

This table, preceded by a very able debate on the cases and the types to which they belong, should be of great service towards the description, diagnosis, treatment, and prognosis in lesions of the labyrinth.

Alex. R. Tweedie.

Kerrison, Philip D., M.D.—**The Vertigo of Vestibular Paralysis.** "Laryngoscope," October, 1911.

In addition to the vertigo of vestibular irritation, so generally recognised, there is also a form of vertigo due to loss of vestibular function which has so far escaped notice. The accepted features of "vestibular vertigo" are its occurrence during the acute stage of labyrinthine irritation, its constant co-existence with nystagmus, and with a subjective sensation of the rotation of surrounding objects.

If Bárány's law be accepted that vestibular vertigo is invariably accompanied by vestibular nystagmus, then when the nystagmus has subsided the vertigo must of necessity have also ceased.

The author maintains that this is not always so, but that it will be frequently found that after the vertigo and nystagmus due to vestibular irritation have subsided another variety of vertigo may be present due to loss of vestibular function. It is characterised by being only noticed on the performance of sudden unaccustomed movements, and differs from the former variety in the absence of nystagmus, sense of rotation, or a tendency to fall in any given direction.

The occurrence of this condition is explained by the defective orientation due to loss of vestibular function. When the vestibular function is lost its place in the orientation of the body has to be taken over by the muscular, arthro-dial, tactile, and visual senses.

This readjustment takes a variable time in different subjects, and until it is completed there will be a liability to vertigo on sudden and unusual movements. Thus a man, aged twenty-eight, who has become suddenly totally deaf as the result of a syphilitic infection, showed complete absence of both the caloric and rotatory vestibular reactions, but yet complained as much of vertigo as of deafness. He was compelled to keep his eyes on the ground while walking, but could walk straight and stand steadily with his eyes shut. He had no nystagmus, sensation of rotation, or tendency to fall in any given direction.

Since both vestibules were inactive his vertigo was presumably due to the as yet incomplete compensation by the other senses.

A. J. Wright.

PHARYNX.

Badgerow, Geo. W.—**Pharyngeal Suppuration: Course and Direction of Various Types.** "Lancet," March 23, 1912, p. 780.

After considering certain points in the anatomy and physiology of the pharynx, the aetiology of pharyngeal suppuration is discussed, and the various types, are classified, according to the seat of origin, as (1) lymphoid, (2) submucous, (3) subaponeurotic, (4) prevertebral. The first is by far the commonest. In the second dysphagia is the most prominent symptom. The most important structure in connection with the pharynx is the pharyngeal aponeurosis and its attachments. The muscles are important because their involvement gives rise to one of the most characteristic symptoms—dysphagia.

Macleod Yearsley.

Stewart, D.—**Pulmonary Embolism as a Sequel of Diphtheria.** "Lancet," March 30, 1912, p. 866.

The subject of this rare sequel of diphtheria was a female child, aged four. The attack of faucial diphtheria was mild, but, after fourteen days she showed signs of pulmonary trouble and died in twenty-four hours. A large infarct of the right upper lobe was found, with no valvular lesion, but with some dilatation of the right side of the heart.

Macleod Yearsley.

Mackay, Charles W.—**The Value of Temperature Readings in Administration of Diphtheria Antitoxin, and the Value of Large Antitoxin Dosages.** "Australian Medical Journal," June 22, 1912.

Temperature observations are made every four hours. The initial dose cannot be decided on the temperature, but if the four-hourly readings do not show a rapid fall the dose is repeated in eight to twelve hours. Where no fall is shown the initial dose is too small. In mild, recent cases the initial dose is 6000 to 8000 units. In severe cases, of some days' duration, the initial dose is from 16,000 to 30,000 units. The temperature observations are a useful guide in faucial cases only. The observations were on 400 cases, in a children's hospital. Charts illustrate paper.

A. J. Brady.

REVIEWS.

The Skiagraphy of the Accessory Nasal Sinuses. BY A. LOGAN TURNER, M.D., F.R.C.S.E., F.R.S.E., and W. G. PORTER, M.B., B.Sc., F.R.C.S.E. Edinburgh and London: W. Green & Sons, 1912, Pp. 45, plates 40. 10s. 6d. net. (Continuation of previous review.)

The reviewer would wish to add to what he has already stated with regard to this excellent atlas, that the technical skiagraphical part of it is mainly the outcome of the labours of Dr. Porter, and we see in it the admirable result of the combination in one person of the clinician and the radiographer. Dr. Turner has expressed his appreciation of the value of the co-operation of such a colleague in a work which his own wide clinical experience and judgment have enabled him to organise in so useful and instructive a way.

Dundas Grant.

Pye's Surgical Handicraft: A Manual of Surgical Manipulations, Minor Surgery, and other matters connected with the Work of House Surgeons and Surgical Dressers. Edited and largely rewritten by W. H. CLAYTON-GREENE, B.A., M.B., B.C., F.R.C.S. Sixth edition, fully revised, with some additional matter and illustrations. Bristol: John Wright & Sons, Ltd. London: Simpkin, Marshall, Hamilton, Kent & Co., Ltd., 1912. Price 12s. 6d. net.

Walter Pye's work on "Surgical Handicraft" seems to have equalled the popularity of its lamented author. The sections on diseases of the ear, nose and throat are, as before, in the hands of Mr. Carson, who has brought it still further forward, and it may be said now to be quite up-to-date. The chapter on the X rays and taking of skiagrams is, of course, mainly devoted to considerations of fractures, but the section on the examination and interpretation of skiagrams is full of practical