extra-dural granulations. 21st May 1928—Temporo-sphenoidal abscess opened; half an ounce or more of pus evacuated. 28th May 1928—Large hernia cerebri developed gradually, $4\frac{1}{2}$ inches in diameter on 13th June 1928. 13th June 1928—Hernia cerebri explored and about an ounce of pus removed. Gradual shrinking of hernia. 30th September 1928—Completely healed. *Present Condition*—Mentality good; slight mental depression; acoumeter heard 8 inches.

Mr SYDNEY SCOTT asked the President on which side of the brain was the abscess in the first case?—[The PRESIDENT: The right side.]—Were the indications for the exploration specially neurological or were they general surgical indications? It was difficult to diagnose brain abscess on the right side in right-handed people.

The PRESIDENT (in reply) said that exploration had been decided upon because extradural granulations had been found when the mastoid was opened up (17th May 1928), but in spite of free mastoid drainage, the temperature remained high, the patient became drowsy, and slight weakness of the left side of the face developed.

ABSTRACTS

THE EAR.

Vincent's Organisms in Chronic Otorrhœa. P. CALICETI. (*Archivio Italiano di Otologia*, Vol. xxxix., Fasc. 6, 1928.)

P. Caliceti reviews the reports of a large number of cases of chronic otorrhœa and finds that in the majority of them there is a description of very extensive destruction of the membrana tympani, prolific formation of granulation tissue and polypi, and an abundant discharge of fœtid, greyish-yellow pus.

In such cases the presence of the spirochæte and the fusiform bacillus will constantly be discovered on investigation of the pus. The author practises—as do many of the writers whom he quotes—treatment by local application of neosalvarsan or one of the similar preparations. It has been applied as a powder, as an aqueous solution, and as a suspension in glycerine. After such treatment the specific organisms very quickly disappear and recovery is hastened.

F. C. ORMEROD.

Benign Necrosing Osteitis of the External Auditory Canal. Dr JACQUES. (*Annales des Maladies de l'Oreille, du Nez, du Pharynx et du Larynx*, April 1928.)

In 1923, Boulay drew attention to this uncommon and little understood affection, describing it as a slowly progressive destruction of a part of the floor and posterior wall of the bony canal under the

influence of a process of indeterminate nature but resembling that which governs the formation of a simple ulcer on the nasal septum. As regards the pathological anatomy of the disease, he could only advance several hypotheses without arriving at any definite solution. Excluding the theories that it was the result of an otitis media or a mastoid infection (producing "the cholesteatoma of the canal" of German otologists), that it was a complication of furunculosis, or a manifestation of syphilis, Boulay came to the conclusion that it was due, as in the case of simple ulcer of the septum, to two main factors, viz., repeated small traumatisms on an area subjected to a trophic disturbance.

The writer agrees with Boulay and advances further arguments to support this view, and to refute those theories suggested by various other observers. L. GRAHAM BROWN.

Mastoidectomy and Dakin-Ambrine Treatment. Dr MILLET. (*Annales des Maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, July 1928.)

The writer states that he has met with great success in the employment of this method of treatment after the radical mastoid operation.

One end of a small L-shaped glass tube is introduced via the meatus down to the tympanic orifice of the curetted Eustachian tube; the remainder of the cavity is then filled with ambrine, which on solidifying keeps the tube fixed in position. Dakin's solution is introduced twice daily by means of this tube. At the end of eight days the tube and ambrine are removed—a painless procedure—and the cavity inspected. If necessary, granulations are treated with zinc chloride. The tube with fresh ambrine is reintroduced and lavages with Dakin's solution carried out for another four days, when inspection again takes place. This process continues for periods of four days at a time until the Eustachian orifice is closed (normally at the end of fifteen days). Ordinary simple dressings are then substituted until the cavity has completely cicatrised (two months at least).

The value of this method is that the orifice of the Eustachian tube can always be seen, and if it does not close, can be made to do so by means of the silver nitrate bead. Moreover, it prevents superficial osteitis occurring in the cavity, and leaves the latter as extensive as on the day of operation. L. GRAHAM BROWN.

