The PRESIDENT said this case reminded him of one he had shown some years ago at the Society[1]—a young person with stenosis of the lower part of the pharynx.

Abstracts.

NOSE, Etc.

Bronner, Adolph.—*Diseases of the Maxillary Antrum: Their Symptoms, Causes, and Treatment.* "Lancet," May 11, 1901.

This is a clinical paper, read before a meeting of dental surgeons.

StClair Thomson.

Lombard, E.—*Instruments for the Radical Cure of Maxillary Sinusitis by the Method of Luc.* "Annales des Maladies de l'Oreille," etc., December, 1901.

The instruments described and figured in this short communication are a gouge forceps, designed to enlarge the opening made in the canine fossæ, and a punch forceps to rapidly resect the internal wall. The steps of the Caldwell-Luc operation are recapitulated, in order to demonstrate the uses of the instruments described.

Macleod Yearsley.

Luc.—*Mucocele of the Frontal Sinus and of the Maxillary Sinus on the same Side.* "Archives Internationales de Laryngologie," etc., September-October, 1901.

This case occurred in a lady, aged twenty-nine, with a swelling of the infra-orbital region, and of part of the forehead on the left side. It was associated with rarefying osseous lesions. There was pain, and the eye was displaced down and out, with accompanying diplopia. The frontal mucocele had existed for seven years, the maxillary for two years. The frontal sinus was opened by the Ogston-Luc method, and contained a quantity of clear yellow, slightly viscid fluid. There were no granulations, the lining membrane being of normal pale colour. The maxillary sinus was opened by the Caldwell-Luc method, and was found to contain no granulations, but simply a yellow, turbid, viscous, non-fœtid fluid.

Macleod Yearsley.

Osler, William.—*On a Family Form of Recurring Epistaxis, associated with Multiple Telangiectases of the Skin and Mucous Membranes.* "Johns Hopkins Hospital Bulletin," November, 1901.

The association described in this paper is rare, as, after a careful search through the literature, the author can find but one reference to a similar case.

An hereditary form of epistaxis has been well described by Babbington.[2]

The association of epistaxis with angeiomata of the nasal septum has long been known, but for the associated condition of multiple telangiectases of other mucous membranes and of the skin, he has been able

[1] See JOURNAL OF LARYNGOLOGY, vol. vii., p. 343.
[2] *Lancet*, 1865, vol. ii., p. 362.

to find only the following report by Rendu:[1] A man, aged fifty-two, whose father had had repeated attacks of melæna, and whose mother and brother had been subject to epistaxis, was admitted in a condition of profound anæmia, having had for three weeks a daily recurrence of epistaxis. He had had his first attacks of bleeding from the nose at the age of twelve, and had been subject to them ever since, particularly in the spring. He had never had any other hæmorrhages. On the skin of the nose, of the cheeks, and of the upper lip there were numerous small red spots, due to dilatation of the superficial vessels of the skin. Similar small telangiectases were seen on the internal surfaces of the lips, the cheeks, the tongue, and on the soft palate. The punctiform angeiomata were not seen on the mucous membrane of the nose.

In the three cases described in this paper, two belonged to a family in which epistaxis had occurred in seven members. Both of the patients had had bleeding at the nose from childhood, and both presented numerous punctiform angeiomata on the skin of the face and of the mucous membrane of the nose, lips, cheeks, and tongue.

The third patient had suffered in an unusual degree from recurring epistaxis, and the telangiectases were most abundant over the body, and very numerous also on the mucous membranes.

The condition has nothing to do with hæmophilia, with which the cases had been confounded.

The following remarks are appended:

Angeiomata are very peculiar and remarkable structures, in which the author has been interested for many years. Apart from the big nævi and angiomata with surgical relations, there are:

1. The pin-point, punctiform, capillary angeiomata, of which few skins lack examples. They may be numerous, but they are rarely disfiguring; they appear and disappear. For ten years the author himself had one the size of a pin's head on a finger.

2. The solid, nodular nævus, ranging from 1 to 4 or 5 millimetres in diameter, forming a definite little tumour, either sessile or pedunculated, and very common on the back.

3. The spider angeiomata, formed by (*a*) three or four dilated veins, which converge to and join a central vessel; or (*b*) which unite at a central bright-red nodule projecting a little beyond the skin. They are very common, and doctors are often consulted about their presence on the face.

