ABSTRACTS

THE EAR

Otologic Observations in Trauma of the Head. W. E. GROVE. (*Archives of Oto-Laryngology*, 1928, Vol. viii., pp. 249-299.)

The author presents a study of 42 cases of head injury. His main conclusions are:—

(1) There is no direct relation between the severity of the injury and the occurrence or degree of vestibular or cochlear symptoms.

(2) In civil life head injuries are usually caused by a widely distributed compressing force which affects:—

(*a*) The Skull. As the base is composed of parts of unequal strength, the greatest effect of the force will be here; as the middle fossa is weaker than the anterior or posterior it will be most often affected, and in the middle fossa the weakly attached pyramid is the weakest spot.

Such fractures of the pyramid the author classifies as:—

(i) Longitudinal. These are the commonest; they usually involve the middle ear and sometimes the external canal. If the canal is opened there is danger of meningeal infection through the labyrinth, both immediately, from the compound fracture into an opened middle ear, and later, owing to the closing of the fracture by fibrous rather than bony union. Apart from direct injury to the external canal, damage to the labyrinth is usually due to concussion.

(ii) Transverse. These are less frequent. They cross the pyramid at right angles and destroy cochlea and vestibule. Although the immediate prognosis is bad there is little danger of meningitis, as the middle ear is rarely opened by such an injury. The damage to the 8th nerve is usually complete and permanent.

(iii) Avulsion of the petrous tip. This is rare.

(*b*) The Brain. Damage may be caused by direct injury or by "contrecoup." The author believes that compression of the lateral ventricles may drive the cerebrospinal fluid into the fourth ventricle with sufficient force to damage the vasoconstrictor centres, and so produce stasis in the brain tissue with injury to the central vestibular area.

(3) Within the temporal bone all the autopsies showed that hæmorrhage was the salient feature. Unless the labyrinth capsule was

fractured such hæmorrhage was always perilymphatic. The usual site was the scala tympani, near the round window. The nerves may be damaged by pressure from hæmorrhage (*a*) before entering the pyramid, (*b*) within the porus, (*c*) in the terminal canals.

(4) In patients dying years after injury were found atrophy of nerve-fibres and of the organ of Corti, especially in the basal coil, and more or less complete filling of the inner ear spaces and canals with hyaline tissue and bone. In this connection the author points out that a middle ear deafness (such as may follow a longitudinal fracture) can improve; but, on the other hand, where perilymph or endolymph has been disturbed or replaced by hæmorrhage, a progressive type of deafness follows.

(5) Experiments on animals show similar results of mild injuries—hæmorrhages in the inner ear, especially at the round window and in the basal turn, always in the perilymphatic spaces, and never in the endolymphatic. Degenerative changes are found in the nuclear region of the 8th nerve in the floor of the fourth ventricle, mainly affecting the cells of triangularis, *v.* Bechterew, the tuberculum acusticum, and the posterior corpora quadrigemina.

(6) Hæmorrhage from the meatus occurred in 9 cases. The author regards this as "almost indisputable evidence" of a longitudinal fracture.

(7) The Rinné was + in 35 cases, – in one case, not recorded in 6. B.C. was short in 24, normal in 6, not recorded in 12. Traumatic deafness caused by injury was present in 31 cases; in one case there was complete unilateral deafness; in a large proportion the deafness was bilateral, and the upper tone limit was more affected than the lower. Vestibular symptoms were present in 28 of these 31 patients.

(8) Vertigo, spontaneous nystagmus, and pointing errors are cardinal symptoms of vestibular injury. Unless the vertigo comes on in attacks, or is produced by bending movements of the head, and is accompanied by nystagmus, the author regards it as "apt to be neurotic," especially if "present after the first two weeks" or "accompanied by severe nausea, vomiting, and great mental excitement."

(9) Nystagmus is always horizontal-rotatory, and more marked to one side. No general rule can be laid down for the direction of falling, pointing, or nystagmus in any case.

(10) Caloric tests showed a normal response in 10 of the cases showing vestibular symptoms. In the production of symptoms an inequality of irritability between the two labyrinths is more important than the actual change of irritability.

