

## Abstracts.

### NOSE.

**Grayson, Charles Prevost.—Exploratory Opening of the Sphenoidal Sinus.** "Laryngoscope," 1915, p. 65.

Grayson states that a large number of empyemata of the maxillary and frontal sinuses are cured after the establishment of proper drainage combined with cleansing and antiseptic irrigation. These cases include many of the chronic class. Grayson now advocates the making of an artificial opening in the anterior wall of the sphenoidal sinus at a point as close as possible to the angle of junction of the floor with the internal wall. He considers this opening on a par with the puncture of the nasal wall of the antrum beneath the inferior turbinate, and states that it is usually even more easily performed. The opening can be utilised for both exploratory and therapeutic purposes. The point indicated is the safest at which the sinus can be entered, and it is most remote from those intracranial structures which lie in relation to the roof and external wall of the sphenoidal sinus. Grayson deprecates the frequently unnecessary removal of the middle turbinal in order to attack the sphenoidal sinus through the natural ostium. The floor of the sinus lies, with remarkably few exceptions, not more than 2 or 3 mm. above the crescentic line that marks the base of the sphenoid body and the upper margin of the choana. Further, the septum between the right and left sinuses, however much it may deviate to one or other side posteriorly, almost invariably occupies the middle line anteriorly. Grayson recommends that a series of radiographs should be taken at different angles, in order that we may have all the knowledge necessary to make the opening of the sphenoid as nearly as possible free from risk. The technique of the operation is as follows: The nasal portion of the anterior surface of the sphenoid body is exposed as widely as possible by shrinking the turbinates with an adrenal preparation combined with cocaine. The course of the sphenopalatine artery is now usually so distinctly visible that it can be readily avoided. Grayson now paints on dilute tincture of iodine and then applies a straight drill, tipped with a conical burr, 6 mm. in length, and measuring  $2\frac{1}{2}$  mm. from its point to its greatest diameter. Behind the conical burr there is a collar. The point of attack is 2 or 4 mm. above the line which divides the anterior from the inferior surface of the sphenoid body and close to the attachment of the ethmoid plate in the middle line. The opening that it makes is 2 mm. in diameter, quite sufficient to permit the escape of any fluid and to allow the introduction of an irrigating cannula or the distal jaw of a biting forceps, with which the opening may be enlarged. The operation is not accompanied or followed by any pain or shock, and if the exploration be negative the hole will close within twenty-four hours. Grayson holds that we should begin our operations upon the anterior wall of the sphenoidal sinus at the point of greatest safety instead of ending there. The following indications for the operation are given: (1) When we cannot be positive whether a stream of pus coming from the sphenoidal recess has its source in the posterior ethmoidal cells or in the sphenoidal sinus, or in both. (2) In certain cases of neuralgia of the fifth nerve, which may be associated with trouble in the sphenoidal

sinus. Certain severe and persistent headaches also come into this group. (3) Cases of naso-pharyngeal catarrh in which the nasal cavities proper and the other accessory sinuses can be excluded.

*J. S. Fraser.*

**Hanger, Frank M.—Intranasal Operation for the Cure of Dacryocystitis.**  
—“Laryngoscope,” 1915, p. 23.

Hanger enumerates the following operations for the cure of dacryocystitis: (1) Slitting the lower canaliculus. (2) The use of probes and irrigation; intranasal operation is not justified until these methods have been faithfully tried. (3) Extirpation of the lacrimal sac; this causes scarring, and leaves the patient with an annoying epiphora. (4) Toti's operation consists in making an opening externally over the lacrimal sac and removing the bone so as to expose the mucous membrane of the middle meatus. A hole is then made into the sac and one in the nasal mucous membrane. The edges of the two openings are then united by fine sutures. This operation leaves a scar, and in many cases the internal opening slowly closes. (5) The window resection of the lacrimal canal is performed from within the nose. Part of the ascending process of the superior maxilla and part of the lacrimal bone are chiselled away so as to expose the lacrimal sac, which is then opened. West claims to cure 90 per cent. of his cases. (6) Yankauer tries to preserve the long arm of the lacrimal syphon, and therefore dissects up a muco-periosteal flap from over the site of the lacrimal nasal duct. (Yankauer's operation is too complicated to be explained without the aid of diagrams.—J. S. F.) Hanger himself operates with the patient in the sitting position and uses local anæsthesia. A few drops of equal parts of a 20 per cent. solution of cocaine and adrenalin are injected into the lacrimal sac. A small lacrimal probe coated with cocaine powder is now passed into the sac and the cocaine worked down into the nasal duct. In a few minutes the canal is anæsthetised so that larger and larger probes can be passed into the nose. Theobald's No. 13 is now left *in situ*. The inferior turbinal and the region of the nasal duct are then anæsthetised, special care being given to the outer surface of the inferior turbinal. The anterior third of the turbinal is now removed, exposing the lower end of the lacrimal probe. It may now be necessary to chisel away the lower anterior part of the lacrymo-nasal duct, but in many cases even without this procedure it is possible on slowly withdrawing the lacrimal probe to introduce the male blade of the special punch forceps into the canal, and so to bite away the inner wall up to a point beyond the stricture. The duct is thus converted into an open gutter, which can be extended into the sac if necessary. It is best to pack the nose for twenty-four hours and to irrigate the lacrimal sac for a few days. Drainage of tears should be perfect in a week's time or less.

