# ABSTRACTS.

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*Authors of Original Communications on Oto-laryngology in other Journals are invited to send a copy, or two reprints, to the* JOURNAL OF LARYNGOLOGY. *If they are willing, at the same time, to submit their own abstract (in English, French, Italian or German) it will be welcomed.*

## TONSILS.

**Bacillus Tuberculosis in the Tonsils of Children Clinically Non-tuberculous.—R. S. Austin.** "Amer. Journ. Dis. Child.," vol. xviii, No. 1, July, 1919.

This paper gives the results of a very extensive investigation of the excised tonsils from forty-five children for the presence of tuberculosis, using a special inoculation test, and also making use of histological examination of sections of cultures in Dorset egg-medium and direct smears. In all cases the histological examinations showed no evidence of tuberculosis, and no tubercle bacilli were demonstrated in any of the cultures or direct smears.

Fifteen of the children were from two and a-half to five years of age, and thirty from five to twelve years of age. All were fairly well developed and nourished. A family history of tuberculosis existed in two cases, while the personal history of all the cases did not record any evidence of tuberculosis, past or present. The cervical glands were enlarged in twenty-one cases, but not in any marked degree or in any way suggestive of tuberculosis. Physical examination for tuberculosis was negative.

The inoculation test yielded a positive result in only one of the forty-five cases. No evidence in this case of any past history of tubercle was obtained; a von Pirquet test had been negative, but a history of otitis was admitted (no mention is made as to otitis being suppurative). Guinea-pig inoculations after the method of the British Commission were used.

The author offers an explanation as to the differences between his results and those of Mitchell on tuberculosis associated with the milk supply of Edinburgh. The children of the author's series came from a community where the supply of cow's milk is far less likely to be contaminated with the tubercle bacillus.

The author considers that although tuberculosis of the tonsils in children is not rare, yet most of the cases occur when there are tuberculous lesions to be found elsewhere in the body, especially in the cervical lymph-glands. The occurrence of the bacillus in the tonsils of children without clinical evidence of tuberculosis, however, is not frequent.

*Perry Goldsmith.*

**Mechanical and Physiological Considerations in Tonsillectomy.—H. C. Masland** (Philadelphia). "New York Med. Journ.," August 16, 1919.

The author points out that with the accumulated wealth of data regarding the results following complete tonsil enucleation, there has followed a reaction by which too energetic surgery in this region is meeting with considerable criticism.

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In the author's experience only 2 per cent. of cases are free from deformities of the palate or pillars. He agrees that while a very large proportion of cases are relieved of the condition for which they were subjected to operation, there exists still a goodly number of patients who complain of various discomforts in the throat and adjacent areas which they attribute to the operation, or to defects of the speaking or singing voice.

In considering the mechano-physiological formation of the fauces, he says that the tonsil swings as an elastic bumper between the two pillar muscles, and by virtue of its looser attachment to the superior constrictor permits an accommodation between these muscles necessary in their varying contractions. All tonsils have crypts, and these crypts constantly show the presence of micro-organisms, since the tonsil is the most exposed of all lymphatic glands, and thereby more constantly liable to infection. Unless the tonsil has a neutralising and destructive effect upon the ever-present organisms the throat would never be free from disease. When the crypts become diseased their function is lessened and infection occurs. Then it is that operative measures are to be considered.

The author advocates the retention of a shallow layer of tonsil with the capsule. Some crypts remain, but they are shallow, and usually return to health; but if this does not follow a wedge-shaped piece removed from their length will be sufficient. The absence of scar-tissue greatly enhances the operative results. The paper is a plea for the skilful removal of the major portion of the tonsil in most cases and the removal of the tonsil and capsule in a small minority.

*Perry Goldsmith.*

**Anterior Dislocation of Atlas following Tonsillectomy.—Harold Swanberg.** "Journ. Amer. Med. Assoc.," vol. lxxii, No. 2, January 11, 1919.

A private soldier, in civil life a farmer with negative family and past history, was admitted to an American base hospital suffering from measles and acute tonsillitis. Tonsillectomy was performed a month later, and the same evening the neck became stiff and remained so ever since. Five months later, at another hospital, X ray showed osteo-arthritis of the first and second cervical vertebræ. Fragments of tonsils remained, and these with some septic teeth were removed. At another base hospital from which the case is recorded he was found to still have a stiff neck. All motions restricted, no ability to rotate the head, and pain in the cervical muscles with headache.

