## LARYNX.

**Mendoza, Suarez de.**—*Loss of Voice following Thyrotomy.* "Archives Internationales de Laryngologie," etc., July—August.

The author reports a case of aphonia after thyrotomy which was cured so far as the speaking voice was concerned, but the patient was quite unable to sing. On laryngoscopic examination, one cord was found to be slightly raised above the level of the other. The author invites opinions as to treatment. *Anthony McCall.*

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## EAR.

**Andrew, J. G.**—*Case of Cerebellar Abscess following Middle-Ear Disease.* "Brit. Med. Journ.," May 2, 1903.

The abscess was consecutive to chronic left-sided otitis media purulenta. On admission to hospital the patient complained of severe headache, sickness, and vomiting. His temperature was 103·6° F., and his pulse 80. There was no mastoid pain and no tenderness along the course of the jugular vein. The left membrane was perforated, and a small quantity of very offensive pus was present. In the first instance a mastoid operation was performed, but subsequently it was found necessary to explore the interior of the cranium. An anæsthetic was given and the patient placed upon the operating-table. Suddenly respiration failed. The cerebellum was rapidly explored, but no abscess found. During the continuance of artificial respiration the temporo-sphenoidal lobe was also explored, but with negative results. Upon post-mortem examination, a small abscess, containing about a drachm of pus, was found in contact with the sinus. The surrounding portions of the cerebellar lobe were softened, friable, and discoloured. A thrombus was found in the sinus. *W. Milligan.*

**Ballance, C. A.**; **Ballance, H. A.**; and **Stewart Purves.**—*Remarks on the Operative Treatment of Chronic Facial Palsy of Peripheral Origin.* "Brit. Med. Journ.," May 2, 1903.

The idea of the authors is to effect an anastomosis between another healthy nerve and the distal segment of the paralyzed facial, and the rationale of the procedure is based upon conclusions arrived at by them that regeneration occurs in the distal segment of a divided nerve even when separated from the central end, but that such regeneration does not reach full maturity unless the distal segment is joined to the proximal, so as to permit of transmission of impulses between the centre nerves and the periphery.

In the first place, the authors assured themselves that muscle fibres still survived upon the paralyzed side of the face by means of the galvanic current. The facial nerve was then exposed at its point of exit from the stylo-mastoid foramen. The nerve trunk was cut across as high up as possible. The spinal accessory nerve was then exposed, and its sheath divided at a level convenient for union with the divided facial. The distal segment of the facial and the proximal end of the spinal accessory were now united by means of fine sutures. When the operation wound had healed, the muscles upon the paralyzed side of the face were stimulated by daily galvanism for months, until faradic excitability returned, when faradism was substituted.

Seven cases are recorded, in six of which a facio-spinal anastomosis was effected and in one a facio-hypoglossal.

The conclusions arrived at are:

1. Peripheral facial palsy is remediable by facio-accessory anastomosis, but the extent of recovery appears to be limited to associated movements in conjunction with the shoulder. In most cases the previous deformity disappears when the face is at rest.

2. For reasons above stated, they would in future recommend facio-hypoglossal anastomosis rather than facio-accessory.

3. The cases suitable for operation are those in which the paralysis has lasted so long that no recovery is to be expected—say, facial palsy lasting six months, without any sign of recovery. In their opinion, the sooner the operation is done after this date the better.

4. A suppurative causal condition producing an infective neuritis renders the prognosis after operative treatment less favourable than in cases due to trauma. *W. Milligan.*

## PHARYNX.

**Escat** (Toulouse).—*Treatment of Chronic Hypertrophic Pharyngitis by Scarification.* "Archives Internationales de Laryngologie," etc., July—August, 1903.

The author advocates this method in those cases that are not improved by the usual means. Brushing with solutions of iodine, sprays, and constitutional treatment, prove effective in most cases, but where we have much interstitial thickening he believes scarification offers the best chance of success. The scarifier consists of eight blades, with points shaped like a lancet, which can be lengthened or shortened at will, the handle being made of malleable metal to allow of bending to any desired angle. An antiseptic gargle is used for five minutes, followed by cocaine, then the soft palate and uvula are scarified longitudinally and transversely. The hæmorrhage soon ceases. An application of Ranault's solution of iodine or zinc chloride 1 in 30 completes the operation. The pillars of the fauces and posterior wall of the pharynx can be treated in a similar way at a later date. Should there be any dysphagia, Dr. Escat recommends a gargle of menthol, cocaine and borate of soda. *Anthony McCall.*

## ŒSOPHAGUS.

**Butlin, H. T.**—*An Account of Eight Cases of "Pressure-Pouch" of the Œsophagus removed by Operation.* "Brit. Med. Journ.," July 11, 1903.

The symptoms of "pressure-pouch" are: (1) Return of fragments of undigested food hours, or even days, after it has been taken; (2) gurgling of gas from the throat, more especially when pressure is made low down upon the left side of the neck; (3) the arrest of a bougie 9 inches from the teeth. In some cases, especially when the pouch has attained large size, wasting may be a marked symptom. Cough, due to pressure,