As examples may be found on the skin of nearly everybody, these three varieties may be regarded as almost normal structures.

When the punctiform or spider angeiomata increase greatly in numbers they are very disfiguring. In the third case described the skin of the face was peppered with them, and at a distance the patient looked disfigured with a bright, fresh acne rash. In the first case they had also proved a source of danger, as he had bled from them repeatedly. An individual spider angeioma may increase in size, or, as in the cases related, they may become very numerous.

Angeiomata have a curious relationship with affections of the liver. In cirrhosis, in cancer, in chronic jaundice from gallstones, spider angeiomata may appear on the face and other parts. They may be of the ordinary stellate variety, like the stars of Verheyen on the surface of the kidney, or the entire area of the star may become diffusely vascularized, so that there is a circular or ovoid territory of skin looking pink or purple, owing to the small dilated venules. A dozen

[1] *Gaz. des Hôpitaux*, 1896, p. 1322.

or more of these may appear on the trunk. And, lastly, in a few cases of disease of the liver appear large, mat-like telangiectases or angeiomata, involving an inch or two of skin, and looking like a very light birth-mark, but which had appeared during the illness. The skin was not uniformly occupied with the bloodvessels, but they were abundant enough on the deeper layers, apparently, to give a deep change in colour and to form very striking objects. The dilated venules on the nose, and the chaplet of dilated veins along the attachment of the diaphragm, are not infrequently accompaniments of the spider angeiomata in cases of disease of the liver.

The author has recently seen the spider angeiomata appear in the face in a case of catarrhal jaundice. *Jobson Horne.*

C. A. Parker.—*Notes on Acquired Syphilis of the Nose and Pharynx.* "Lancet," January 26, 1901.

This is a very practical paper calling attention to the importance of early recognition and suitable treatment of the frequently met with manifestations of syphilis in the upper air-passages. While very amenable to treatment in the early stage, there is, if neglected, hardly any limit to the amount of damage they may produce. The treatment is much the same as it is in syphilis elsewhere. Primary and secondary lesions must be met by the internal administration of mercury in some form, and tertiary lesions must be treated with iodide of potassium. There is, however, one special feature in the treatment of tertiary syphilis of the throat and nose which must be borne in mind, and that is that very often iodide of potassium alone, even in very big doses, is inefficient, whilst the affection will readily yield to iodide of potassium and mercury combined. The best way of administering the mercury in these particular cases is by inunction. It is often surprising how rapidly improvement will result from this method even in cases where iodide of potassium has been taken for months without any benefit.

There is one other point to be remembered in the treatment of tertiary syphilis. When there is much stenosis of the larynx iodide of potassium must be given with great caution, for its first effect is often to cause rapid œdema of the laryngeal mucous membrane, and so greatly to increase the obstruction. If, therefore, there is much obstruction to start with, iodide of potassium should only he given if the patient is within easy reach of help, for tracheotomy might become urgently necessary.

Primary Syphilis in the Nose.—*Primary Sore.*—This is very rare, although there are several cases on record. Its seat is generally on the alæ or just within the vestibule, though cases have been seen where the sore was on the mucous membrane of the meatus. A hard swelling about the alæ or vestibules of the nostrils, causing stenosis but comparatively little pain or inconvenience, and accompanied by unilateral swelling of the submaxillary glands, should arouse a suspicion that the trouble may be primary syphilis. The tumour has always a very hard base, and bleeds easily. The disease with which this trouble is most likely to be confounded is sarcoma, especially if the chancre is on the true mucous membrane.

Secondary Syphilis of the Nose.—The following manifestations of this disease are met with: (1) Coryza, (2) mucous patches, (3) rhinitis erythematosa and rhinitis papulosa, and (4) superficial ulceration.

1. *Coryza.*—This is the earliest and commonest manifestation of

secondary syphilis in the nose. It is, however, hardly distinguishable from an ordinary catarrh, and is often overlooked. In syphilis the rhinitis is of a subacute type, and lasts for a long time. The discharge is scanty, and sometimes brownish in colour. The mucous membrane, especially that over the inferior turbinated body, is dark and purple-coloured in appearance and looks dry. The coryza commences about the time of the appearance of the rash.