Further X-ray findings were found very interesting. There was a simple complete anterior dislocation of the atlas and skull on the axis (epistropheus), unaccompanied by fracture, yet with no symptoms of pressure on the spinal cord. No evidence of any osteo-arthritis was found. Palpation of the naso-pharynx revealed a large, rounded bony mass occupying a large part of the cavity. Attempts under general anæsthesia to reduce the dislocation failed and the patient declined further treatment.

Careful investigation of the history and details of the first operation, which was with local anæsthesia, points to the condition not having resulted from trauma. This case illustrates the diagnostic errors following incorrect histories, and the care one should take in the interpretation of an X-ray plate.

*Perry Goldsmith.*

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**Some Clinical Observations on the Lingual Tonsil concerning Goitre, Glossodynia and Focal Infections.—Greenfield Sluder** (St. Louis). "Amer. Journ. Med. Sci."

Acute inflammation of the lingual tonsil is a frequent accompaniment of acute follicular faucial tonsillitis in both old and young. It is frequently overlooked, chiefly due to the non-use of the laryngeal mirror. It may replace the acute faucial tonsillitis in cases when the palatine tonsils have been enucleated, but is liable to be less frequently recurrent. Lingual quinsy is rare.

The evidence of the acute lesion is striking—*e.g.* dysphagia, fever, redness and swelling of the mass at the base of the tongue, with or without white or yellow spots marking the openings of the follicles. In chronic cases the sensation of mucus which cannot be removed is frequently referred to the naso-pharynx or larynx—the latter more frequently. In acute cases pain may be referred to the ear, while in chronic cases a feeling of stiffness is often present on swallowing. Sluder has never found a "gouty" throat with a normal lingual tonsil. A sensation of foreign body, falling of the palate or long uvula are frequently described. Lingual varix with bleeding, cough, and at times suffocative symptoms may be induced. Difficulty with the singing voice is more often due to the lingual than the faucial tonsil. As a focus of infection it is quite as important as the palatine tonsil, and may even keep up a rheumatic infection after the faucial tonsils have been removed.

The author is convinced that thyroid enlargement is a frequent association with lingual inflammation, and cites a case in his own family in which the connection seemed very definite, the thyroid behaving like the cervical glands in acute faucial infection. Experiments with coloured pigments and injections in the lingual region did not show the presence of these substances in any thyroid removed two weeks later.

Measures directed to the lingual tonsil have, in the author's experience, materially benefited some cases of goitre and hyperthyroidism. In the treatment of the acute and chronic inflammation of the lingual tonsil nothing has been found as satisfactory as applications of a small amount of silver nitrate saturated in 50 per cent. glycerine. Salicylic acid and alcohol is useful but not so efficacious. The applications are made daily, or less often as required. For definite enlargement the galvano-cautery or the guillotine are generally required. Hæmorrhage, while rare, is very difficult to control. *Perry Goldsmith.*

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## EAR.

**A Study of the Aural Complications of the Recent Influenza Epidemic with Special Reference to the Clinical Picture.—Frederick T. Hall.** "The Laryngoscope," June, 1919, p. 351.

Out of a series of 6870 cases of influenza at the U.S.A. General Hospital No. 14, there were only 120 cases of acute suppurative otitis media. There were 1600 cases of pneumonia in this series and 66 of the cases of otitis media occurred among these. Of the 120 cases, 17 were bilateral, 21 cases developed "mastoids," 1 case developed otitic meningitis and died. In practically every case the type ran true to form. The onset was quite sudden, generally occurring on from the first to the third day of the disease. The first symptoms were intense pain, some-