*J. S. Fraser.*

### E. A. R.

**Grant, J. Dundas.—Shell Shock without Visible Signs of Injury.** “Proceedings of Royal Society of Medicine, Sections of Psychiatry and Neurology,” February, 1916, p. 33.

The speaker confines himself to remarks concerning mutism, stammering, and deafness.

In the treatment of mutism he deprecates the employment of violent measures during the period of exhaustion. He looks upon these patients

as having, in a manner of speaking, forgotten how to speak. The first step is to place the back of the patient's hand under the teacher's larynx, so that he may feel the vibrations produced by the utterance of the voice; the hand is then transferred to the patient's own larynx, and he is encouraged to produce the same feelings, and ultimately the same sort of sound, in the larynx.

From this he is gradually led to alter the shape of the mouth cavities for the production of vowels and later of consonants. In some cases of concussion-mutism the voice is restored at one sitting, but in others it is a gradual process. There is no simulation about the inability to speak; the patient's anxiety to do so is unmistakable, and his delight at the gradual acquisition of words and phrases quite confirmatory. In two cases the observer has noticed that the voice returns before the hearing, and he thinks that the act of uttering sound has helped to arouse the hearing faculty.

*Archer Ryland.*

**Brady, A. J.—Foreign Bodies in the Ear.** "The Medical Journal of Australia," April 22, 1916.

At a clinical demonstration Brady demonstrated a number of foreign bodies removed from the ear, and the region of same. Two were unusual—they had not gained entry through the external auditory canal.

CASE 1 was a piece of slate pencil, sharp at the end and 2 in. in length. The patient, a boy, aged seven, had suffered from a running ear all his life. He had been treated in hospital by a specialist before he came under Brady's care. The latter found a granulomatous condition in canal which recurred several times after removal. Noticing a dark spot on the post-meatal wall, about two-thirds the depth of the canal inwards dead bone was believed to exist. The mastoid was opened in the usual manner, and the slate pencil was found lying horizontally embedded for its whole length in the mastoid process. It had broken off flush with the bony canal, so that none of it showed in same. There was no history of how it got there. The mother remembered that when a small child he one day cried for a long time as if in pain.

CASE 2 may throw some light on how the accident in Case 1 occurred.

A girl, aged two and a half, was brought to Brady on account of a running ear of some weeks' duration. There was a granuloma showing in meatus and a free flow of pus. The father mentioned that seven weeks previously the child had fallen on a stick which she had in her mouth. He had to use some force to pull the stick out of the soft palate in which it was embedded. Under open ether the ear was curetted, and the sharp end of a wooden skewer one half-inch in length was extracted. Evidently after penetrating the soft palate the skewer had penetrated the posterior wall of the glenoid cavity, and broken off in the middle ear during extraction of the main shaft. Both cases healed completely in a short time after operation.

Cases of previous unskilled attempts to remove foreign bodies were detailed. A bead which had been forced into the middle ear gave much trouble. A fine forceps moved it, till a fine hook was inserted in the eye of the bead.

Two cases, where a large red beetle  $1\frac{1}{2}$  in. in length had flown into the ear and become impacted there, were recorded. In these cases the pain is maddening. One was encountered when bicycling; there being no immediate means at hand to remove the insect, the ear was filled with lubricating oil, which stopped the struggles of the creature.

Brady warned against the dangers of unskilled attempts to remove foreign bodies. Most foreign bodies if not impacted will come away by syringing with warm water. A clean foreign body may remain in the ear for a considerable time without harm. Living creatures must be removed at once, or killed on account of the pain which they cause by their struggles. Filling the ear with a mineral oil will kill them.

*Author's Abstract.*

**Dawson, G. de H.—A case of Shell Concussion: Treatment by General Anæsthesia.** "Lancet," February 26, 1916, p. 463.

This was the case of a private, aged thirty, partly buried by a mine explosion, and becoming deaf and mute. The onset of mutism and general collapse was delayed until admission to hospital. The administration of an anæsthetic within three weeks of the onset of the disorder, while the patient was still in a very shaken state, did no good, but rather aggravated the condition, and caused distress. Speech was restored under the influence of alcohol, and recovery of hearing followed the administration of a general anæsthetic when five months had elapsed and other measures had failed.