2. *Mucous Patches.*—There is a great divergence of opinion as to the occurrence of mucous patches in the nose. I have never seen a case, though I have examined for them in cases where there has been a plentiful supply of them in the mouth and throat.

3. *Rhinitis Erythematosa and Rhinitis Papulosa.*—These conditions are said to accompany the roseolar and papular eruptions of the skin respectively. They are undoubtedly seen round the nostrils and in the vestibules, but probably they never extend on to the true mucous membrane.

4. *Superficial Ulceration.*—This is said to occur through the breaking down or erosion of mucous patches, and of necessity it must be extremely rare. Superficial ulceration, when it does occur, is generally an early tertiary symptom, and it will be described under that head.

From the foregoing remarks it may be gathered that secondary syphilis does not attack the nose in any very definite or serious way. The only symptom that one is likely to be called upon to treat is the coryza, which, by producing stenosis of the nostril, often causes distress and headache. If the coryza itself, or any other accompanying symptom, leads one to diagnose syphilis, mercury must be given internally, and such simple local remedies as would be employed for ordinary catarrh must be used.

Tertiary Syphilis of the Nose.—This may be met with in any of the following forms: (1) gummata; (2) superficial ulceration; (3) deep ulceration and necrosis; or (4) scars, adhesions, and deformities.

1. *Gummata.*—In the nose these break down and ulcerate so quickly that they are seldom seen intact; yet it is most important to be able to recognise them, for appropriate treatment, administered promptly, may save the patient from all the distress of ulceration and necrosis which are sure to follow if the case is left untreated.

2. *Superficial Ulceration.*—Not common, but occasionally occurs from three to five years after infection. It is most probably due to the breaking down of superficial gummatous infiltration.

3. *Deep Ulceration and Necrosis.*—A fairly frequent result of syphilis. The periods of greatest danger are from one year to three years and from eight to fourteen years after infection, from three to eight years being the period of greatest freedom.

4. *Scars, Adhesions, and Deformities.*—These lead to the "saddle-backed," the "bull-dog," and other nasal deformities.

Complications.—Amongst these are affections of the ear and accessory sinuses, pharyngitis, laryngitis sicca, perforation of the hard palate, and cerebral complications.

Diagnosis.—This must be made from lupus, ozæna, and malignant disease.

Treatment.—The general treatment must be on the lines already suggested. Locally, the nasal passages must be cleansed and cleared as soon as possible of all crusts and necrotic tissue, sequestra must be removed with forceps, and the granulations must be scraped away

with a curette, and the patient must afterwards keep the passages clean with an alkaline lotion. In obstinate cases, after cleansing, heated calomel should be insufflated, and the nose should be packed with double cyanide gauze. The gauze should be changed daily, about which there is no difficulty, as the patient can easily be taught to do it for himself. Packing the nose has a marked effect in preventing the formation of crusts and in keeping the mucous membrane clean and moist.

Syphilis of the Naso-pharynx.—Primary and secondary syphilis of the naso-pharynx are very rare. Tertiary syphilis in this region is by no means rare, and though there are generally signs of the disease in the nose or pharynx as well, yet occasionally the naso-pharynx is the first place to be involved by tertiary syphilis, and may sometimes be alone affected.

Syphilis of the Pharynx.—The *primary sore* occurs in the pharynx fairly frequently, and is generally located on one or other of the tonsils, the cryptic character of which lends itself to the retention and development of the poison. Seifert was able to collect 179 instances of chancre occurring in the pharynx. Of these, 149 were on the tonsils and 30 were about the palate and arches. Infection seems to be generally conveyed through kissing or through the use of infected glasses, cups, tooth-brushes, pipes, etc. The symptoms may be thus tabulated: 1. Aggravated and prolonged sore-throat. 2. Painful deglutition, always referred to the affected side. 3. An indurated swelling of one tonsil. 4. A sluggish ulcer in the centre of the swelling, granular in appearance, covered with inspissated mucous, and of a grayish colour. 5. Early and unilateral swelling of the glands at the angle of the jaw, usually painless, though sometimes tender on pressure. 6. Sometimes marked febrile disturbance and headache. The diagnosis is difficult, and often is not cleared up until the appearance of secondary symptoms, when the absence of a primary sore elsewhere will point to the case being one of tonsiilar chancre. It may be mistaken for (1) mucous patch, (2) for epithelioma, or (3) for ulcerating gumma.

