspond to the infiltrations, and so too the frequent alterations in the middle ear. In the labyrinth, however, we must suppose an intracellular œdema. The affection of the sound transmission characteristic of Ménière patients depends upon a fixation of the fenestræ, an increase in the content of the labyrinth—

intracellular œdema—and eventually hypersecretion. An explanation of the problem of tinnitus is suggested, but this will be the subject of a future paper.

The various labyrinthine phenomena in morbus Ménièri are explained by the hypothesis of increase of fluid in the labyrinth, which is corroborated by several facts, both clinical and experimental, viz., the action of atropine, amyl nitrite, alcohol; the results of narcosis, fever, post-operative shock; the post-infectious stage, *e.g.* after influenza; the presence of other diseases and morbid processes. The deafness, buzzings and giddiness in chlorosis and other simple anæmias depend on hydræmia, as also does that due to the intake of salicylates (this producing a hydræmia of 10 to 20 per cent.). The general beneficial effect of Finsen light and exercise on general metabolism and vasomotor reaction is discussed.

The writers summarise their conclusions as follows:—"According to our view, Ménière's disease is not a *morbus sui generis*, but a characteristic, though changeable, complex of symptoms, by which the ear in predisposed individuals like an extremely sensitive manometer indicates any change in the general vasomotor and, especially, capillo-motor state, and in the water metabolism of the body.

"It is a matter of course that corresponding processes of water deposition take place in other parts of the body. In nearly all our Ménière patients different pathological phenomena in all parts of the body were observed, appearing and disappearing in sympathy with the ear troubles. In the following papers we will endeavour to analyse these extra-aural phenomena from the same point of view which, in our opinion, has been able to give a systematic and exhaustive explanation of the aural phenomena in morbus Ménièri." H. V. FORSTER.

*Vestibular Phenomena of Patients suffering from Morbus Ménièri.* S. H. MYGIND (Copenhagen). (*Acta Oto-Laryngologica*, Vol. xiii., Fasc. 4.)

In a previous paper from this clinic (*Acta Oto-Lar.*, Supplement, No. ix.) Dida Dedering described the acoustic phenomena of patients suffering from morbus Ménièri, and discussed some of the problems of the disease. In continuation this paper deals with the vestibular phenomena of the disease preliminarily defined in the above work as a disease with an unspecific etiology, which, so far as the ear is concerned, shows itself by a changing function, acoustic as well as static. This paper is based on the same clinical material as the earlier one, and references are made to the cases described in it. All cases suspected of such complicating factors as syphilis, parotitis, encephalitis, cerebral tumour, disseminated sclerosis, etc., have been

omitted, and only patients manifesting distinct nystagmus abnormalities have been included. The total number of cases is 135.

Spontaneous nystagmus is always to be found during the attacks of giddiness, and sometimes in the intervals, though perhaps only by using Bartel's spectacles, and generally not at all in the calm periods.

The material may be divided into two groups, corresponding with the severity of the nystagmus abnormalities found.

The first group comprises only nine cases, all exhibiting a markedly reduced post-rotatory irritability on the side principally affected, and a slow or feeble caloric reaction even to ice-cold water. In nearly all the hearing was very poor on the affected side and often on the other side.

The second group comprises the majority of the patients (126), all with symptoms less severe. When rotation was performed no reduced function was found, though in some cases nystagmus was prolonged to one side, and often corresponding to a present spontaneous nystagmus. The caloric test did not show any serious alteration from the normal. These tests are therefore of doubtful value, and when a spontaneous nystagmus gives enough indication of an abnormal state of the labyrinth this complicates the experimental nystagmus. Counter-rolling was examined in 14 patients, but was not considered of special value.

The different fistula tests (compression and aspiration of the outer meatus, compression of the tragus, and compression of the carotid) were done in 57 cases; a reaction was found in 7 cases.

By catheterisation of the eustachian tube, giddiness and nystagmus is often produced. The test by inhalation of amyl nitrite is considered to be of practical value. In 18 cases an existing spontaneous nystagmus was reinforced, and in 23 cases a latent nystagmus appeared to be awakened. The test cannot be considered as without danger in cases of heart trouble, etc., but it was very useful, since it procured in several cases the only objective sign of a vestibular affection.