Queckenstedt's Test in Cases of Sinuso-Jugular Thrombosis. R. GAILLARD and R. MAYOUX. (*Annales des maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, May 1928.)

This test, largely used in Germany and America, depends upon the fact that the maintenance of the normal intracranial pressure, and hence that of the cerebrospinal fluid, depends upon the free exit of blood from

the cranial cavity via the venous channels and especially those of the lateral sinuses and internal jugular veins.

It consists in measuring by means of a suitable manometer, in the course of a lumbar puncture, the elevation of pressure produced in the intraspinal fluid when the internal jugular is compressed. If, when the jugular on the suspected side is compressed and little or no elevation of pressure results, and then the jugular on the other or healthy side is similarly compressed and a large increase is obtained, then a sinuso-jugular thrombosis can be diagnosed.

The precise technique, as described by the writers, for applying this test must be carefully followed, otherwise many errors may occur which can render the test negative.

Four cases are described in detail to illustrate the value of the test. L. GRAHAM BROWN.

Contribution to the Pathogenesis of so-called Polyneuritis Meatus Auditorii Interni, Herpetica vel non Herpetica. HANS KEY-ÅBERG. (*Acta Oto-Laryngologica*, Vol. xii., Fasc. 3.)

Hammerschlag published, in 1901, from his own material and from the literature, fourteen clinical histories with diagnosis of rheumatic affection of the auditory organ. Common to all was the violent onset in connection with some outward causal factor such as exposure to cold. The clinical pictures, however, differed considerably. Three cases exhibited trigeminus, facialis, and acusticus symptoms, a type some years later designated by Körner as herpes zoster oticus.

In seven cases Von Frankl-Hochwärt's syndrome of polyneuritis cerebralis Ménièriformis was present and in three cases solely acusticus symptoms. Hammerschlag did not attempt to form a theory about the patho-anatomical basis of the variegated symptom picture.

Körner, however, looked upon the morbid process as a trigeminal neuritis within the extension of the auriculo-temporal nerve via the facial nerve to the cochlearis and vestibularis branches of the auditory nerve.

The explanation of Ramsay Hunt, however, is the one which appears most widely accepted. Hunt believes the geniculate ganglion to be the starting-point of the process, the acusticus being implicated because of its close proximity.

Antoni, in 1919, suggested that the term polyneuritis cerebralis acustico-facialis would cover the various forms of herpes zoster oticus and polyneuritis cerebralis Ménièriformis. The writer did not consider this satisfactory, as there are cases where one or other of these nerves has escaped unimpaired. Antoni believes ordinary so-called rheumatic facial paresis to be strongly related to this polyneuritis.

The Ear

Since in ordinary spinal herpes zoster perivascular accumulations of round cells have been found, Ramsay Hunt has held the idea of localising the focus of so-called herpes zoster oticus to the ganglion geniculi, but he presupposes the rather unnatural presence of a cutaneous region of innervation in the facialis instead of the following likely connections of the auriculo-temporal nerve in the skin area, of which herpes zoster oticus is commonly seen: ganglion geniculi—ramus anastomoticus nervi facialis cum plexu tympanico—nervus petrosus superficialis minor-ganglion oticum—ramus anastomoticus cum nervo auriculo-temporalis—nervus auriculo-temporalis.

After discussing the subject further and describing two cases in detail—one of herpes zoster lumbalis and one of facial paresis in soldiers of the same regiment occurring at the same time—he concludes by suggesting that the three symptom complexes, zoster oticus, polyneuritis meatus auditorii interni and so-called banal facial paresis, represent a series of morbid conditions gradually decreasing, with regard to the virulence of which the herpetic type would form the top point of the curve.

He recalls that paralysis is occasionally found combined with herpes zoster lumbalis and intercostalis, and that this disease has much in common with the polyneuritis of the meatus.

H. V. FORSTER.

Concerning the Origin of Forced Movement in Connection with Semicircular Canal Stimulation. KOZO ONO. (*Japanese Journal of Medical Sciences, Translations, XII, Oto-Rhino-Laryngology*, Vol. i., No. 1, 1927.)