F. W. Watkyn-Thomas.

The Ear

Pyolabyrinthitis in Childhood. Professor GHERARDO FERRERI. (*Atti di Clinica Oto-Rino-Laringolatrica della R. Universita di Roma.* Anno xxv., 1927.)

The internal ear with its bony capsule is a definite clinical and developmental entity. It is separated from the tympanum by a bony wall, complete except for the two windows, which are adequately closed. Its integrity is shown by the great number of cases of suppuration in the middle ear, and of cases of cholesteatoma where enormous excavation of the mastoid region has taken place, but where the internal ear is intact and functioning normally. The barrier can however be overcome—as readily in acute as in chronic inflammation—and pyolabyrinthitis set up. The greatest proportion of cases is met in the second decade of life, and the number decreases until cases over 60 years of age are very rare. The author quotes Logan Turner, that in pyolabyrinthitis following acute or subacute conditions the superior canal is more often the point of entry, following chronic conditions the horizontal canal. Pyolabyrinthitis may follow acute or chronic disease, but serous labyrinthitis always follows acute otitis. Scarlet fever is the commonest original cause of labyrinthitis.

Examination of 32 cases following acute otitis showed that the oval window was penetrated six times, the round window seven times, and both windows nineteen times. Another danger-point is the niche between the round window and the ampulla of the posterior canal. Here are foramina for several small vessels. If a perforation of the outer wall occurs the labyrinthitis is usually restricted to that canal, or to the posterior portion of the labyrinth. If infection enters the canal of the facial nerve it tends to spread into the internal meatus and so reaches the meninges. In other cases the whole of the capsule of the labyrinth becomes necrotic and forms a sequestrum representing the whole of the skeleton of the internal ear, and can be removed as such. Here the danger lies in a spread of infection by the saccus endolymphaticus.

Pyolabyrinthitis is rare in cases of tuberculosis or of cholesteatoma. It most commonly occurs in childhood in association with otitis media, complicating scarlet fever. Other cases of labyrinthitis occur as sequelæ of cerebrospinal meningitis, where the path of infection is along the internal auditory meatus. Mumps is also another frequent precursor of suppuration of the labyrinth associated with a concomitant otitis media.

The author has made sections of the labyrinth of a full-term fœtus, and finds that the layer of compact bone between the middle and internal ears is very thin and fragile. There is a great proportion of medulla and spongy bone with a most liberal supply of vessels and blood spaces through which an acute suppurative process can spread with great rapidity.

F. C. ORMEROD.

Abstracts

The Reaction of the Cerebrospinal Fluid in Inflammation of the Ear. DOTT. ALLESANDRO BUCCELLI. (*Archivio Italiano di Otologia*, Vol. xxxix., Fasc. ix., 1928.)

In an average healthy adult there is from 80 to 100 c.c. of cerebrospinal fluid, which is colourless and contained at a pressure of 4 to 20 c.c. of water in the erect posture. It has a specific gravity of 1006 to 1007 at 15° C. and consists of 99 per cent. water. Of the remainder, the reducing substance, mostly glucose, represents .5 per cent. to .75 per cent. The fluid contains albumen in about the same proportion as the perilymph of the ear.

In acute inflammation of the middle ear the neighbouring meninges may be affected to varying degrees leading up to purulent meningitis and death. This may occur via the tegmen antri and tegmen tympani or by way of the labyrinth.

The author has done lumbar punctures in a number of cases of acute inflammation of the ear. These cases did not show signs of meningitis and the fluid was clear and sterile.

In cases of acute otitis or acute meningitis the glucose and albumen were unchanged and lymphocytes were the only cells.

In cases of chronic otitis, with cholesteatoma and with dehiscence of the tegmen, of pachymeningitis circumscripta, of sinus thrombosis, and of cerebral abscess, the albumen was usually increased and the glucose diminished or absent, and polymorphonuclear cells were present. The reduction in the amount of glucose is the graver of these signs. F. C. ORMEROD.

