

101.6°. The discharge had diminished. He was dull, stupid, and irritable, and appeared to have difficulty in collecting his thoughts when trying to answer questions. On the 19th the temperature, which was 99.2° in the morning, rose to 104.8° in the evening. On the 20th the morning temperature was 99.6°, and the evening temperature was 103.2°. An accumulation of pus was incised and evacuated over the left elbow-joint. On the 21st an abscess over the left metacarpus was opened. The discharge from the ear, which had diminished somewhat, became more copious. Perspiration was very profuse, alternating with rigors. When addressed he "rambled" in an incoherent manner. The morning temperature was 102°, and the evening temperature was 101°. On the 22nd the temperature in the morning was 100°. A collection of pus over the right ankle-joint was opened. The condition of the patient was very grave. There was marked pallor of the countenance, and he was unable to speak, though able to take fluid nourishment. He died at 12.30 p.m.

Extract from Post-mortem Book.—The dura mater over both petrous and mastoid portions was unaffected, as were also both anterior and posterior surfaces of the petrous and external surface of the mastoid. There was no change in the lateral sinus. The bone forming the roof of the tympanum was removed and disclosed pus in that cavity. The mastoid antrum was full of thick, cheesy pus; its walls were thin but hard and dense. Free communication existed between this cavity and the tympanum.

Remarks.—It seems reasonable to suppose that the injury inflicted in January, 1893, interfered with the nutrition of the mastoid cells and was the starting-point of the whole train of ill-effects, while the fall on November 16, 1899, hurried on the process to a fatal termination. Several circumstances in the case strike one as being peculiar: (1) the fact that the disease commenced in the mastoid portion and spread to the middle ear instead of *vice versa*; (2) the long period of latency during which the only symptoms were deep-seated pain and slight deafness; (3) the rapid progress to a fatal termination when once the process had spread to the tympanum; and (4) the limitation of the disease to the mastoid and tympanic cavity, and the non-implication of the membranes and lateral sinus, although the ultimate cause of death was pyæmia.

StClair Thomson.

PHARYNX.

Holzknrecht, G.—*The Diagnosis of Oesophageal Stenosis.* "Deutsche Medicinische Wochenschrift," No. 36, 1900.

The method of examination consists in the radioscopic observation of the œsophagus while the patient swallows bismuth. Transillumination should be from behind on the left towards the front and the right or the reverse. In this position the shadows of the vertebral column and the bloodvessels are separated, and the picture of the œsophagus lies free in the middle, so that the passage of the bismuth can be followed in its whole length. This method shows the position and length of a stenosis in a simple, safe way, and obviates in the majority of cases the necessity of passing a bougie.

Guild.

Kelling, George.—*Endoscopy of the Œsophagus and Stomach.*
"Lancet," April 28, 1900.

After a historical review of the efforts made during the last thirty years to obtain a view of the interior of the œsophagus in a living subject, the writer describes his own instrument based on the principle of a curved hollow tube, which after introduction can be straightened. The paper, while interesting, is too long to abstract, but it is worth studying, as the writer feels sure that excellent results will be obtained by well-trained specialists with œsophagoscopy and gastroscopy.

StClair Thomson.

Lack, H. L.—*Curtain Ring for Eight Years in Pharynx of a Child.*
"Lancet," April 28, 1900. Harveian Society.

Dr. H. L. Lack showed a curtain ring which he had removed from the pharynx of a child, aged nine years. The ring was swallowed when the child was nine months old, and produced violent fits of coughing and choking which soon passed off. For years the ring had caused no symptoms. The upper edge was free in the post-nasal space, the lower part lay free behind the arytenoids, while the two sides were firmly embedded beneath the mucous membrane of the lateral pharyngeal walls. The ring was cut through with bone forceps at its lowest part, opened out, and pulled upwards until free. Dr. Lack emphasized the importance of the coughing and choking attacks following a history of swallowing a foreign body, attention to which would lessen the number of these cases which had been overlooked.

StClair Thomson.

McWeeney, E. J.—*Rupture of the Apparently Healthy Œsophagus.*
"Lancet," July 21, 1900.

Considerable doubt has been thrown on the possibility of a rupture taking place in a healthy œsophagus. A sufficient number of cases have now been recorded to establish the occurrence as an undoubted, if rare, morbid entity. The writer records a case which appears to have been simply due to vomiting. It is particularly interesting, not only from the full post-mortem report given, but because of the histological report of the margins of the torn œsophagus. Particulars are then given of sixteen other cases, and the writer comes to the following conclusions:

Age.—Mostly men in the prime of life, the average age being forty-two.

Alcoholism.—This seems to be a predisposing factor.

Vomiting.—In every case tabulated the accident appears to have occurred either during vomiting or retching.

Symptoms.—There were a feeling of something having given way, pain, collapse, dyspnoea, and subcutaneous emphysema,

Duration of life.—In one case seven and a half days; on an average seventeen hours.

Position and shape of rupture.—Generally a prolonged slit, just above the diaphragm.

Etiology.—After a careful study of existing data the writer arrives at the conclusion that the two main factors are (a) softening of the coats, and (b) sudden increase of pressure from within. The softening is due partly to intravital digestion, and partly to inflammatory infiltration. The intravital digestion is to be accounted for by (a) circulatory

disturbance, which in the author's case took the form of venous thrombosis, and (b) prolonged sojourn of peptic matters in the gullet from prolonged retching.
StClair Thomson.

Seiss, Ralph W.—*The Atrophic Pharynx.* "Jour. Amer. Med. Assoc.," October 13, 1900.

The old term "Pharyngitis Sicca" is a clinical one, and bears no relation to any definite form of disease. All types of simple chronic pharyngitis tend to progress into the atrophic form. The common form of chronic pharyngitis is characterized by enlargement of the lymph glands giving so-called follicles, dilation of superficial blood-vessels and especially by the formation of small masses of granulation tissue which are situated behind the posterior arches of the palate. Atrophic areas, showing as sunken, glistening, light-coloured spots, occur in the central part of the pharyngeal wall. It may remain so for years, giving very little trouble; but in some cases the chronic interstitial inflammation steadily extends, the granulation tissue becomes more extensive, and the greater portion of the pharyngeal wall is infiltrated.

The pathological process is identical with fibrosis elsewhere: migration and aggregation of leucocytes, their fibrilization, the conversion into connective tissue, contraction and extension of this formation with resultant pressure atrophy. In advanced cases most of the structures of the pharynx are replaced by fibrous tissue, and the anatomical relations and functions more or less changed.

Its etiology, like fibrosis elsewhere, is mainly unknown. Gouty subjects are more prone than others, but it occurs in all types. A clinical history is of years of dry throat, itching, tickling, and recurrent cough, choking while eating, dull pain radiating in the larynx or up to the Eustachian tubes, and interference with the voice. Normally, the posterior pharyngeal wall is concave, but in the atrophic throat the glandular and muscular tissue are atrophied, so the vertebræ push forward, giving a convex appearance; and gorged and varicose veins are frequent, due to the return circulation being obstructed.

The possibilities of treatment are limited to palliation and perhaps arrest of progress. Stimulant and alterative sprays, such as oil solutions of gaultheria, thymol, and the like, are beneficial. In tolerant cases massage of the pharynx can be done by patting the whole membrane with a medicated mop. The best stimulant is the faradic current, the positive pole being applied to the pharynx, and the negative held in the patient's hand.
Dodd.