In this very detailed article, the author has divided the matter into seven sections; the first two parts deal with his experimental methods and findings, and are followed by a summary; the last five parts deal with a theoretical discussion of the more common theories of labyrinthine and semicircular canal function, which are also summarised.

The rabbit was the animal used in these experiments. Each of the three semicircular canals and their ampullæ were stimulated separately. Methods of stimulation used were—mechanical, in the form of a fine brush, electrical stimulation and finally destruction. He does not mention whether post-mortem examinations were carried out to find the exact extent of the lesions which he attempted to produce. Examinations were made immediately after operation presumably, though the time is not always specifically stated. In discussing the results which follow his manipulations, he does not mention the possible effect of utricular macula stimulation or injury. Forced movements of the body musculature, and head and eye nystagmus

follow stimulation, destruction or cocainisation of any or all three canals or ampullæ of one side, and in the majority of cases, forced positions result. For instance, stimulation of a sagittal ampulla causes the head to be bent forward and rotated to the sound side and the eye nystagmus is directed backwards; injury of the right sagittal ampulla causes the head to be permanently thrown back and the occiput turned to the right. The author regards the first as an irritation phenomenon, the second as a manifestation of paralysis. The forced position which he describes, following destruction of all three semicircular canals of one side, suggests the position which usually results from a complete labyrinthectomy, but he does not discuss possible injury to the otolithic mechanism to which Versteegh's recent very carefully controlled experiments on the utricular macula ascribe these positions. In discussing some of the complex results which followed his manipulations of the frontal ampulla, the author does suggest the possibility of simultaneous injury to the horizontal ampulla.

In the last five sections, the theories of Flourens, Galtz, Ewald, von Cyon, and others, as to the mechanism of labyrinthine function, together with the author's own opinions, are discussed at great length. He believes that the labyrinth which is constantly acting, initiates and exerts a controlling influence upon central innervation of the muscular mechanism concerned in forced movements. He discusses the mechanism of crista stimulation which he ascribes to the weight of the cupula exerting pressure upon the hairs of one side, and a pull upon the hairs of the other side of the crista simultaneously. In pointing out that the specific gravity of the cupula is more than that of the endolymph, he refers to the fact that in the cupula, Kubo discovered a fairly large quantity of calcium salts; he also refers to the function of the cupula as a damper for the swaying hairs of the crista.

W. J. McNALLY.

THE NOSE AND ACCESSORY SINUSES.

The Method of Choice for the Correction of Saddle-Nose. J. N. ROY, Montreal. (*Surgery, Gynæcology and Obstetrics*, Vol. xlv., No. 1, p. 88, July 1927.)

The writer gives a brief review of the various methods which have been used for correcting this deformity.

The method he advocates is the introduction of costal cartilage, taken from the first floating rib, as less pain results than when the 6th, 7th or 8th rib cartilages are used.

He used the endonasal incision of Roe (1887), made at the inferior border of the triangular cartilage of the nose. A tunnel is made, and

the moulded cartilage inserted. Adhesive plaster over the external nose retains the graft in position.

Photographs of two patients—treated by this method—are shown: the first a case of trauma; the second of arrest of development, probably resulting from chronic rhinitis, which was still active.

A useful bibliography is attached. W. STIRLING ADAMS.

Variation in the form of the Antrum of Highmore. MARIO SILVAGNI. (*Archivio Italiano di Otologia*, Vol. xxxix., Fasc. 8, 1928.)

The antrum is first indicated at the fourth embryonic month by a column of cells on the outer nasal wall, which extend outwards and later form a depression. The maximum growth takes place during the second dentition and may produce certain prolongations or recesses, of which the commonest are:—

1. Alveolar:—a deep excavation into the alveolar process.
2. Suborbital:—into the frontal process of the superior maxilla.
3. Malar:—into the pyramidal process of the maxilla.
4. Superior palatine:—into the postero-superior angle of the maxilla, which may communicate with a cell in the orbital process of the palatine bone.
5. Inferior palatine:—into the arch of the hard palate, where it is separated from the nasal and buccal passages by a thin layer of bone.

