three sittings will be sufficient to remove growths safely and efficiently. In children always use a general anæsthetic to save shock, and complete operation at one sitting. If tonsils also enlarged, remove them without an anæsthetic a few days before, especially in young and weakly children. In older and stronger children, may first remove tonsils and then adenoids under one administration of anæsthetic. The safest position and the most convenient for operation is with the hanging head. Dalby's position is also safe if using gas. Any other position is unsafe.

Of anæsthetics, chloroform is the most handy and the most easily administered, but even in careful hands so many deaths have occurred in this operation that the author, though he has used it hundreds of times "with fear and trembling," has now taken to nitrous oxide. Given with oxygen it is the best anæsthetic for most cases of adenoids.

With regard to instruments, Gottstein's curette is the most generally useful, but when growths are firm forceps must be used. Of these, Löwenberg's remains the best. In weakly children use forceps for whole operation, as hæmorrhage is less than when curette is used. *Middlemass Hunt.*

LARYNX.

Kirstein, A.—*Autoscopy of the Upper Air Passages.* "Therap. Monats.," July, 1896.

To see directly into the larynx and trachea the observer, wearing a frontal mirror, or, still better, a frontal lamp, and sitting opposite the patient, places the patient in such a position as to bring the axis (theoretical) of the mouth (with the tongue removed) and that of the trachea as nearly as possible into a straight line. The tongue and epiglottis alone obstruct his view of the larynx. He must therefore make a depression in the tongue reaching as far backwards and downwards, and as exactly in the axis of the trachea, as possible. In doing so he will at the same time pull the epiglottis out of the way. This can be done with a long, narrow tongue depressor, slightly bent downwards at its distal extremity. Care must be taken not to produce retching. By this means he will be able to see: (1) in very numerous cases, the posterior wall of the larynx; (2) often, the posterior two-thirds of the vocal cords; (3) seldom, the whole larynx, including the anterior commissure of the cords. The amount of the trachea visible will vary correspondingly. The part most easily seen, viz., the posterior wall of the larynx, is the most difficult to observe accurately with the laryngoscope. Little children are most difficult to examine with the laryngoscope, most easy by the direct method.

This method is of great service in finding and removing foreign bodies in the air passages. It is also often of great value in laryngeal operations (specially polypi), permitting the complete removal of even large tumours in one sitting (Bruns).

The larynx and trachea can be very easily and thoroughly examined in all children deeply under chloroform. If the anterior commissure is not visible, it can easily be brought into view by gently pressing the thyroid cartilage backwards.

The importance of this simple procedure in children suspected to have papilloma of the larynx is at once apparent. Should papilloma be found, it would be wise to at once tracheotomize, and either then or later proceed to operate.

In little children good results are often obtained even without narcosis.

Arthur J. Hutchison.

https://doi.org/10.1017/S175514630015766X Published online by Cambridge University Press

Krebs (Hildesheim). — *Treatment of Chronic Pharyngo-Laryngeal Catarrh.* "Therap. Monats.," 1896, Nos. 6 and 7.

THE author believes that the dried secretion in cases of pharyngitis and laryngitis sicca is not produced *in loco*, but that it comes of the nose. Therefore the nose must be treated in such cases. Many chronic catarrhs are only neuroses, and must be treated by psychic therapy. The author concludes with a review of the different methods of local therapy. *Michael.*

Neurath (Wien).—*Laryngeal Syphilis in Children.* "Jahrbuch für Kinderheilk.," Band 41, Heft 3 and 4.

A CHILD, six years old, diseased by hoarseness, dyspnœa, and difficulties of swallowing for a year. The examination showed a perforating ulcer in the hard palate, necrotic sequestræ in the nose, ulceration of the epiglottis and the vocal bands. Inunctions. Improvement. Relapse of the symptoms; sudden death by asphyxia. The *post-mortem* examination confirms the diagnosis.

Savery, Frank, and **Semon, Felix**.—*Bilateral Paralysis of the Recurrent Laryngeal Nerves due to Malignant Stricture of the Œsophagus.* "Lancet," Sept. 19, 1896.