Pointing tests were found to be of no practical value.

Concerning the subjective vestibular symptoms, *i.e.* the giddiness with all its accompanying phenomena, the attacks range from the classic apoplectiform attack, with its well-known sensation of rotation, vomiting, tinnitus and hard hearing, to the most vague sensation of unsteadiness with, apparently, normal acoustic function. The periodicity of the attacks is the most characteristic feature of the disease. It is erroneous to consider a sensation of rotation as inseparably connected with a vestibular giddiness—the feeling of a vertical motion is almost as often met with.

In a few cases diplopia has been complained of, but never verified by ophthalmological examination. In bad periods nausea may be

continuous and diarrhœa sometimes found, but diarrhœa has never been found in the experience of the writer, even in the most severe cases of labyrinthitis following middle-ear suppuration.

Other secretory and circulatory phenomena are often found in an attack. Before an attack deafness and tinnitus often grow worse. During an attack they may be better or worse, but nearly always alter one way or the other, whereas during calm periods (without giddiness) they are either consistently bad or consistently good.

After thus describing the vestibular phenomena explanations are offered. In the disease of Ménière it is concluded that we have to deal with an affection of the labyrinth, not of the nerve or the nuclei as Thornval suggests.

On account of the striking power of recovery of the vestibular and acoustic apparatus, except in a few cases, an intermittent hypertension or œdema of the labyrinth is suggested.

Dida Dedering has shown that the acoustic phenomena are due to a changing content of fluid in the labyrinth. It is suggested that the vestibular phenomena are produced by the same cause, and may be experimentally produced, diminished or abolished by increasing or diminishing the total quantity of fluid of the body.

In the vestibular phenomena, however, one has to take into consideration the influence of a difference in function between the two labyrinths and the suddenness of onset of this alteration, and, further, the change of balance taking place during recovery.

In the cases showing fistula symptoms an abnormally mobile stapes is thought to be present. In the very few cases which showed considerable degrees of alteration in the acoustic and vestibular functions an intralabyrinthine hæmorrhage is denied, but degenerations are presumed because of numerous attacks during many years.

H. V. FORSTER.

## NOSE AND ACCESSORY SINUSES.

*The "Valve Sign" associated with Chronic Maxillary Antritis with Partitions.* G. GOUFAS (Athens). (*Archives Internationales de Laryngologie*, September-October 1929.)

A case is described in detail of an obvious left suppurative antritis, in which fluid under pressure would not flow with the exploring needle. The phenomenon was interpreted as being a "valve" closure of the natural maxillary orifice by a polypus (Terracol).

At the subsequent operation it was found that the cavity opened up was very small, and the surgeon hesitated exploring further for fear of opening into adjoining structures. He thought that he had entered an antrum of the infantile type. He was led to explore further by

the fact that there was no communication whatsoever with the nasal fossa, whereas anterior rhinoscopy had shown very definitely a flow of pus into the middle meatus. Further exploration showed that the antrum was divided up into three cavities by two partitions. These cavities were filled with septic granulations. The exploratory needle had penetrated a cavity which did not communicate with the nasal fossa.

The author is of opinion that this condition is not of developmental, but of inflammatory origin. MICHAEL VLASTO.

*Ethmoiditis in the Child.* ROUGET and FERRAND. (*Archives Internationales de Laryngologie*, September-October 1929.)

Whereas in adults ethmoidal infection is rarely an isolated infection, and is usually associated with infection of the frontal and sphenoidal sinuses, in children the ethmoidal cells are usually alone infected.

Infection of the middle ear associated with adenoids is frequently present. Measles, diphtheria, and especially scarlet fever give rise to a particularly severe form of ethmoidal suppuration.

Clinically, evidence of infection shows itself by a swelling at the inner canthus, with œdema of the eyelids. And when the swelling is very marked the eye is pushed downwards, outwards and forwards. Diplopia is frequently present. The conjunctiva and fundus are normal.

Radiography is of great assistance in these cases, but it sometimes shows too much. In some cases it shows other sinuses to be infected, whereas, in the author's experience, this has been found at operation not to be the case.