The latter prolongation has been particularly investigated and it was found to be present three times in about 250 skulls. In each of these three cases there was an alveolar prolongation. In some cases a bony crest partly separates the prolongation from the rest of the sinus. The author has observed two cases in which the prolongation was present, partly shut off, and infected from caries around the upper bicuspids which projected into the alveolar process.

F. C. ORMEROD.

The Frequency of Bilateral Chronic Inflammation of the Maxillary Antra. Professor TONNDORF, Göttingen. (*Zeitschrift für Hals-, Nasen- und Ohrenheilkunde*, Band xxii., Part I.)

Out of 845 patients submitted to nasal operations, 210 were cases of inflammation of the antrum, 9 of frontal sinus suppuration operated on externally and 12 intranasally. There were no cases of isolated ethmoidal or sphenoidal disease. Of the cases of antral inflammation, 236 in number, 143 were bilateral and only 93 unilateral. When one

antrum is obviously diseased, Tonndorf considers it desirable to make an exploratory puncture of the other in view of the great possibility of it being also affected in spite of the absence of indications.

JAMES DUNDAS-GRANT.

A Self-Retaining Antrum Catheter for Drainage and Irrigation of the Maxillary Sinus. M. J. MANDELBAUM. (*Laryngoscope*, Vol. xxxvii., No. 2.)

In the entire domain of rhinology, there is perhaps no more difficult nor more common problem than the treatment of sinus infections in infants and young children. Shea has recently employed soft rubber drainage tubes for drainage and irrigation of the maxillary antra. The author uses a soft rubber catheter which has been made by Eynard of Paris. It is in fact a miniature self-retaining urinary catheter. It is 8 cm. long and 12 mm. diameter; its antral end has two wings whose fenestræ permit the largest size of openings consistent with strength and small dimensions. A specially made stylet was constructed to fit the catheter so as to facilitate introduction beneath the inferior turbinate.

An opening is made into the antrum in the usual way and the catheter and stylet are passed through into the antrum, the wings being flattened out by the stylet in the process of introduction. On unlocking the clasp of the stylet, the stretched catheter resumes its shape and is retained in the antrum. Through this the antrum may be irrigated or medicated. The proximal end of the catheter, which projects 3 cm. to 4 cm. beyond the nasal opening, may be folded back on itself, and in this way prevents leakage externally of medication or antral discharge. The catheter causes no irritation and may be retained for many weeks. It seems to be an excellent method of antrum lavage without the trouble and discomfort of frequent proof punctures.

ANDREW CAMPBELL.

PHARYNX AND NASOPHARYNX.

Tonsillectomy in Singers. Dr BOUTOT. (*Annales des Maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, February 1928.)

The writer expresses the view that the removal of tonsils, when indicated, even in well-established singers, can have no ill effects on the quality and tone of the voice, provided that the method of re-education as advocated by Stern is carefully followed. This consists in commencing the exercising of the singing voice as early as the fourteenth to eighteenth day after operation by a carefully considered system of graduated exercises in the musical scale, which is fully described.

L. GRAHAM BROWN.

Pharynx and Nasopharynx

The Tonsil-Adenoid Operation and some of its Results. J. HUNTER PATON. (*Quarterly Journal of Medicine,* Vol. xxii., No. 85, October 1928.)

The writer gives an analysis of the state of the tonsils, as found in 424 girls of the well-to-do classes on admission to school between the ages of 13 and 14.

He found that in 42 per cent. the tonsil-adenoid operation had been performed before admission to school. Tonsillar tissue was still present in 53 per cent. of these. From a consideration of the state of the anterior cervical glands in these cases the writer concludes that this reveals no evidence that the remaining tonsillar tissue is necessarily pathological.

The group of those operated upon (182) is compared with those not operated on (242), while the latter are grouped according to the degree of visibility of the tonsils.

