

opinion against the use of the galvano-cautery in the larynx. The case he referred to was one of extensive lupus, not only of the epiglottis, but also of the ary-epiglottic folds, and treatment with the cautery resulted in complete arrest.

Mr. BUTLIN said that with regard to the use of the galvano-cautery in the larynx, a well-marked case of lupus was once handed over to him. The patient was in the hospital. He applied the cautery very freely indeed, and in the end succeeded in getting the disease cured. But he was bound to admit that on one occasion the patient nearly died, and certainly would have died had he not instantly performed tracheotomy in the ward. Anybody who was going to apply the cautery in the larynx in the case of lupus, unaided, should be prepared for such a contingency.

Case of Laryngeal Swelling. Shown by Dr BOND.

The patient, a boy, aged fourteen, has had a peculiar voice since infancy. On the left side the cord is masked by a swelling, especially in front and low down, red in colour, slightly granular, and moving with phonation. Occasionally a small portion of base of cord can be seen. The boy is unable to obtain work because of his peculiar voice. Suggestions as to treatment of the condition were asked for.

Dr. LAW suggested as a possible, but very improbable, explanation of the condition, the impaction of a foreign body. He remembered when he was house-surgeon at Golden Square a patient coming to the hospital for four or five months presenting a very similar appearance in the larynx to this patient. He heard a year or two afterwards that a piece of rabbit bone was one day extracted, which had not been visible during the previous year's observation.

Abstracts.

DIPHTHERIA.

Ausset, E.—*Preventive Inoculation of Diphtheria Antitoxine.* "L'Echo Méd. du Nord.," June 23, 1901.

In a family of three children, one child took diphtheria; a second child, of eight years, was at once sent to live in another place, but developed diphtheria; whilst the third child, a baby still being nursed by its mother—who attended the diphtheria patient—was injected with diphtheria antitoxine, and did not take diphtheria. Had no preventive injection been given, the baby would probably have taken diphtheria; certainly it was much more exposed to infection than the

older child. Diphtheria antitoxine, as prepared nowadays, is a perfectly safe drug to use. Some argue that if the other children in a family in which diphtheria has occurred are carefully watched, the very earliest signs of diphtheria will be detected, and antitoxine can be at once injected, with practically as good results as if a prophylactic injection had been given. This Ausset emphatically denies, and quotes a case in which, in spite of antitoxine having been given at the very onset of an attack of diphtheria, the disease spread to the pharyngeal tonsil, and the child only recovered after a serious illness.

Arthur J. Hutchison.

Biernacki.—*The Treatment of Severe Diphtheria.* "Edinburgh Med. Journ.," November, 1901.

The primary feature of diphtheria is the local lesion. Generally speaking, the degree of toxæmia is proportionate to the extent and thickness of the membrane. No local application has any deterrent effect on the development of the membrane, and its removal is more and more discredited. The parts should be kept as clean as possible by syringing with boracic acid or saline solution. Syringing, in nasal and naso-pharyngeal cases, is more effective than spraying the parts, and if carefully carried out does not increase the number of attacks of otitis.

After a time the toxine, having entered the organism in sufficient quantity, produces its physiological effects, the most obvious of which is a relaxation of the bloodvessels, producing a *primary fall* in blood-pressure. It is probable that if at this stage sufficient antitoxine could always be introduced to neutralize the toxine, other treatment would be scarcely needed. In mixed infections the author has tried the injection of mixed antistreptococcus and antidiphtheria toxin, but without specially beneficial result. The introduction of antitoxine is followed by a rise of blood-pressure, which is sometimes very striking. Of drugs to raise blood-pressure during this stage, the best are strychnine and caffeine. The latter is supposed to have some special action in promoting diuresis—*i.e.*, its diuretic effect is not due, as is that of strychnine, entirely to the increased blood-pressure. Digitalis is dangerous, because its cumulative effect may last on into the third stage—*viz.*, the stage in which the most prominent feature is degeneration of the heart muscle, resulting in cardiac dilatation and a *secondary fall* in blood-pressure. The blood now tends to collect in the splanchnic region; the surface of the body is cold and blue; there is oliguria or anuria, and often persistent vomiting. The blood-pressure is already so low that to lower it still more, in order to relieve the labouring heart, is extremely dangerous; on the other hand, it is equally dangerous to attempt to raise it by increasing the pressure in the arteries. Hence the danger of digitalis, and hence the danger even of saline infusions. Alcohol is here the chief agent, and should not be given earlier. If there are successive critical attacks of syncope, ether and a hypodermic syringe should be kept by the bedside; the lower end of the bed may be raised about a foot.

For the apyrexia of this stage heat must be applied, and this is best done by means of hot blankets. In the treatment of oliguria or anuria, when other methods fail and the condition of the heart warrants it, saline infusion may be tried. Saline infusion may also be required in cases in which there is persistent vomiting and diarrhœa. Repeated

small injections should be given, so as to avoid the risk of a sudden rise of blood-pressure. As soon as it can be retained, water should be given by the rectum; then rectal feeding, and a few drops of water by the mouth, the quantity being gradually increased. But extreme caution is required in commencing to feed by the mouth in these very severe cases, lest the vomiting be brought on again.

In the fourth stage of a severe case—viz., that of peripheral paralysis—if there is difficulty of swallowing, nasal feeding is required, and in the early part of this stage “absolute rest should be the golden rule of treatment.” It is doubtful whether medicinal treatment has any effect, but strychnine and galvanism may be tried.

Arthur J. Hutchison.

Cary and Lyon.—“American Journal of the Medical Sciences,” September, 1901.

Pseudo-membranous inflammation of the visible mucous membranes and of the gastro-intestinal tract resulting from infection by the pneumococcus is reported. The report is accompanied by an interesting review of the few known cases of this character.

MOUTH, FAUCES, Etc.

Moure, E. J.—*Tonsillar and Peritonsillar Abscess.* “La Presse Méd.,” August 24, 1901.

That abscess occurs in the parenchyma of the tonsil itself is now generally admitted. The tonsil is red and bulging, but the pillars, uvula, etc., are not affected—*i.e.*, when the case is seen early.

Peritonsillar abscesses may be divided into three main groups. Most common is the classical or antero-superior group (26 out of 46 cases); next is the posterior group (12 out of 46 cases); least common is the external group. The last group is by far the most serious. Abscesses of this class give rise early to swelling of the neck and of the glands of the neck, to fixation of the neck and of the jaw. Sometimes, having perforated the limiting aponeurosis, they spread into the tissues of the neck, giving rise to so-called lateral pharyngeal abscess. They may produce fatal hæmorrhage.

All peritonsillar abscesses ought to be opened early—within three or four days of their onset. At that time it is foolish to explore for pus with a knife, because (1) considerable, or even dangerous, hæmorrhage may be produced, and (2) the wound closes long before the abscess cavity has had time to heal up. It is much safer to use a cutting galvano-caustic point, which is aseptic, almost painless, and produces a wound that will remain open from eight to ten days. Tonsillar, antero-superior, and posterior abscesses are generally pretty easily opened (details are given in the paper); but to open an external abscess is often both difficult and dangerous. In these the galvanic knife is plunged through the whole thickness of the tonsil towards its upper third, then is drawn from behind forwards, and from within outwards to the bottom of the tonsillar fossa ($2\frac{1}{2}$ to 3 centimetres). If this has not opened the abscess, the pus may be sought for with a cannula. Even if the pus cannot be found, it is most likely that it will find its way to the incision within twelve or twenty-four hours. Hæmorrhage may also occur after ten or twelve hours.