This short article has two radiographic reproductions.

*Some Remarks concerning Ozæna.* M. DELIE (Brussels). (*Archives Internationales de Laryngologie*, September-October 1929.)

After summarising the various treatments of ozæna, the author infers that one object is common to them all. They all seek to revive or awaken in the nasal fossæ a failing vitality by producing congestion and irritation.

The latest form of treatment described is that of pericarotid sympathectomy. This operation is based on considerable clinical and experimental work—notably that of Halphen. Portmann has had dramatically successful immediate results, but a few weeks later all the ozænic features reappeared. The marked positive effect of the operation is due, it is believed, to the partial obliteration of a large number of the fibres of the parasympathetic. This allows greater play for the dilator fibres of the vagus. The later return of the ozænic features may be due to the action of other constrictor fibres which are not surgically accessible. It occurred, therefore, to the author

to take a leaf out of the surgeon's book and try drug therapy, which, while producing local congestion, would be more lasting in its effect and more accessible to the average medical man.

The drug which has been very successful in the author's practice is neopancarpin. One or two granules of this drug, or 10 to 15 mins. of the solution, are given three times a day.

No ill effects have been noted in its use. MICHAEL VLASTO.

*End-Results of Operations for Ozæna.* MAX MEYER. (*Zeitschrift für Laryngologie, Rhinologie, etc.*, Band xix., January 1930.)

In Lautenschläger's operation both antra are opened and the inner walls with the inferior turbinates are loosened and pushed towards the septum. In the author's opinion this operation is not justifiable when the antra are healthy, as chronic antrum suppuration may be caused without relieving the atrophic rhinitis.

It is not the narrowing of the nasal cavity which causes the beneficial effect, but the inflammatory reaction which follows the operation and the prolonged packing. This effect is more easily obtained by introducing a foreign body under the mucosa of the septum, generally a piece of bone from the tibia or from a rib (Steurer's operation). The author prefers to use several small bone implants. Even if suppuration results, one or other of these may remain in position. He describes several cases where the implant had remained and the narrowing of the nasal cavity had persisted. Yet after a time, when all inflammatory reaction had ceased, the mucous membrane again began to shrink and crusting recurred.

Nineteen patients who had undergone one or other of these operations were re-examined after a time interval of two years or more. Among these there was not a single case where the author could discover a definite improvement. Five of the patients stated that they were better, but on questioning them it was found that they also needed frequent douching to keep the crusting under control.

Very reluctantly Professor Meyer reaches the conclusion that in no single case has the operation been worth while, and that we have to rely on purely symptomatic treatment, as heretofore.

J. A. KEEN.

*A Case of Intractable Sneezing lasting Ten Days and Nights, and yielding only to Anæsthesia of the Spheno-palatine Ganglion and Resection of the Nasal Septum.* LAPOUGE. (*Archives Internationales de Laryngologie*, September-October 1929.)

The patient was a female aged 20. The writer had enucleated her tonsils in 1925. In 1926 he performed a cortical mastoid operation on the left side. During the process of healing of the mastoid wound

the patient started her attacks of paroxysmal sneezing, which were to last for 240 hours without ceasing in spite of every form of medical treatment. Cocaine, atropine, peptones, auto-sensitisation, darkness, etc., were all tried without avail.

The patient complained of a tickling high up in the left nasal fossa. The nurse in attendance counted on one occasion 250 sneezes in ten minutes. The patient was becoming exhausted through lack of sleep and nourishment. Something had to be done.

The only obvious local physical sign was a deflection of the upper part of the nasal septum, where the middle turbinate was making contact.

As a last resort the following surgical interventions were carried out:—(1) The spheno-palatine ganglion was anæsthetised by the injection of 2 c.c. of scurococain by the palatine route. (2) A high submucous resection.

The paroxyms of sneezing immediately ceased and never returned.

The author believes that the sneezing was due to some disorder of the sympathetic system. No similar case is recorded in medical literature. MICHAEL VLASTO.

*Bronchosinusitis Disease.* W. W. WASSON, Denver. (*Journ. Amer. Med. Assoc.*, 28th December 1929, Vol. xciii., No. 26.)