The results of the investigation are classified as follows :—

(a) *Enlargement of the Anterior Cervical Glands.*—(1) This was commoner among those with large than among those with small tonsils (as 19 : 13). (2) It was also commoner among those whose tonsils were intact than among those in whom they had been removed (as 16 : 11); but even among those operated on these glands were definitely palpable or enlarged in 11.5 per cent.

(b) *Deafness or History of Otorrhœa.*—These defects showed no preponderance among those whose tonsils were intact; while among those giving a history of the tonsil-adenoid operation as many suffered from otorrhœa subsequent to the operation as did before it.

(c) *Dental Caries.*—This was commoner among those who had had the tonsil-adenoid operation than among those who had not (as 60 : 42). Among those whose tonsils were intact, dental caries was commoner among those with large tonsils than with small tonsils (as 48 : 39).

(d) *Granular pharyngitis* was present in 24 per cent. of those in whom the tonsils were intact, in 30 per cent. of those in whom the removal of tonsils had been incomplete, and in 38 per cent. of those in whom it had been complete.

No association could be demonstrated between the incidence of postural spinal defects or of visual acuity and the state of the tonsils, nor between the state of the tonsils and the incidence of the exanthemata.

(e) *Rheumatism.* — In the series no relation was observable between the condition of the tonsils and true rheumatism; but a higher incidence of "low" forms of arthritis (of the type commonly held to be associated with toxic absorption) was demonstrable among those whose tonsils (intact) were larger.

(f) *Rickets.*—No association between the occurrence of rachitic stigmata and the condition of the tonsils could be shown; but a comparison of the writer's figures with those of a community in which rickets was very prevalent brought out the fact that though rickets is commoner among a poorly housed and fed population, dental caries is more frequent among the well-to-do classes. This suggested the question, "What factor is active in both groups but commoner among the well-to-do, which affects the incidence of caries?"

The writer sums up his general conclusions from the study as follows:—

"While it is undoubted that in a considerable number of cases great benefit results from the tonsil-adenoid operation, in view of these facts, it is evident that a more conservative method of dealing with many of the cases must be devised, and especially that attempts should be made to discover some method, other than surgical removal, of dealing with adenoid overgrowth in the nasopharynx."

AUTHOR'S ABSTRACT.

THE LARYNX.

Therapeutical Indications in Laryngeal Tuberculosis. HENRI CABOCHE, Paris. (*Internationales Archives de Laryngologie*, September-October 1928.)

In a lengthy article on this subject the following conclusions are reached.

There is no one special local treatment for laryngeal tuberculosis but rather a number of local treatments each of which has its value in a particular case.

Local treatment should always be supplemented by treatment directed to the pulmonary condition (hygiene, diet, artificial pneumothorax, etc.).

All local treatment should be preceded by disinfecting laryngotracheal instillations.

Major surgery such as laryngofissure and laryngectomy should not be performed. Even excision of the epiglottis is contra-indicated except in those few cases where the disease is strictly limited to the free border of the epiglottis. For such a condition diathermy coagulation is preferred.

Local applications of lactic and trichloracetic acids are indicated in certain forms of ulceration of the true and false cords.

The author grants that in certain sluggish forms of laryngeal tuberculosis proliferating granulations may have to be removed by endolaryngeal manipulations, but the galvano-cautery is the most useful therapeutic measure which we have at our command.

Other methods of treatment such as radiotherapy, electro-coagulation, high frequency, etc., are too recent to allow of a definite opinion as to their value.

The author is convinced that many cases of laryngeal tuberculosis are curable if treated early, methodically, and with perseverance.

This assertion may be true with reference to patients who are under treatment in a sanatorium, but is certainly less so in the case of out-patients at our hospitals, and others who for one reason or another cannot avail themselves of sanatorium treatment.

The author enters a plea for the institution of a hospital organisation for the treatment of the latter class of case. Such a special hospital should have the requisite armamentarium, radio-therapeutic appliances, etc., and should be in charge of a laryngologist acting in conjunction with a specialist physician.

An extensive bibliography is appended. MICHAEL VLASTO.

