

ABSTRACTS

EAR

Local Sulfonamide Therapy in Acute Mastoiditis.

GEORGE S. LIVINGSTON, M.D. (Chicago). (*Jour. A.M.A.*, September 27th, 1941. cxvii, 13.)

In this study two groups of cases were treated in the usual complete surgical manner.

In the first group from one to three grams of sulfanilamide crystals were placed in the mastoid cavity, after operation and before closure. The usual rubber tube drain was placed in the antrum emerging from the lower end of the wound. Purulent drainage ensued and the average post-operative period until complete healing occurred was about the same as if no sulfanilamide had been used.

In the second group consisting of thirteen cases, reported here in some detail, the operation was done in the usual way, the cavity filled with crystals of sulfanilamide and the wound sutured tightly without drainage in each case.

In this latter group the post-operative period was greatly shortened and primary healing occurred in nearly all cases.

ANGUS A. CAMPBELL.

NOSE

Osteomyelitis of the Skull following Frontal Sinusitis.

A. S. MACMILLAN, M.D. (Boston). (*Jour. A.M.A.*, October 5th, 1940, cxv, 14.)

As a radiologist the author feels that before one can arrive at an intelligent interpretation of the density of a sinus as seen in the antero-posterior view, one must examine the lateral view for the depth of the sinus and for the thickness of the anterior and posterior walls. He must then note the character of the bones of the skull. At least four views should be taken: lateral, antero-posterior, a Water's position in the prone, and a fluid level position.

Acute inflammation of the mucous membrane causes decalcification of the underlying bone in from seven to ten days and may cause a loss of the entire outline of the sinus. In subacute and chronic sinusitis there is an increase in the density of the anterior and posterior walls, resulting in the sclerosis so consistently seen in chronic infections. This sclerosis makes it difficult to make out fluid levels and shows how small a part the density of the contents of the sinus has to do with total density.

Abstracts

Constant watch should be maintained for minute perforations of the anterior wall caused by the enlargement of small, penetrating, thrombosed vessels. These minute perforations are early signs of bone infection and localized loss of outline at one point is due to actual necrosis. Involvement of the posterior wall may be determined by noting the change in the pattern of the composite picture of the anterior and posterior wall as seen in another view.

Involvement of the diploic veins is often rapid and change may be detected from day to day.

Osteomyelitis of the skull is such a serious disease that X-ray evidence should not be waited for in the presence of pitting oedema extending to the hair line.

ANGUS A. CAMPBELL.

Osteomyelitis of the Frontal Bone. H. P. MOSHER, M.D. (Boston).
(*Jour. A.M.A.*, October 5th, 1940, cxv, 14.)

The disease occurs in two types—the fulminating, which is a rapidly spreading form, often caused by swimming; and the less virulent localizing form which tends to form sequestra. In the former type the patient is very septic, with pitting oedema over the forehead and extending towards the hair line. The disease spreads as a thrombophlebitis of the diploic veins in the frontal sinus and bone marrow. The organisms found are generally staphylococcus, or more rarely the streptococcus.

Intracranial complications are exceedingly common in the fulminating type, and the surgical treatment of choice is the removal of practically the whole of the frontal bone, preferably in one piece. A blood transfusion should be given on the table. An inverted T incision gives the best exposure and drainage. Three months should elapse before closing is attempted.

Natural repair is good only in young patients, and plastic surgery has to be resorted to, to repair the damage.

X-ray examination is not positive for a week or ten days, and therefore is not very helpful.

ANGUS A. CAMPBELL.

TONSILS

Significance of the Tonsils in the Development of the Child.
ALBERT D. KAISER, M.D. (Rochester, N.Y.) (*Jour. A.M.A.*,
October 5th, 1940, cxv, 14.)

Follow-up studies on tonsillectomized and non-tonsillectomized children were undertaken to show the trend of certain complaints in two groups over a ten-year period.

Frequently inflamed tonsils and markedly hypertrophied tonsils impare normal physical development and should be removed after

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four years of age. It may be expected that at least half of these children will be materially improved.

It cannot be demonstrated that the tonsils are often a causative factor in the common cold, otitis media, sinusitis and laryngitis, and tonsillectomy does not offer a solution for their eradication. The tonsils are not often responsible for pulmonary infections such as pneumonia, bronchitis and tuberculosis. They play a less significant roll in the causation of rheumatism and nephritis than was formerly supposed. However, a reduction in the number of throat infections following tonsillectomy has a beneficial effect on the rheumatic patient.

On the whole the writer feels the tonsils are not as great a menace as has been frequently suggested.

ANGUS A. CAMPBELL.

MISCELLANEOUS

Chemotherapy in Infections of the Bones and Soft Tissues.
REX L. DIVELEY, M.D., and PAUL R. HARRINGTON, M.D.
(Kansas City, Mo.). (*Jour. A.M.A.*, November 29th, 1941,
cxvii, 22.)

The writers base their paper on fifty-six cases of infected bone and soft tissue, thirty-eight of which were chronic osteomyelitis.

The treatment employed was the administration of sulfathiazole by mouth, or sodium sulfathiazole intravenously, thorough débridement of the focus, the introduction of sulfathiazole powder into the infected area, and complete closure of the wound.

In fifty-three cases healing was by primary intention with an average healing period of 21/6 days. Two other cases might be termed successful, but with a much more prolonged healing time.

ANGUS A. CAMPBELL.

ERRATUM

In Mr. J. B. Horgan's article on the "Transantral Approach to the Ethmoidal and Sphenoidal Sinuses", 1.40 p. 295, and 1.6 and 10, p. 296, "Tilley's punch forceps" should read "Lilly's punch forceps". As the author considers that this error makes nonsense of the whole article, particular attention is drawn to this correction.