

## Abstracts.

### NOSE.

**External Nasal Deformities, Correction by Sub-cutaneous Method.—**  
**Lee Cohen** (Baltimore). "Journ. Amer. Med. Assoc.," December, 1916, p. 1663.

Cohen has adopted the methods introduced by Joseph for the correction of nasal deformities. He lays great stress upon the importance of proper technique. The vestibule of the nose should first be prepared by careful removal of all hairs with small scissors. The nose should then be thoroughly douched with sterile normal salt solution, after which soap and water, ether, and alcohol are used to complete the process in the vestibule. The entire face is also cleansed in the same manner, and is afterwards so draped with sterile towels that only the nose and mouth remain exposed. The mouth is covered with gauze. The entire nose, with the exception of the vestibule, is packed with sterile gauze and over this a pledget of cotton saturated with alcohol is placed. Local anæsthesia is usually employed. Cohen considers it of importance, in undermining the skin and in all subsequent steps of the operation, to introduce as seldom as possible the same instrument after its withdrawal from the wound. Rubber gloves should be used by the operator and his assistants.

Cohen records a case of a woman, aged thirty-seven, whose external nose showed a convex vertical deformity involving the bony and cartilaginous dorsum from the frontal notch to the tip. The tip drooped and the columna extended  $\frac{1}{4}$  in. below the plane of the edges of the alæ. The deformity caused the patient much unhappiness. Under local anæsthesia the skin over the entire nose was undermined through the usual incisions, one on each side, made from the interior of the vestibule parallel with and just below the edges of the nasal bones and nasal (frontal) process of the superior maxillæ. The entire bony dorsum was now sawed through from the frontal notch down to the beginning of the cartilaginous portion. Before sawing, the periosteum was cut through along the same line with the sharp edge of a small periosteal elevator. The saw was introduced first on the left side. A fresh saw was then introduced into the right side. But slight lateral pressure was then needed completely to mobilise the bone. Pressure on the lower end of this segment removed every appearance of a hump nose. (In cases with a very marked hump the portion sawn off may be removed through the incision in the nose.)

There still remained the elongated tip and the rather low plane of the columna to be corrected. This was accomplished by the removal of a triangular piece from the lower portion of the septum, the apex of the triangle being situated at the anterior nasal spine, the base upward and forward beneath the cartilaginous dorsum of the nose, just above the fleshy tip. This was done by first transfixing the membranous septum with a small knife and cutting upward and forward to the dorsum. A similar diverging incision was made above, through the lower part of the quadrilateral cartilage, forming the upper arm of the triangle. The piece removed consisted, therefore, partly of the membranous and partly of the cartilaginous septum. The edges of the wound were brought together by four superficial sutures of black silk on each side of the septum, after which two deep mattress sutures were introduced

through the cartilaginous septum above and the columna below so that, should the superficial ones pull out, a sagging of the tip would be prevented.

The vestibule was packed with iodoform gauze and a copper splint lined with lint applied externally. The first dressing was allowed to remain four days, and later the dressing was renewed every forty-eight hours. All sutures were removed on the eighth day.

Cohen also records a case of a male, aged twenty, whose nose was so deformed that he could not obtain a position. The nose bore some resemblance to the back of a camel. The deformity had resulted from an injury eleven years before and had been made worse by a second injury which was followed by abscess of the septum. The contraction following the abscess causes the depression. Altogether Cohen performed three operations on this case. He first made an attempt to furnish some substantial support for the tip of the nose. Under local anæsthesia, after separating the two layers of the septal mucous membrane, two-thirds of the right lower turbinal was removed with the Struckyen scissors. The bone was completely stripped of muco-periosteum, straightened out and cut to the desired shape. The piece of bone was then planted between the layers of the septal mucous membrane, one end against the anterior nasal spine and the other beneath the nasal dorsum just above the fleshy tip. The septal incision was united and a Roe spring clamp introduced into the anterior nares to relieve pressure. The nose was packed with iodoform gauze. Healing took place by first intention.

Three weeks later, under local anæsthesia, the large bony hump was sawed off by the method described in Case 1, and moved downward to fill in the depression over the cartilaginous portion. Healing was uneventful, but there still remained a slight indentation over the cartilaginous portion of the nose.

The patient was so satisfied with the result that it was only seven months later that his consent was obtained for the final step. Under ether anæsthesia, after again undermining the skin and preparing the dorsum nasi, a longitudinal section was removed from the fourth right sternocostal cartilage and placed on the nasal dorsum to fill in the depression. As before, the vestibule was packed and the copper splint applied. From the photographs the result appears to have been excellent. The psychologic effect on the patient was most interesting. Before operation he gave no heed whatever to his attire whereas afterwards he dressed with the greatest care!

*J. S. Fraser.*

**Vincent's Angina.**—**A. T. McClintock** (Wilkes-Barre, Pa.). "Amer. Journ. Med. Sci.," February, 1917.

The writer refers to the question of the pathogenicity of the two organisms described by Plaut and Vincent. He concludes that "in many serious-looking anginas if the causative organisms are not those of Vincent, at least the predominance of the latter in the picture of a smear, appears to be a sure guide to a diagnosis of great importance, prognostically and economically." He believes that the difficulty of culture has prevented the more frequent recognition of the disease, since "smears are too rarely made." By the latter means the diagnosis is easy. Eleven cases are reported.