*Macleod Yearsley.*

### MISCELLANEOUS.

**O'Malley, J. F.—Warfare Neuroses of the Throat and Ear.** "Lancet," May 27, 1916, p. 1080.

The author discusses functional aphonia, mutism, loss of volitional coughing, and functional deafness. Of these neuroses aphonia alone is the commonest, aphonia with loss of volitional cough coming next; mutism is still more rare. Deafness alone is rare; but mutism with deafness appears to be the least frequent of all. The laryngeal neuroses which came under O'Malley's care were decidedly more common in the winter and spring, and some gave a history of catarrh at the time of onset. He found that the more pronounced the catarrh, the greater the difficulty in getting patients to phonate properly.

O'Malley discusses the physiology of speech and hearing, and remarks that the nearer a function approaches to a purely reflex act, intended to protect and preserve the animal existence, the less prone is it to neuroses. He gives a summary of 24 illustrative cases, of which 17 were pure aphonia; 4 aphonia with loss of phonatory cough; 1 of mutism, and 2 of mutism with functional deafness. Two cases had bullet wounds of the larynx; one followed "gassing." Ten cases showed laryngeal and tracheal hyperæmia, and eleven showed no evidence of catarrhal trouble at the time of examination.

Treatment is described. That for aphonia is by using a laryngoscope mirror, and, if the vocal cords do not approximate, making moderate friction with it until secretion drops into the larynx, which, acting as a foreign body, starts an involuntary cough. Functional deafness is treated by exciting the vestibular apparatus by syringing with hot or cold water until giddiness is excited. The surgeon then shouts into the ear through a speaking tube.

*Macleod Yearsley.*

**Cameron, Hector Charles.—The Reaction of the Child to a Faulty Environment.** "Practitioner," xcvi, p. 61.

A most instructive paper, in which the author insists upon the great frequency, among the children of the poor, of catarrhal infections of all

sorts, and that this is due to the evil effects upon the organism of a faulty diet and a faulty environment. The tendency to catarrhal infections is a special characteristic of childhood, and even of healthy childhood. This commonness of catarrhal affections in the children of the poor is such that a considerable percentage show, after death, lymphatic enlargement (save after long illness). Although "status lymphaticus" may be the reason for sudden death without adequate cause being patent *post-mortem*, many such deaths are undoubtedly due to lowered resistance to infection. The author points out that out-patient children, though catarrhal, may often be plump, rounded, and high-coloured. On examination, however, there can be found a host of manifestations indicative of lowered resistance. A second group of children is pale, undersized, and wasted, with intractable secondary dyspepsia, the children who have suffered a constant repetition of catarrhal affections. One paragraph is specially worth quoting: "For some years I have felt convinced that the *post-mortem* appearance, to which the name status lymphaticus has been applied, is found only in children who have exhibited this fictitious appearance of health with persistent, though quiescent, catarrhal infections, and who have met their death without preliminary wasting or de-hydration of the body." No name has yet been given to the conditions thus described by the author, who suggests the expression "catarrhal state." In discussing ætiology, three factors are considered—heredity, faults of hygiene, and faults of diet. Confinement to hot rooms and a town life are important causes. Air-borne respiratory infections are very common, even in hospitals, and something is said as to the evils of the "hospitalising" of infants. Among faults of diet, artificial feeding and excess of one constituent (generally sugar or starch) in the food are prominent. In conclusion, attention is drawn to the relation between the catarrhal state and rheumatism and tuberculosis.

*Macleod Yearsley.*

**Cameron, H. C.—Osteogenesis Imperfecta.** "Proceedings of Royal Society of Medicine." Section, Disease in Children, p. 43, April, 1916.

The exhibitor brings forward one or two points in connection with osteogenesis imperfecta—none of them perhaps of the first importance, but some of them novel.

The shape of the skull in the case shown, viz. a child, aged five months, was typical of the disorder. The bones of the skull generally were very thin, and in many places yielded on pressure. The ossification was most defective in the lateral parts of the skull, which was formed largely in membrane, making persistent lateral fontanelles of considerable size.

In the temporal region, only marked on the left side, there was a bulging outwards above the ear, the apex of which was displaced a little downwards.

In osteogenesis imperfecta, properly so called, we have to deal with a condition characterised not only by deficient ossification and fragility of the long bones, but also by a typical and peculiar formation of the skull. The exhibitor believes that the condition has in the past been generally confused with hydrocephalus.

In later childhood, in cases in which life was prolonged, the most striking characteristic is a marked bulging in the temporal region sufficient to turn over the upper part of the ear.

*Archer Ryland.*