Experimental Investigation of Labyrinthitis Caused by Various Bacteria. YUGORO HONDA. (*Japanese Journal of Medical Sciences, Transactions*, XII., *Oto-Rhino-Laryngology*, Vol. i., No. 1, pp. 73-93, 1927.)

In this article the author discusses the different types of labyrinthitis which follow the experimental introduction of various kinds of bacteria into the vertebral canal. The guinea-pig was the animal used in over one hundred experiments. Very careful pre-operative examinations were made, the operative technique is described in detail, and careful post-mortem operations were carried out in all cases, including histological examination. A very full bibliography is given.

The author finds that different types of labyrinthitis are caused by the various bacteria, and according to the various toxic strengths; just as the colon bacillus, which has a somewhat weak toxic action, causes a hæmorrhagic labyrinthitis of a weaker destructive nature than the other bacteria. He has differentiated five types of inflammation: hæmorrhagic, serous, sero-fibrinous, purulent and necrotic. A very careful description is given of the method of spread of the inflammation through the cochlea and vestibular apparatus. The

nervous elements are more or less strongly affected, and the ganglion cells always more strongly than the nerve fibres. As the author was able to produce in some cases a circumscribed inflammation of the cochlea, without affecting the vestibular apparatus, he considers this an experimental proof of the fact that in certain cases of deaf-mutism in man, following labyrinthitis, cochlear function is destroyed while vestibular function remains normal. W. J. M'NALLY.

THE NOSE AND ACCESSORY SINUSES

The Tear Reflex Test for Asthma of Nasal Origin. H. MORTIMER WHARRY. (*Brit. Med. Journ.*, 1st December 1928.)

To this test the author attaches considerable importance and he considers it as a ready and reliable way of differentiating between nasal and other forms of asthma. He has used it successfully for six years. *Definition.*—In a normal nose, if the anterior mucous surface of the nasal septum or inferior turbinated bone be gently stroked with a smooth silver probe no reflex is produced; but if the same thing be done in a patient suffering from asthma and produces lacrymation in the eye on the same side as the nasal fossa so tested, but not in the other, then the asthma is of nasal origin and is usually curable. R. R. SIMPSON.

Osteomyelitis of the Superior Maxilla in the Infant. J. TERRACOL. (*Archives Internationales de Laryngologie*, May 1928.)

Osteomyelitis of the superior maxilla in the infant is often referred to as "maxillary sinusitis of the infant." The author concludes from his embryological and clinico-pathological studies that infection of the maxillary sinus is not a primary causal factor.

The middle meatal depression of the rudimentary maxillary sinus can be seen in the embryo of three months. The epithelial encroachment pushes outwards the cartilaginous capsule, until by the seventh month there exists a tubular cavity 7 mm. long surrounded by bone.

In the newly-born, the antrum is represented by a small cavity filled with mucoid material, embedded in spongy bone and communicating with the meatal groove through a pin-point orifice.

The further development of the maxillary antrum is conditioned by the development of two neighbouring parts — the teeth and the superior maxilla.

Etiologically, infection occurs most frequently soon after birth, and contamination takes place either through an infected nipple or through an infected maternal genital tract.

The symptomatology, diagnosis and treatment of this condition are discussed and diagrams assist the text. MICHAEL VLASTO.

Abstracts

Suppression of Sweating of the Tip of the Nose in Ozæna. O. MUCK. (*Zeitschrift für Hals-, Nasen-, und Ohrenheilkunde*, Band xix., Heft 5, p. 421.)

The skin covering the alæ nasi, the tip of the nose and the membranous portion of the septum is supplied by the external nasal branch of the anterior ethmoidal. Sympathetic fibres which stimulate the sweat-glands are distributed with the sensory nerves. If such a diseased condition in the nose causes interference with the functioning of this external nasal nerve the sympathetic fibres are involved and sweating is absent. Ozæna is a disease which has this effect. Muck has observed this absence of sweat in very early stages of ozæna.

JAMES DUNDAS-GRANT.