The Treatment of Laryngeal Tuberculosis by Ultra-violet Rays produced by Currents of High Frequency. J. MORIN and M. AUBRY (*Annales des Maladies de l'Oreille, du Larynx, du Nez et du Pharynx*, May 1928.)

The authors describe the method of production of the ultra-violet rays and the technique of their introduction to the interior of the larynx. They record fully the results of treatment in six cases, not specially selected, which show, with the exception of a single case, very satisfactory improvements as regards both the local and general condition.

Their conclusions, though somewhat guarded in view of the small number of cases treated, embrace the following claims:—

(1) The method is absolutely harmless and the reactions both local and general are minimal.
(2) Definite improvement occurs in almost every case.
(3) From the point of view of lesions, ulcerations, especially the longitudinal vegetative ones of the posterior commissure, appear to be particularly benefited.
(4) These rays, since they act directly on the diseased mucosa of the larynx, must replace all other methods of natural or artificial heliotherapy.
(5) Besides the ultra-violet rays the production of a cold spark of condensation certainly has a beneficent action towards increasing the vitality of the mucosa.
(6) Finally, this therapeutic measure, without attempting to replace the older classical methods of galvano-cautery and "fulguration," deserves to rank equally beside them.

L. GRAHAM BROWN.

Abstracts

Stenosis of the Larynx treated by Sub-mucous Exenteration. A. SERCER, Zagrab. (*Revue de Laryngologie*, 15th September 1927.)

The reporter of the three cases in which this operation was carried out states that the procedure is suitable for cases of laryngeal stenosis, due to inflammatory infiltration, without destruction of mucous membrane. Two of the operations were done on cases of post-enteric subglottic stenosis. In the third case the cause of the stenosis was not clear until histological examination of the cicatricial tissue removed revealed the presence of tuberculous foci. It was regarded as one of unusually chronic fibroid tuberculous infiltration. The results of the operations appear to have been excellent. The air-way was fully restored in all cases, and the voice was surprisingly good in view of the nature of the operation.

Local anæsthesia was obtained by infiltration of the overlying tissues and of the superior laryngeal nerves with novocain, and tamponading the interior of the larynx with 10 to 20 per cent. solution of cocain. Cocain was applied to the pharynx. Preliminary injection of pantopon-atropin was made. An aspirator, connected to a tube introduced through the nose into the pharynx, kept the pharynx free from secretions. Laryngofissure was performed with division of the mucous membrane strictly in the middle line. A horizontal incision was made below the edge of the vocal cord and careful dissection of the triangular flap of mucous membrane thus formed. The whole of the underlying cicatricial tissue and thyro-arytenoid muscles, together with the vocal processes of the arytenoids, were dissected out. Where the stenosis involved the vestibule of the larynx, a second incision was made along the edge of the ventricular bands with formation of mucous membrane flaps, and dissection out of the tissues surrounding the ventricles and contained in the aryteno-epiglottic folds. Replacement of the mucous membrane flaps and tamponading of the interior of the larynx were carried out with iodoform gauze. Tampons are gradually reduced, and if necessary renewed for about seven days. A cannula is introduced below the tampon into the trachea. One advantage of the post-operative tampon is that it allows of adrenalin being used freely during the operation to stop oozing, without fear of reactionary hæmorrhage.

In one of the cases, stenosis following typhoid fever in which a high tracheotomy had been done six years previously, the cartilaginous framework of the larynx had collapsed, and the airway after performance of complete submucous exenteration was found to be insufficient. The following elaborate and ingenious plastic operation was done to prop open the sides of the laryngeal box, and to close the laryngofissure.