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times preceded by a feeling of fulness. The headache and malaise must be attributed to the general effect of the influenza, and the temperature, which ran from 101° to 104° F., must be considered in the same way. (Otitis media in non-influenza cases ran a normal temperature.) Otoscopic examination within two or three hours after the onset of pain shows vesicles on the membrana tympani. In almost every case there was marked redness and some bulging of Shrapnell's membrane (*sic*). The superior posterior quadrant showed the greatest change and there was frequently a large hæmorrhagic bleb bulging outward. Often there were two or three of these blebs, always superior, either anteriorly or posteriorly, and often extending to the wall of the external auditory meatus. There was no tenderness over the mastoid process at this stage. Incision of the blebs evacuated a small amount of bloody serum. In the older cases this could be expressed from the vesicles only with some effort, as if some clotting or organisation was taking place. In one case the bleb became a pedunculated sac of considerable length but narrow pedicle. This was removed and gave the microscopic appearance of mucous membrane. Incision of the membrana tympani in the earlier cases was followed by considerable bleeding. Later this became a profuse sero-sanguineous discharge. Pain generally subsided about two hours after the incision. The sero-sanguineous discharge continued profusely for several days and then gradually changed to a thin purulent discharge which later became of thicker consistency. Nose and throat examination showed congestion of the mucous membrane with purulent secretion and acute pharyngitis. Epistaxis was a fairly frequent incident. Occasionally there was laryngeal involvement. Two cases showed hæmorrhagic vesicles on the true cords.

In other cases, in from ten to twelve days from the onset, the whole superior canal wall became flattened. Usually there was no mastoid tenderness or œdema. Hitherto the flattened superior canal wall has been considered one of the most reliable signs of a suppurative mastoiditis and frequently an indication for operation. Hill found the reverse to be true, both by clinical observation, X-ray of the mastoid, and also by operation.

Cultures upon blood-agar showed streptococci in practically every case. Occasionally an admixture of staphylococci was also found.

Even after the membrana tympani had regained almost normal appearance and colour a certain percentage had increase in the discharge with thickening of the mastoid periosteum, slight tenderness and œdema over the tip. Of the twenty-one cases which came to mastoid operation one showed a normal mastoid, two simply a congestion of the mucous membrane of the cells; the rest showed a hæmorrhagic cortex and more or less free pus in the cells. The bone was not broken down. One of the cases with erosion of the tegmen developed leptomeningitis and died. This was complicated by a severe pneumonic process involving both lungs. Many cases which showed a flattened superior canal wall and a cloudy X-ray of the mastoid cleared up without operation.

*J. S. Fraser.*

**Severe and Uncontrollable Hæmorrhage Following Mastoidectomy in a Patient Suffering from Purpura.—Thos. J. Harris** (New York). "New York Med. Journ.," August 23, 1919

The patient had bilateral acute middle-ear suppuration, for which the membrane was incised early. There was a family history of hæmophilia and a personal history of recent arthritis and numerous subcutaneous

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bleeding areas. Every effort was made to avoid operative interference on the mastoid, but it was eventually unavoidable. The pre-operative state was associated with chills, fever 102° F., nausea, bleeding from the gums and pain, with swelling at the tip suggesting Bezold's mastoiditis. Operation followed transfusion, which was repeated the following day. There was no unusual bleeding during the operation, but subsequently oozing from the wound followed, which was controlled by 5 per cent. coagulen ciba. Considerable bleeding occurred during the next few days, which, not being controlled by packing, necessitated suturing the wound, which accomplished the desired result. Even the transfusion wound bled as late as a week following the operation. The bleeding continued at intervals for seventeen days, when it finally stopped and the wound looked normal. The subsequent history of the case was one of slow but complete recovery. He was discharged from the Army, but died shortly after returning to civil life. This last illness was brief and not accompanied by bleeding.

A consideration of the chief distinguishing features between hæmophilia and purpura follows. In the former there is added to the element of heredity a deficiency in one or more of the clotting properties of the blood which results in prolonged coagulation-time, which in the latter, representing many different conditions, is associated with a deficiency of the blood-platelets, and is often combined with subcutaneous hæmorrhages.

*Perry Goldsmith.*

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## MISCELLANEOUS.

**The Bacteriology of Mumps.—Russell L. Haden.** "Amer. Journ. Med. Sci.," clviii, No. 5, p. 698.

This paper is interesting to otologists in connection with mumps-deafness, which is probably of meningitic origin.

The organisms recovered from the blood, the parotid secretion and the testis have been quite uniformly Gram-positive diplococci, which grow slowly. Attempts to reproduce the disease have, however, been for the most part fruitless. Herb reports the recovery of a Gram-positive diplococcus from the heart's blood and tissues of a patient dying subsequent to an attack of mumps. This organism, when injected into the parotid gland of a dog, caused a parotitis simulating mumps. The injection of cultures intra-peritoneally also produced an orchitis.