The term is applied to infections involving the entire respiratory tract, especially those of a chronic nature. The author has studied ninety children from birth to eight years of age. There is no common etiology. Numerous bacteria are found. The condition is greatly influenced by lack of vitamins, heredity, environment, climate, and air contamination. In young infants the condition is recognised by mucous rattling in the trachea, which in a few months develops into thymic stridor. This stridor is caused by infection of part or all of the respiratory tract. Some recover spontaneously, while many, as a result of frequent colds, develop asthma or bronchitis in the second or third year. Some have hay fever. The condition, which is more or less acute in childhood, later develops into the adult chronic type of disease. The pathological condition gives typical manifestations clinically, roentgenographically, and at necropsy. The portion of the lung most involved is the hilum, which develops a great deal of connective tissue. The lymphatics are not specially involved. X-ray of the sinuses and chest presents an appearance which is pathognomonic. After studying an X-ray picture of the chest a roentgenologist may often foretell the conditions present in the sinuses, although the converse is not true. Its importance is equal to that of tuberculosis, but there is clinically a definite difference.

The article occupies three columns. ANGUS A. CAMPBELL.

# Abstracts

## LARYNX.

*A New Method of Treatment for Habitual Over-tightening of the Vocal Cords.* Prof. FRÖSCHELS (Vienna). (*Zeitschrift für Hals-, Nasen- und Ohrenheilkunde*, Band xxiii., Heft 4, p. 340.)

This remainder from the physiological breaking of the voice at puberty may show itself by unintentional transitions from a high soprano to a deep bass during speaking, or perverse acquisition of a deep male voice by a girl, or, again, persistence of falsetto voice in a man. These are attributable to defective co-ordination of the internal and external tensors of the cords. The pitch of the voice may be lowered by pressure on the thyroid cartilage, but Fröschels' new method consists in shaking the lower jaw from side to side to relax the pharyngeal muscles and, consecutively, the tensors of the vocal cords. He claims to have made the voice deeper and clearer in a very short time by this method. JAMES DUNDAS-GRANT.

## TONSIL AND PHARYNX.

*Islands of Cartilage and Bone occurring in the Tonsils of Members of one Family.* HANS LEICHER. (*Zeitschrift für Laryngologie, Rhinologie, etc.*, Band xix., January 1930.)

Small islands of cartilage and bone in the tonsils are not very uncommon. There appears to be a hereditary factor, as the author was able to collect three instances where this abnormality occurred in the tonsils of two sisters aged 24 and 27, two brothers aged 7 and 9, and of twin sisters aged 22. A hereditary factor is most easily explained on the embryonic theory, viz., that the cartilaginous areas are remains of the cartilage of the second arch. J. A. KEEN.

*Islands of Cartilage and Bone in the Tonsils.* JOSEPH HEINZ. (*Zeitschr. für Laryngologie, Rhinologie, etc.*, Band xix., January 1930.)

Six hundred tonsils were examined histologically, and among these were found 14 specimens which contained areas of cartilage or bone. The clinical history of the patients, including three microphotographs of typical sections, is given.

Then follows a theoretical discussion. There are three possible ways of explaining the origin of these cartilage and bone remnants:—

(1) An ossification of the stylohyoid ligament.
(2) Fœtal remains connected with the cartilage of the second arch.
(3) A metaplasia of the connective tissue in the tonsils.

The first explanation is not supported by the author's research. There is no single instance of an isolated bony focus which could represent a piece of an elongated styloid process.

As a rule the islands of cartilage or bone are found near the pillars of the fauces, and very often quite near the surface of the tonsils. In some cases the cartilaginous foci were surrounded by a well-defined perichondrium; in other sections these areas were not sharply defined from the surrounding connective tissue. Cartilage islands may become bony in character, and there are several specimens with both kinds, and with areas showing the transition.

Islands of cartilage have been demonstrated in sections of fœtal tonsils where an inflammatory factor could certainly be excluded (see references). As a rule there is more than one island of cartilage—as many as ten have been described in one tonsil. This multiplicity of foci has been used as an argument against the embryonic theory.

