shown there was a question as to whether it should be done through the mouth or through the neck. This patient's age was twenty-five, and her child had recently been operated upon for tuberculous glands in the neck. I thought this abscess might be found to be tubercular, and therefore it would be better to drain it from the outside to prevent the discharge re-infecting her. The pus from the abscess contained tubercle bacilli. The sac of the abscess was so much thickened that the question of dissecting it out was raised, but I did not attempt it. The wound healed up in six weeks, and the thickening and swelling have now disappeared.

(*To be continued.*)

Abstracts.

PHARYNX.

Wound of the Pharynx by Bullet; Fracture of Fourth Cervical Vertebra; Meningitis; Death.—A. Mouchet. "Bull. de la Soc. de Chir.," t. xliii, no. 23.

Senegalese soldier, admitted with small, round wound on each side of neck, almost symmetrical, but the right wound a little anterior. On admission, before being seen by a surgeon, the patient, being very hungry, obtained some food which he attempted to swallow. This caused him great pain, and the food came out through both wounds. After this, patient was fed through a tube. Subsequently both wounds healed up. About a month later patient's temperature rose, and he had pain on swallowing. Soon neck rigidity and other signs of meningitis appeared. Death.

Post-mortem.—Bullet had entered the right side of the neck, perforated the right ala of the thyroid cartilage, traversed the pharynx, and had entered the body of the fourth cervical vertebra, the left half of which was shattered. There was a tiny perforation of the dura, probably due to a spicule of bone. The track of the exit wound was behind the left common carotid artery. The whole spinal subarachnoid space was full of thick pus right up to the bulb. *J. K. Milne Dickie.*

NOSE.

Adrenalin-pituitary Treatment of Asthma.—Bensaude and Hallon. "Presse Médicale," April 8, 1918.

Good and prompt results are obtained by subcutaneous injection of adrenalin or pituitary extract or a mixture of the two. The action of pituitary extract is slower than that of adrenalin but is more durable, and seems to act not only on present attacks but as a preventive to a certain extent of future attacks. The solution used by the writers contains 0·5 mgr. of adrenalin hydrochloride and a quantity of extract of whale pituitary, disalbuminised, corresponding to 0·25 grm. of fresh gland to the c.c. It is sterilised and put in ampoules.

The dose generally used for adults has been 1 c.c. *per diem.* In one instance a patient, without the doctor's knowledge, took three injections

in twelve hours without any bad effect. For children the dose is diminished according to weight.

In nearly all cases the injection causes a diminution of the severity of the attack. The effect takes place usually in twelve to fifteen minutes, and one injection is enough to control the paroxysm. There is generally immediate and complete relief. In cases where patients have required injections on several days successively, the effect of the second and third doses is superior to that of the first. In every case in which one dose produces a definite result, the same dose will always suffice and always retain its full effect. Thus one patient has used the remedy for four years always with the same dose and with equal success.

Out of fifty-six cases only five were a complete failure and did not react to this treatment. The writers have seen no bad effects from the injections. In most cases not the slightest malaise is produced, but in some a slight tremor, or feeling like an electric thrill, or agitation and palpation were noticed, but these unpleasant effects disappeared in a few minutes.

J. K. Milne Dickie.

Intranasal Drainage of the Frontal Sinus.—E. Fletcher Ingals. "Annals of Otology, etc.," xxvi, p. 656.

After dealing with the history of this method of draining the frontal sinus, the author describes his own in detail, detailing his essential instruments. The nasofrontal duct is first anæsthetised by a special canula and a probe is passed into the sinus. To avoid danger, frontal and lateral skiagrams are taken with the probe *in situ*. In all cases the anterior third of the middle turbinated body is removed before operation and the sinus well washed out, if possible. A perforated bar is slipped over the probe and the sinus opened "in a second or two." A bent tube packer is then passed in and gauze introduced through it, saturated with camphor and carbolic acid, and allowed to remain for five minutes. A gold drainage-tube is left in for three to four months.

Macleod Yearsley.

LARYNX.

Technique of Extirpation of the Larynx under Local Anæsthesia.—P. Sabileau. "Bull. de la Soc. de Chir.," xliii, 7.

With local anæsthesia the patient does not run the same risk of broncho-pneumonia as with general anæsthesia, and therefore it is not necessary to do a preliminary tracheotomy, and, indeed, it is preferable to do the whole operation at once as a preliminary tracheotomy makes the operation more difficult. Under general anæsthesia, on the other hand, it is much safer to do a preliminary tracheotomy; under local anæsthesia it is fairly easy to dissect out an intact trachea; but if there is a tracheotomy opening, the slightest amount of blood trickling through the opening causes violent efforts to expel it, and the operator finds it very difficult to proceed. Many cases come for operation already tracheotomised, and for these the writer has devised a method of preventing blood from entering the trachea.

After removing the tracheotomy tube the trachea is anæsthetised by mopping it with 10 per cent. cocaine. A rubber tube as large as possible is introduced for 2 or 3 cm., and is fixed by three sutures to the skin. After anæsthetising the operative field in the ordinary way, two parallel incisions are made from the hyoid to the suprasternal notch at a distance

of 3 cm. from the middle line. The skin marked out is freed from above downwards and then stitched round the rubber tube, thus sealing off the trachea and preventing any blood from trickling down. The writer claims that the dissection of the deeper parts is made much easier by the skin resection. There is no difficulty in bringing the parts together afterwards. *J. K. Milne Dickie.*

ŒSOPHAGUS.