The Conservative and Surgical Treatment of Chronic Ethmoiditis. WALTER HOWARTH, M.A., M.B., F.R.C.S. (*Brit. Med. Journ.*, 29th Sept. 1928.)

Mr Howarth uses the same classification as Skillern:—

1. Chronic catarrhal inflammation (polypoid degeneration).
2. Chronic suppurative inflammation.

His treatment for the former is on very similar lines to those of Skillern—a simple middle turbinectomy for the mildest cases, leaving nature to effect resolution, and a graduated removal of the cellular structures as indicated by the extent of the disease. The formation of polypi almost always indicates the involvement of the muco-periosteum and bone must be removed as well as the polypi. This cannot be done efficiently by the snare, and he has ceased to use this instrument many years ago. It is in the radical treatment of the suppurative variety that he differs from Skillern. His experience has been that an external approach enables him to reach the varying groups of cells with greater certainty. "Through a very small incision in the delicate skin, just internal to the inner canthus, which leaves an almost invisible scar, practically the whole ethmoid can be dealt with, and particularly the fronto-ethmoidal and orbito-ethmoidal cells which are so often at fault, and which tend to keep up the ethmoidal disease. These cells cannot be safely and satisfactorily removed by the intranasal method." "If an infected high ethmoidal cell is found to be producing a mound in the floor of the frontal sinus, and is affecting this cavity, it is the work of a few moments to remove a portion of the floor of the sinus and thereby improve its drainage. Moreover, it gives excellent access to the cells of the superior meatus and especially to that large posterior cell which is plastered on to the anterior face of the sphenoid." He finds that the open operation discloses frequently a remarkable number of cells which have never been touched by a previous apparently thorough intranasal operation.

T. RITCHIE RODGER.

The Larynx

THE LARYNX

Radium Treatment of Intrinsic Carcinoma of the Larynx. N. S. FINZI and DOUGLAS HARMER. (*Brit. Med. Journ.*, 17th Nov. 1928.)

The authors devised an operation resembling that of Professor Bayet for the treatment of intrinsic cancer of the larynx by radium. Fifteen cases were treated. A large window is made in the thyroid cartilage. The outer surface of the growth covered by perichondrium is exposed. From five to ten needles are inserted and kept in position by tucking the ends under the cartilage framework. The needles do not penetrate into the growth or the larynx. Each needle is attached to a linen thread soaked in flavine. The wound is closed and no drainage is employed. If the growth has extended across the middle line, a second window is made in the thyroid cartilage on the opposite side and needles are buried there also. A low tracheotomy is the last stage of the operation. The needles are left *in situ* for four and a half to eight days according to the dose employed. Suppuration occurred in all cases, but ultimately the wounds healed soundly with soft movable scars. Changes in the growth occur rapidly, and after six weeks all signs of growth may have disappeared. The dosage of radium and the theory of its action are discussed.

The results are grouped in three classes:—

(1) Early cases in which the growth was strictly confined to one vocal cord—namely, cases that could have been treated by laryngofissure. There were 8; in 6 the growths entirely disappeared and the patients remained well for periods of from one to three years.

(2) Advanced cases that could have been treated by laryngectomy. There were 5; one remains cured after four years.

(3) Inoperable cases—2. In one case the growth disappeared but recurred two and a half years later.

The authors think it possible that radium will be found to be the best treatment in all cases of intrinsic cancer. They claim that the after-results are far superior to those obtained by operation.

In advanced cases radium should be tried before laryngectomy. The case histories and the results of the 15 cases are given.

R. R. SIMPSON.

Surgical Aid in the Radio-therapeutic Treatment of Cancer of the Larynx. GEORGES PORTMANN, Bordeaux. (*Acta Oto-Laryngologica*, Vol. xii., Fasc. 3.)

Although the presence of the cartilaginous box of the larynx acts as such a favourable barrier to the extension of intrinsic cancer, yet if one wishes to treat such a case by radio-therapy from without, a serious difficulty is the predisposition of this cartilage to radio-necrosis.

The author therefore describes his method of subperiosteal resection of the thyroid cartilage, either in part or in whole. This is carried out without making any perforation into the lumen of the larynx.