After considering the various views and arguments the author concludes that the explanations (2) and (3) are both correct. Small areas of bone or cartilage which are not sharply defined are due to a metaplasia of the connective tissue, the result of chronic inflammation. Larger areas of cartilage with a well-defined perichondrium must be looked upon as embryonic in origin—*i.e.* they are remains of the cartilage supporting the second branchial arch. J. A. KEEN.

*Fœtor Oris of Tonsillar Origin and certain Bacilli causing it.* ALDO CASTELLANI. (*Lancet*, 1930, Vol. i., p. 623.)

The author concludes that oral fœtor of tonsillar origin is not rare, evident lesions of the tonsils being present in some cases, while in some they are merely enlarged without other apparent lesions. The author has found two bacilli present, one belonging to the genus Escherichia and the other to the genus Alkaligenes. For the former he suggests the name *Escherichia colofœtida* (bacillus colofœtidus); for the latter *Alkaligenes alkalofœtidus* (b. alkalofœtidus).

MACLEOD YEARSLEY.

*Caseous Retrotubal Retention and its Treatment.* E. ESCAT. (*Archives Internationales de Laryngologie*, September-October 1929.)

The retrotubal collection of caseous secretion resulting from prolonged nasopharyngeal catarrh is not a very uncommon condition. It reveals itself symptomatically in the following manner:—

(1) Cacosmia on sneezing and forced nasal expiration. Although usually only subjective, the smell is sometimes perceptible to others.

It may be only unilateral. (2) The hawking of fœtid particles of whitish-yellow colour. (3) Attacks of labyrinthine vertigo.

Diagnosis is made either by posterior rhinoscopy or by naso-pharyngoscopy. It may be necessary to raise the soft palate under local anæsthesia in order to obtain a satisfactory view.

The only satisfactory form of treatment is the digital disintegration of the septic cavernous tissue. The technique recommended by the author assumes that the nasopharynx has been anæsthetised by insufflations of cocaine and adrenalin through the nose and mouth. The surgeon, standing on the patient's right side, uses the right index-finger for clearing the right side of the nasopharynx. His left hand passes around the head, and the fingers are used for compressing the cheek in between the teeth, and conversely for the left side of the nasopharynx.

Three illustrative cases are described. MICHAEL VLASTO.

*Treatment of Acute and Chronic Tonsillitis by means of Cauterisation or Radiation with Concentrated Solar Rays.* J. BEN RAANAN. (*Münch. Med. Wochenschrift*, Nr. 3, 77 Jahr, S. 102.)

The writer, who suffered from chronic tonsillitis, contrived by means of a mirror and a concentrating lense to cauterise and radiate his own tonsils with the sun's rays, making regular short applications over a definite period. He experienced early and lasting relief from the attacks of tonsillitis which had previously occurred. These were finally only induced on rare and extreme occasions.

The opinion is expressed that by means of a suitable lamp it should be possible to carry out this treatment independently of the prevailing weather. It would, however, first be desirable to ascertain what actual combination of solar rays proved most effective in attaining the object in view. J. B. HORGAN.

## ŒSOPHAGUS.

*Pulsion Diverticulum of the Pharynx.* ALAN NEWTON. (*Journ. of the Coll. of Surgeons of Australasia*, 1929, Vol. ii., pp. 3-20.)

The author states that "it is not pedantic to insist on the use of correct nomenclature for this condition, namely, pharyngeal pulsion diverticulum." The etiology is unknown. A congenital defect in the pharyngeal wall or inco-ordination between the propulsive and sphincteric mechanism of the pharynx may be responsible. The author regards trauma, by the impaction of a piece of hard food in the pharynx,

as a very probable cause of the condition. In two of the five cases on which he operated there was such a history—in one case of the impaction of a piece of apple; in the other of a rabbit bone. In this he agrees with Zenker, who believes that such a foreign body can cause separation of the muscle fibres in the lower part of the pharynx, where the lumen is narrowest and the wall is thinner and more immobile than elsewhere.