Portion of Dental Plate Stuck in Œsophagus; Extraction by External Œsophagotomy.—A. Mouchet. "Bull de la Soc. Chir.," xliii, 15.

An upper denture consisting of four teeth and two hooks was swallowed by a French soldier during sleep. Woke up with feeling of suffocation; thought he had swallowed some straw, but soon noticed that his denture was missing; vomited frequently. Next morning reported sick, and his *médicin major* gave him an emetic of ipecac. The retching increased the pain very considerably, and patient felt the plate slip further down. He went to another major, who sent him to hospital at once, where he was seen by the writer Patient radiograped, and plate seen to be in the cervical œsophagus. Removed by œsophagotomy. On incision the œsophagus was found to be considerably infiltrated. The plate was then extracted by gentle manipulation. One of the hooks was deeply embedded in the œsophageal wall. Œsophagus sutured. Small drain left in lower angle of skin wound. Recovery uneventful. Mouchet does not recommend œsophagotomy as a method of choice, but it was the only method possible as no œsophagoscope was available.

J. K. Milne Dickie.

EAR.

Amberine as a Dressing for Mastoid Operations.—Major Dawse, French Medical Corps. "Rev. de Laryngol. et d'Otol. et de Rhinol.," December 30, 1917.

The melted max is simply poured into the cavity, in the depth of which a wick of gauze has previously been laid. The gauze wick is 2 in. long, and its distal end lies free in the concha, on the surface of the amberine wax. By gently pulling on the wick, the dressing may be removed *en bloc*. The author recommends a daily renewal of the amberine for two weeks. *H. Lawson Whale.*

Murphy's Intra-rectal Infusions in the Treatment of Lateral Sinus Phlebitis.—G. Liébault. "Rev. de Laryngol. et d'Otol. et de Rhinol.," November 30, 1917.

Three cases are described minutely. In only one was the sinus thrombosed; this was treated by curettage without ligature of the jugular. The saline used was always dextrosed; the amount always one litre; and the rate (checked by watching the flow through a glass siphon-tube) from 80 to 100 drops per minute. In the first case six infusions were given in twenty-seven days; in the second, two in seven days; in the third (the case with thrombosis), twenty-seven in twenty-seven days. All three cases recovered after repeated rigors and meningeal symptoms.

The authors follow Moure in decrying the value of ligaturing the vein, chiefly on the ground that any such local measures cannot check

what has already become a systemic infection—that, in fact, the horse has already escaped, so why close the stable? They rely chiefly on general treatment, especially on rectal proctolysis.

H. Lawson Whale.

MISCELLANEOUS.

The Incidence of Chronic Focal Infection in Chronic Diseases.—L. Langstroth (San Francisco). "Amer. Journ. Med. Sci.," February, 1918.

This paper is the outcome of work done in the Medical Clinic of the University of California Hospital, where special attention has been devoted to the subject. The results in the majority of cases show the coincidence of focal infection with the different diseases rather than clinical cure or amelioration of the disease. In a number of cases, however, the therapeutic results have been very good, and in a few brilliant. The teeth, prostate, accessory nasal sinuses and tonsils have received particular attention as possible sources of focal infection. The tonsils are often evidently infected, but in many cases it is impossible to say whether they are infected or not; they are a much less frequent focus of infection in adults than in children. The frequently repeated phrase, "small atrophied tonsils," found in the records of the physical examinations, makes it seem probable that the tonsils are very rarely at fault in a patient over sixty, and that in the chronic hypertrophic or atrophic type of arthritis little is to be expected from their removal. Focal infections have been found to be present in 84 per cent. of patients with ulcer of stomach or duodenum, 66 per cent. of acute or subacute cases of arthritis, 73 per cent. of chronic cases of arthritis, and 100 per cent. of gall-bladder cases. The acute and subacute cases have responded well after removal of the foci, even to the point of absolute cure. The chronic cases, when it has been possible to follow them, have in many instances had less pain and no further progression of the disease.

Thomas Guthrie.

REVIEW.

The Medical Annual, a Year Book of Treatment, and Practitioner's Index, for 1918 (thirty-sixth year). Pp. 838. Bristol: John Wright & Sons, Ltd.; London: Simpkin, Marshall, Hamilton, Kent & Co., Ltd. Price 10*s.* net.

We have received the volume of the *Medical Annual* for this year, and found it as usual full of information in and around our speciality. As an instance of a point of somewhat distant relationship we may mention the article on transverse ridges on the finger-nails. These have been instanced by Chavigny in his lectures on war neuroses as evidence of the genuineness of the "shell-shock" complained of by the patient. It is, therefore, of interest to those who have to deal with the disorders of hearing and speech attributed to this factor. We have sought elsewhere in vain for such a clear statement of the chronology of nail ridges as Dr. French gives us here (p. 355). The article on "Concussion Injuries to the Eyeball" is most valuable in the elucidation of cases of deafness produced by injury to the skull at some distance from the