THE interest of this case centres in the occurrence of complete bilateral paralysis of the recurrent laryngeal nerves. Whilst more or less incomplete paralysis of both these nerves is not of infrequent occurrence, really complete bilateral paralysis is but exceedingly rarely met with, owing to the fact that the lesion which causes the laryngeal paralysis almost always ends fatally before the stage of complete paralysis is reached. The symptoms resulting from this condition have always been described as complete aphonia with dyspnœa—the latter on exertion only. The present case teaches that another important symptom may be the result of the bilateral paralysis—viz., impossibility of taking nourishment in the ordinary erect position. The explanation is that when both recurrents are paralyzed closure of the glottis is impossible, and food and drinks are, therefore, apt to penetrate into the larynx. The mucous membrane of the larynx being supplied by the internal branch of the superior laryngeal nerve, the sensibility of the larynx is not affected by the lesion under consideration, and hence the entrance of any foreign body into the larynx will be immediately followed by reflex cough, as in this case. The position recommended by Wolfenden for cases of painful dysphagia was found to be successful—viz., horizontal position on the side, with the head well over the edge of the bed, and fluid nourishment to be taken through a feeding-cup inserted into the lower angle of the mouth. When drinking in this position the fluid passes, not over, but by the side of the larynx through the hyoid fossa, and penetrates into the œsophagus without coming in contact with the posterior surface of the larynx. Semon warmly recommends the adoption of this method in cases of tuberculous and malignant disease of the larynx, and malignant disease of the œsophagus. He suggests its use in post-diphtheritic anæsthesia of the larynx in which the entrance of nourishment into the air passages must be feared.

St Clair Thomson.

Stoker, G.—*Impaired Movements of the Vocal Cords.* "The Clin. Journ.," June 10, 1896.

FOR clinical purposes, the causes of impaired movement of the cords may be divided into neuropathic, myopathic, obstructive, and functional. Under the head of "obstructive" come all cases of thickening of the laryngeal mucous membrane, new growths, inspissated mucus, and foreign bodies.

Mr. Stoker is of opinion that an ordinary catarrh does not usually affect the

https://doi.org/10.1017/S175514630015766X Published online by Cambridge University Press

laryngeal muscles; that in chronic syphilitic laryngitis there is always thickening of the inter-arytenoid mucous membrane; and that a triangular opening between the vocal cords is an essential characteristic of functional aphonia. In laryngeal phthisis, he finds it is no use to apply irritating treatment, such as scraping and rubbing in lactic acid, as the only result is to create a tuberculous ulcer which one never succeeds in healing. *Middlemass Hunt.*

EAR.

Adams, J. L.—*Thrombosis of the Lateral Sinus, with Recovery after Operation.* "New York Med. Journ.," Aug. 29, 1896.

THE author narrates a successful case of removal of a septic thrombus from the lateral sinus in which the jugular was not exposed in the neck, and in which the lower end of the thrombus does not appear to have been removed. He then appends a very clear and concise summary of the history of the operation, and the views held by those who have considerable experience in this operation.
R. Lake.

Bacon, G.—*A Case of Brain Abscess secondary to Chronic Suppurative Otitis Media and presenting Unusual Symptoms. Operation. Recovery.* "New York Med. Journ.," Aug. 15, 1896.

THE patient, thirty-two years of age, who suffered with otitis media suppurativa on the left side, was seized with intense headache on December 5th, 1895, aural pain, and fever (104° F.); in the afternoon he had general convulsions and foamed at the mouth. The evening temperature was 100° F.; pulse, 104; respiration, 26. The eburnated mastoid was opened; the lateral sinus, being wounded and containing fluid blood, required plugging. For some days he was better; but aphasia and a rigor were observed on the 9th. The former becoming marked and the temperature continuing high, a second operation was undertaken the next day. A piece of bone was removed three-quarters of an inch in diameter, and two inches above the meatus, and pus was found between the brain and tegmen tympani, and a large abscess cavity was found in a direction in- up- and backward, the amount of pus being in all about an ounce and a half. There was reaccumulation of pus on the 14th; and on June 1st all aphasia is gone, and the facial palsy which had existed since the first operation is disappearing. *R. Lake.*

Bernstein, Edward J.—*Primary Tuberculosis in Relation to the Middle Ear.* "Charlotte Med. Journ.," June, 1896.

THE middle ear may become infected at any period in tuberculosis, and in a considerable number of cases it is the primary seat of the disease. If any suspicion, seek for bacillus; but remember a negative result does not exclude, nor the actual presence of the bacilli is not, *per se*, conclusive of tubercular origin. The membrana tympani may be first affected, small greyish-yellow elevations forming, which on breaking down leave numerous perforations—the "sieve-like" drum. The meatus is large and wide, owing to the absorption of subcutaneous fat, and the skin lining it is pale, hard, and dry. The left ear is attacked by preference, but, though usually unilateral, it is often bilateral. In conclusion, Dr. Bernstein relates two cases of primary (?) tuberculosis of the middle ear occurring in his own practice.
Middlemass Hunt.

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