He regards noisy deglutition as an early sign, which should arouse suspicion. Other symptoms are a feeling of pressure in the neck, regurgitation of unaltered food, and fits of coughing. There may be a visible swelling in the neck. Patients often find out for themselves that washing out the pouch after meals makes them more comfortable. Wasting occurs more frequently than is supposed, and was conspicuous in four out of the five cases reported. In one case dysphagia was so great that gastrostomy had to be performed.

In treatment, co-operation between surgeon and endoscopist is essential for success. The œsophagoscope is passed before operation to empty the pouch and to dilate the œsophageal lumen below. Through the œsophagoscope the pouch is packed with gauze, and a bougie is passed into the œsophagus. Thus it is easy to recognise the structures during operation.

Small pouches are best treated by complete invagination into the pharynx. In large pouches the tunica fibrosa of the pouch is divided one inch from the neck and separated from the lining mucosa, which is clamped, divided with a cautery, and invaginated with a purse-string suture. The tunica fibrosa is then overlapped across the weak spot in the pharyngeal wall, as the abdominal wall is overlapped in Mayo's operation for umbilical hernia. Before the tunica fibrosa has been sewn up the œsophagoscope is again introduced to insure that there is not too great a projection into the pharynx and that the pouch has been entirely obliterated. The lower part of the wound is lightly packed with gauze, smeared with B.I.P.P., and the wound loosely sutured. Feeding is carried out for the first few days by means of a nasal tube.

The operation can thus be performed in one stage, and this the author prefers. If the two-stage method is employed, at the first operation the pouch is isolated and sutured to the deep fascia at the upper part of the wound—"bipped" gauze is packed into the lower part to encourage the shutting off of the mediastinum by adhesions. In ten days' time the pouch is removed, just as in the one-stage method, care being taken to insure adequate repair of the pharyngeal wall. The author operates with intratracheal ether.

Reports of five cases are given. There were no deaths and no recurrences. W. A. MILL.

# Abstracts

## ENDOSCOPY.

*Undescribed Symptoms of Foreign Bodies free in the Trachea.* Dr ALFRED ALCAINO (Chile). (*Revista Española y Americana de Laringologia.* November 1929, p. 451.)

The author notes the classical symptoms described by Jackson and other writers, and goes on to explain that the symptoms produced differ when the foreign body is in movement and when it is at rest. He calls these active and passive symptoms of defence, and it is the first group which produce the classical symptoms already described. The passive symptoms, which he has observed in some 50 cases, are important, because the foreign body is at rest for at least twenty out of the twenty-four hours. The distress produced by the movements of the foreign body instinctively causes resort to the passive symptoms of defence. These are:—

1. Great diminution of the respiratory reflexes so far as they are under voluntary control. The child refrains from coughing and laughing, and avoids any sudden inrush of air towards the lung.
2. The child unconsciously breathes as quietly as possible. On inspection the costal respiration is scarcely perceptible: on palpation there is some rigidity of the intercostal and other respiratory muscles, which restricts the movements of the thoracic box.
3. The peculiar position of the patient, who sits half-bent forwards and sideways with the legs drawn up. Any change of position is resisted. These three symptoms often help to establish the diagnosis. L. COLLEDGE.

## MISCELLANEOUS.

*Experiences of Radium Treatment in Rhino-Laryngology.* F. V. NOVAK and R. KÖHLER (Vienna). (*Oto-Laryngologica Slavica*, Vol. i., Fasc. 2, p. 160.)

For malignant disease in the throat Novak welcomes the use of "seeds." These must all be of equal intensity, and the distribution and dosage must be carefully adapted for the avoidance of extensive necrosis. Although the extremely small seeds may be left *in situ* till eliminated with the necrotic tissue, it is preferable to use removable ones, such as the "platinum removable seeds," with a thread attached. They are introduced by means of trocars—such as are supplied by the Radium Emanation Corporation of New York. The inhalation of radio-active air and vapour offers possibilities which call for further study. In cancer of the œsophagus the best results seemed to follow