Secondary Syphilis of the Pharynx.—The following manifestations of secondary syphilis are met with: (1) Erythema, (2) mucous patches, (3) superficial ulceration.

Tertiary Syphilis of the Pharynx.—The following tertiary troubles are met with: (1) Gummata, (*a*) circumscribed and (*b*) diffuse; (2) ulcerations; (3) scars, contractions, and adhesions.

Treatment.—In all forms of tertiary syphilis of the pharynx the combination of iodide of potassium internally and mercurial inunction is especially useful, and should be employed at the earliest possible opportunity. In tertiary ulceration the surface of the ulcer should be carefully cleansed and insufflated with iodoform, or in some cases with heated calomel. In cases in which there is much pain the insufflation of orthoform will be attended with most grateful results. Both nitrate of silver and chromic acid are also useful applications. The best method of applying either of them is to fuse a little of the pure drug on to a probe, and, having cleansed the surface of the ulcer, to paint it on. Lastly, the patient may be given for use at home a gargle composed as follows: chlorate of potash, 10 grains; lotio nigra, $\frac{1}{2}$ ounce; water to 1 ounce. This is most useful for the relief of pain and for cleansing the throat. As regards the treatment of adhesions, the less the operative interference the better for the patient. Universal experience teaches us that while it is easy enough to make a larger

opening it is almost impossible to maintain that opening, and that the last state of the patient is likely to be worse than the first, owing to readhesions and contractions leaving a smaller opening than before. It is, therefore, never wise to resort to operation unless there are very strong reasons. Should operation be considered absolutely necessary, every conceivable device will have to be tried for maintaining a larger opening. Cleverly-devised plastic operations, the insertion of plugs, tubes, lint, etc., have been resorted to with occasional success, but as a rule, however great the ingenuity displayed, disappointment is only too apt to result, and of this fact the patient should be warned beforehand. It is most surprising how great an amount of contraction may exist and yet cause comparatively little discomfort, and therefore it is seldom necessary to exercise the ingenuity which such cases undoubtedly require if they have to be treated surgically. When the opening is so small as to cause symptoms it is generally sufficient to pass dilating instruments regularly and in increasing sizes in order to render the patient quite comfortable, and this the patient can be easily taught to carry out for himself. *StClair Thomson.*

Schadle, Jacob E.—*Ulcerations of the Triangular Cartilage of the Septum.* "St. Paul Medical Journal" (Minnesota), April, 1901.

Dr. Schadle recommends the removal of any deviation or deformity before proceeding to treat the local ulceration. He says crusts should never be removed by force, but by warm alkaline sprays. After this is accomplished, the use of oxide of zinc or the yellow oxide of mercury ointment is advised. The author prefers "unguentine." If the trouble does not yield to these remedies, a 20 per cent. solution of nitrate of silver or balsam of Peru should be tried. Failing a good result with this, lunar caustic or the galvano-cautery will probably be successful, and should be followed by an after-treatment of lubricants and sprays. *Anthony McCall.*

Scheier, Max.—*Contribution to the Study of Anomalies of the Nasal Accessory Cavities.* "Archives Internationales de Laryngologie," etc., September-October, 1901.

The anomalies of the accessory cavities of the nose are of much importance to the rhinologist, and the paper of which the above is the title is worth perusal. Anomalies of the sphenoidal, frontal, and maxillary sinuses are described. The first-named may be double, or single, or the sinus may be dilated. Rarely the sphenoidal may be so large as to be equal to the maxillary sinuses. The frontal sinus may be also double or single, and in the former case there may be great differences in the size of the two. In 100 skulls examined there was twice complete absence of this cavity. *Macleod Yearsley.*

Viollet, Paul.—*Treatment of Chronic Diffuse Hypertrophic Rhinitis.* "Gazette des Hôpitaux," No. 51, 1901.

In cases where the mucous membrane is swollen, the subcutaneous injection of a 10 per cent. solution of zinc chloride is recommended in preference to the use of the cautery or scissors. A Pravaz syringe is used, with a bent tube about 1½ inches long between it and the needle, so as to allow of proper illumination; after cocainization the needle is pushed along under the mucous membrane, the injection being made as the needle is slowly withdrawn. Spurs, deviations, etc., are treated in the usual manner. *Anthony McCall.*