Plastic Operation.—1. Elliptical excisions of skin on either side of the laryngofissure were employed with subsequent suture to draw the

sides of the opening outwards, and so enlarge it. 2. Parallel incisions of the skin of the neck below and on either side of the laryngostomy opening were carried down to the middle of the sternum. 3. The periosteum under each side of the flap raised towards the middle line, the flap on each side undermined, but a vertical area about 7 cm. wide was left attached to the bone in the middle line. 4. The bone attached to this strip of periosteum was detached from the sternum by chiselling it obliquely from either side. 5. The overlapping soft parts at the sides of the flap were turned under the flap so as to surround the splint of bone, and the whole was raised from its bed by the insertion of a piece of sheet rubber. The "finger" thus formed was nourished by an upper and lower pedicle. 6. The lower pedicle was divided two weeks later, and the finger-like flap was turned over on its upper pedicle and sutured into the laryngostomy gap. The raw surface on the sternum was closed by sutures and Thiersch grafts. 7. The upper pedicle was divided.

The operation of submucous exenteration would seem to be applicable to cases of bilateral abductor paralysis.

G. WILKINSON.

THE ŒSOPHAGUS.

Radium Implantation in Œsophageal Cancer. Description of the Operating Œsophagoscope: Technique of Application. JOSEPH MUIR. (*Laryngoscope*, Vol. xxxvii., No. 9.)

The three prime drawbacks to radium therapy of œsophageal cancer are (1) the difficulty of placing the radium accurately; (2) the practical impossibility of maintaining it in position long enough to be effectual; (3) the great danger of burning the tissues, and its sequelæ.

A special œsophagoscope has been elaborated by the author which incorporates a seed implanter, suction tube, elevator, etc. The technique is as follows: (1) A removable platinum radon seed attached with thread is placed in the loading slot of the implanter. A plunger pushes the seed to the proximity of the site selected for puncture; (2) the elevator contained in the œsophagoscope now directs the seed to the site and the seed is implanted by pushing the plunger home. (3) The plunger and implanter are also slowly withdrawn, permitting the seed thread to disengage from the instrument and hang loose so that one may gauge where the next puncture may be made. This method of application should be read in conjunction with Dr Herriman's paper on "Malignant Disease of the Larynx and Œsophagus treated by Radium Emanation."

ANDREW CAMPBELL.

Reviews of Books

ENDOSCOPY

On the Simplification of the Technique and Instrumentation in Broncho-œsophagoscopy. J. GUISEZ. (*Bulletin d'Oto-Rhino-Laryngologie*, November 1927.)

In the hands of the skilled endoscopist the methods of technique employed show as a rule most brilliant results. The same cannot be said to apply to those who, owing to the comparative rarity of occasions to practise such examinations, are unable to acquire even by experience the requisite skill. It is for the latter especially that the writer of this article draws attention to the commonest of those difficult points that can be met with in the technique of broncho-œsophagoscopy. Thus in the choice of instruments he advocates those types of tubes that should be used together with the best form of illumination, and describes the necessary number of simple and effective kinds of extraction forceps and their method of employment. He then deals with the preparation of the patient, the choice of position and anæsthesia, and the work of the assistant. Finally, he shows how the commonest difficulties that may be encountered should be dealt with.

The article is well illustrated by diagrams.

L. GRAHAM BROWN.

REVIEWS OF BOOKS

Atti della Clinica Oto-rino-laringoiatrica della R. Universita di Roma. Edited by Professor Gherardo Ferreri. Anno XXV. 1927.

Massini has investigated cholesteatoma of the middle-ear and although the etiology is still very much in doubt he considers that the cholesteatoma is not a sequela of inflammation but is more in the nature of a new growth. Ugo Bombelli records the fracture of the malleus at the neck, in the middle of the handle and at the base of the processus gracilis; the tip of the handle was also separated. The fracture was caused by the introduction of a narrow piece of iron. There were no internal ear symptoms, and recovery was very complete with the exception of some slight middle-ear deafness.

Roberto Motta has removed the cervical sympathetic ganglion in dogs and found degenerative changes in the glands and the muscles of the Eustachian tubes. Enterococcal infection of the ear is described in two cases of mastoiditis, where operation was followed by great infiltration of the soft parts; in a third with cerebellar abscess and in a fourth with lateral sinus thrombosis. The first two responded very well to autogenous vaccine but the two last were fatal. Brunetti describes three cases of sinus thrombosis which were cured by draining