the introduction of Muir's platinum filtered seeds. Dr Köhler narrates the only case in which a durable beneficial result was obtained. The first relief followed external radiation, when for a year and a half food in the form of bouillie (? bouillon) could be taken. Then a radiophoric cannula was introduced for six days, and there supervened such intense reaction that nothing would pass for fifteen days. This subsided and the stenosis relaxed sufficiently to allow first liquids and then occasionally solids to pass. This condition of matters has lasted for nearly two years. In no other cases were good effects produced. The writer considers the treatment of cancer of the larynx inefficacious, and apparently leans towards surgical methods. The results on the tongue seem to have been unfavourable, but those on the soft palate good. The experience of cancer of the mouth was discouraging, as also was that of the ethmoid region. Sarcomas of the tonsil and soft palate answered well. Rhinoscleroma and tuberculosis gave very encouraging results. In four out of eight cases of primary otosclerosis after the injection of 1 c.c. of "emanation" solution in the retro-auricular region the tinnitus disappeared and the slightly lowered hearing power became normal. JAMES DUNDAS-GRANT.

*Acute Abscess of the Lung.* Professor ACHARD (Paris). (*Franco-British Medical Review*, p. 115, February 1930.)

A typical case is described, running its course in about four weeks. The expectoration was not that of pneumonia or broncho-pneumonia, but frankly purulent, containing, among other microbes, the pneumococci in fusospirillary association. Radiological examination showed in the middle lobe of the lung a clear pocket surrounded by a dark ring close to the hilum, in which was seen a level of liquid varying according to the patient's position. It supervened after an ordinary sore throat and independently of any operation on the nose or throat.

JAMES DUNDAS-GRANT.

*Some Dutch Families with Hereditary Teleangiectases of the Mucous Membrane of the Upper Air and Food Passages and of the Skin (so-called Osler's Disease) characterised by Recurrent Nose-Bleeding.* K. EDEL, P. H. G. van GILSE and C. POSTMA. (*Acta Oto-Laryngologica*, Vol. xiii., Fasc. 4.)

This disease appears to have been described first by Babington, who in 1865 reported cases of epistaxis in five generations of one family. In 1901 Osler gave the first full description of the disease, since when records of some thirty-eight affected families have been published.

The authors give in this paper an account of six more families, in

each of which a number of the members were affected throughout several generations.

Both in the authors' cases and in those previously recorded the attacks of nose-bleeding began in childhood and gradually increased in severity. They always preceded the appearance of the teleangiectases on the skin.

The disease is characterised by the presence on the mucous membrane of the nasal septum, floor, and turbinals of dilated vessels and small angiomata, some of them punctiform and others attaining a diameter of 5 to 7 mm. Similar angiomata are sometimes present on the mucous membrane of the lips, mouth, pharynx, larynx and palpebral conjunctiva. On the skin they occur most often on the face and head, hands and feet, and especially under the finger-nails. Coughing, sneezing and slight injuries are very apt to be followed by profuse nose-bleeding, and there results in many cases a high degree of secondary anæmia.

The family trees, of which three are given, show the markedly hereditary character of the disease, which passes down from generation to generation as a Mendelian dominant.

In addition to local treatment for destruction by cautery, etc., of the nasal angiomata, general measures are often required for combating the anæmia, a high degree of which seems to predispose to increased bleeding. Liver preparations have proved very useful in some recent cases. THOMAS GUTHRIE.

*The Treatment of Hay Fever by the General Practitioner.* W. STORM VAN LEEUWEN. (*Münch. Med. Wochenschrift*, Nr. 51, Jahr 76, S. 2130.)

By far the greater number of hay fever patients are only hypersensitive to the pollen of grasses or corn. The physician should in the first instance determine whether his patient belongs to this class by ascertaining if the skin reaction is positive to the mixed pollen of grass and corn. If the skin reaction is negative, the case must be considered as belonging to the difficult variety and beyond the scope of the general practitioner. If otherwise, therapeutic injections with mixed grass and pollen serum may be carried out. For this purpose the author recommends the therapeutic series made by the Sächsischen Serumwerk A. G., beginning with ampulle I, Series F, and subsequently the next ampulle until there occurs marked local or slight general reaction. Should this occur it is necessary to wait two days and then restart with a smaller dose. A very small percentage of these patients are prone to suffer from symptoms of polyneuritis when efforts are made to desensitise them by the method described. The latter must be discontinued at the onset of such symptoms. J. B. HORGAN.