*Thomas Guthrie.*

**E.A.R.**

**Tumour of the Auditory Nerve; Removal by the Translabyrinthine Route.**—Arthur af Forselles. "Nord. Tidskr. f. Oto. Rhino. Laryng.," Bd. 1, no. 1, p. 29.

Male, aged forty-nine. History of three months' duration of right-sided headache and later of vertigo, diplopia, and failing vision, with deafness and vomiting. Examination of the cranial nerves revealed hypæsthesia of the sensory branches of the trigeminus of the right side and paresis of the abducens and facial. The right ear was deaf. There was spontaneous horizontal nystagmus to both sides, stronger to the left, although "the movements of the eyes were considerably greater on looking towards the right." The vestibular reactions were absent (from the right ear?). No spontaneous error was observable in the pointing test, but after rotation to the right deviation in pointing occurred. The sense of taste was deficient on the right side of the tongue, and the tongue was directed to the right when protruded. The gait was staggering and deviated towards the right. There was a tendency to fall towards the same side. The tendon reflexes were normal, but complicated movements were imperfectly carried out.

Owing to hæmorrhage, on one occasion apparently from the jugular bulb, the patient had to be operated on at three sittings. The tympanic cavity and antrum were opened up, the lateral sinus exposed, and most of the labyrinth removed as far as the internal auditory meatus. The dura of the cerebellum having been laid bare, it was divided from the lateral sinus to the internal meatus. Thereupon two cysts, as large as a pigeon's egg, protruded and were incised. In the internal meatus a tumour about the size of "the end of the little finger" was found and removed. Microscopically it was discovered to be a fibroma rich in cells. In spite of an attack of erysipelas during convalescence the patient made a good recovery, and two years after the operation he was free from any sign of recurrence and was able to work. The author finds the translabyrinthine route far less dangerous than Krause's operation, and he recommends it warmly when diagnosis is made early.

*Dan McKenzie.*

**Labyrinthitis, with Operation on the Labyrinth.**—Reid, M. A., and Lynch, M. A. "Medical Journal of Australia," December 2, 1916.

Seven cases were encountered among two hundred cases of chronic otitis media in twelve months. Detailed descriptions of symptoms, and methods of testing, and the treatment employed are given. Six cases were operated on, all made a good recovery. Facial paresis of short duration occurred in the majority of operated cases. The danger of injuring the facial nerve, if reasonable care and good lighting are employed is less than might be expected. The paresis in these cases could not be due to direct injury to the nerve. They were probably due to the serous exudation into the canal, or osteitis spreading from the bone wound.

*A. J. Brady.*

**THROAT.**

**Systemic Results of Infections of the Mouth, Nose, and Accessory Sinuses.**—Sydney Pern. "Medical Journal of Australia," October 21, 1916.

As regards the teeth, there are two distinct sources of infection—

*pyorrhæa alveolaris* and apical infection of devitalised teeth. Pern states that statistics show that over 60 per cent. of devitalised teeth have apical infection; and very few of these are causing local trouble. He says "there must be an enormous amount of chronic toxæmia in the community," and one is impelled to say that there must also be much bad dentistry! Diseased tonsils must be enucleated; this leaves us to infer that diseased accessory sinuses must be dealt with. A long list of ills following on toxic absorption is given. Pern goes on to state that there is another and very serious damage caused to the immunising mechanism by being constantly called upon and taxed beyond its resources. The thyroid gland is an important part of the immunising mechanism of the body, and if this organ is constantly being called upon to put forth increased effort thyrotoxic symptoms may appear. All grades of this symptom-complex, from nervousness, irritability, palpitation, inclination to be thin, etc., up to Graves' disease, can be caused by toxæmia from the sources indicated. Graves' disease, in most cases, quickly responds to treatment on the removal of a septic focus.

A. J. Brady.

### MISCELLANEOUS.

**The Influenza Epidemic of Spring, 1915; with Special Reference to Anomalous Throat Signs.**—A. G. Shera. "Lancet," 1917, vol. i, p. 450.

This is a *résumé* of 500 cases occurring in South London. The group of symptoms falls under four headings: (1) Severe initial coryza; (2) erythema and persistent vesicles in the throat; (3) sequential neuralgias; (4) various complications. In no case was symptom (2) absent, and the author considers it to be pathognomonic in this particular epidemic of influenza. The variety of the complications was considerable, persistent neuralgia, vertigo, melancholia, sweating, labial herpes, conjunctivitis, and seventh nerve paralysis being the most prominent. The erythema and vesicles appear not to have been connected with the accumulated secretion of inflamed mucous glands, aphthous stomatitis or epizootic, or herpes zoster, but rather due to an influenzal intoxication of centripetal diffusion.

Macleod Yearsley.

### REVIEW.

*Cerebellar Abscess: its Ætiology, Pathology, Diagnosis, and Treatment, including Anatomy and Physiology of the Cerebellum.* By ISIDORE FRIESNER and ALFRED BRAUN. Pp. 186. With 10 full-page plates and 16 illustrations in text. London: William Heinemann. 1916.

A SOUND and readable contribution to the literature of an important subject. The monograph also gives us the latest views on cerebellar function, including those of Bárány on cerebellar localisation, determined by freezing of the cerebellar cortex in man.

With regard to cerebellar abscess, we have again to draw attention to a statement which we seem to have seen before, but which