In nine cases investigated by Haden the spinal fluid showed uniformly a pleocytosis of the mononuclear type. Cultures and smears were negative in eight cases. In one instance the fluid was opalescent and smears showed numerous Gram-positive diplocococci. All nine patients were clinically cases of classical mumps. The cocci were found in direct smear, so there was no chance of contamination. It seems reasonable to conclude that the organism demonstrated in the spinal fluid was the one causing the primary infection—a parotitis. Blood-cultures were made on all cases of mumps on admission. Of the twenty-five cultures taken nineteen were sterile. Two were contaminated. Four cultures on three different patients showed a small Gram-positive diplococcus. After several transplants it grew readily on all media.

Five cases of mumps are reported by Haden in which a Gram-positive diplococcus was isolated from the spinal fluid, the blood and a lymph-gland. The injection of the organism into the testicle of a rabbit pro-

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duced a severe orchitis in ten days. These findings confirm the earlier reports of similar organisms from cases of mumps. Haden concludes that mumps is probably caused by a Gram-positive diplococcus and not by a filterable virus. *J. S. Fraser.*

## NOTES AND QUERIES.

### A New Library at Manchester.

We understand that, in connection with the establishment of the Ellis Llwyd Jones Lectureship at the University of Manchester, a special library is to be founded. The lectureship is for the purpose of training teachers of the deaf, and those who know of deaf education affairs may remember the very curious controversy that arose among teachers of the deaf as to the methods employed at the election. The new library is to be devoted entirely to works dealing with deaf education and matters connected therewith. M. Y.

### British Medical Association: Annual Meeting in Cambridge, June 30–July 3, 1920.

Although no special section devoted to oto-laryngology has been arranged for this year, we are pleased to see that Mr. H. Tilley is reading a paper (by request) before the Surgical Section on Friday, July 2, at 12.15 p.m., on "Inflammatory Lesions of the Nasal Accessory Sinuses from the Points of the General Physician and Surgeon," which will be followed by a discussion. On the afternoon of the same day he is giving a demonstration (by request) of instruments used in endoscopy of the lower air-passages and the œsophagus.

### Congrès Français d'Oto-Rhino-Laryngologie.

The Annual Session of the French Society of Oto-Rhino-Laryngologie was held in Paris on May 10, 11 and 12, under the Presidency of Dr. Sieur, the well-known professor of this speciality at the large Military Hospital of Val de Grace. The subjects for general discussion were: "Radium and Radio-therapy in Tumours of the Ear, Nose and Throat," introduced by Drs. Lenoir and Sargnon (Lyons), and "Paradental Cysts of the Superior Jaw," introduced by Dr. Jacques (Nancy). There were a large number of papers on various subjects. Another case of spontaneous escape of cerebro-spinal fluid from the nose was put on record by Dr. Constantin (Marseilles), and an interesting series of patients were shown by Dr. Moure (Bordeaux), illustrating the admirable results obtained by laryngo-tracheostomy after stenosis of the larynx and trachea from war injuries. In two of these cases the vocal cords had been destroyed and yet the patients had fair voices, produced by new cicatricial cords, and they had a free airway. The average treatment had been twenty to twenty-four months, but patience and perseverance had enabled them all to dispense with the tracheotomy tube.

Visitors were present from most of the allied countries, including Roumania and the Ukraine. There were a dozen colleagues from Belgium. Great Britain was represented by Messrs. Brown-Kelly, Albert Gray (Glasgow), Paterson (Cardiff), Watson Williams (Bristol), William Hill, Haworth, Wylie and StClair Thomson (London). All of our representatives were entertained by the Society at the Annual Banquet on the evening of May 11 at the Restaurant Marguery.

The President for next year is Dr. Mouret, of Montpelier, who has many friends in this country. StC. T.

### Meetings of the American Special Societies.

This year the Special Societies of America will hold their Summer Congress in Boston on the following dates: The Laryngological, May 27–29; Otological, May 31–June 1; Society of American Endoscopists, June 1; Laryngological, Rhinological, and Otological, June 2–4.

### The Scottish Otological and Laryngological Society.

The next meeting will be held in the Royal Infirmary, Edinburgh, on Saturday, June 12, at 4 p.m. Visitors are welcomed. Hon. Secretary: W. S. Syme.

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Amongst the names of British subjects recently published in Paris who have been awarded the Médaille de la Reconnaissance Française is the following:

*Silver.*—Sir StClair Thomson, M.D., for Valuable Services as Specialist in Laryngology.

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