When the thyroid cartilage is only partially removed and the isthmus and borders of the alæ remain, the lumen of the larynx is retained, but in the more advanced resections of cartilage there is of course collapse of the soft parts and tracheotomy is necessary.

Healing of the carefully sutured operation wound having taken place by first intention, in the space of a week the patient is then ready to be sent to the radio-therapeutist.

The technique is described in detail and is well illustrated.

H. V. FORSTER.

A Discussion on "Lymphoepithelial" Tumours, particularly of the Larynx. ANTON VOSSENBERG. (*Zeitschrift für Laryngologie, Rhinologie, etc.*, Band xvii., September 1928, pp. 153-165.)

The "lymphoepithelial" tumours are a subgroup of the carcinomata and are here defined as growths which arise from branchial cleft remains or from organs which are connected with these clefts embryologically.

The cases described up to the present have been generally connected with the second pharyngeal pouch; from this pouch, as we know, arises the *tonsil*, an organ which produces lymphocytes. The *thymus* is formed by an extension of the third and fourth pharyngeal pouches, and it also belongs to the "lymphoepithelial" organs.

Histologically this type of neoplasm shows two distinct elements, the epithelial, plus a greater or less proportion of small round cells of the lymphocyte type. The small round cell element may be so pronounced that the tumour is classified as a sarcoma or lymphosarcoma, and the author thinks that this has happened frequently in the past. In some cases only the closest examination will enable one to distinguish epithelial cells as a separate entity among the small round cells.

The *larynx* also is closely connected with the embryonic branchial organs; the thyroid cartilage probably arises from the third and fourth arches, the laryngeal muscles and nerves from the corresponding structures in these arches. In spite of this, "lymphoepithelial" tumours have not yet been described in connection with the larynx. The author's single case which forms the basis of this discussion, is apparently the first case in the literature of laryngeal tumours.

The patient, a man aged 66, presented a large growth in the right arytenoid region which caused fixation of that side of the larynx. There was also a hard secondary gland on the right side of the neck. By the direct method a small piece was removed for section and

the pathological diagnosis was: polymorphous sarcoma ? carcinoma. A complete laryngectomy (Glück) was performed and the patient recovered fairly well. There was a recurrence in the neck three months later and radium was then used; this was apparently very successful in clearing up the neck recurrence. After another four months there were signs of mediastinal metastases and these responded extremely well to deep X-ray treatment, as shown by successive X-ray photographs of the chest. In spite of this, death occurred a month later.

Careful sections of this laryngeal tumour showed a typical "lympho-epithelial" growth. The microphotograph which appears in the article certainly gives one the impression of looking at a small round cell sarcoma, but one can see that there are also epithelial cells present. The case shows that these tumours respond well to radium and X-rays. There are 4 illustrations and numerous references. J. A. KEEN.

Lesion of the Recurrent Nerve in Disease of the Mitral Valve. DOTT. MARIO SILVAGNI. (*Archivii Italianii di Laryngologia*, Vol. xlvii., Fasc. 4, Rome 1928.)

Fourteen cases are described in which mitral valvular disease was accompanied by paralysis of the left recurrent nerve, and therefore of the left half of the larynx. All the cases showed stenosis of the valve and in two compensation had failed, while in another seven the heart was only just holding its own. In only two cases had the laryngeal symptoms appeared before the cardiac symptoms. In the remaining twelve cases they had appeared later. All the cases improved as regards the cardiac, but only two as regards the laryngeal condition. In both these there had been paralysis for three months. The duration in all cases varied from one week to two years.

The conclusions are that the lesions of the nerve are not all produced in the same manner, that they do not depend on the gravity of the cardiac condition, and that improvement of the laryngeal condition does not depend on that of the heart, nor does it appear to be influenced by the duration of the lesion. The author thinks that one of the factors is an interference with the blood-supply to the nerve. F. C. ORMEROD.

Abscess of the Larynx in Infants. RUSTIN MCINTOSH, M.D., Baltimore, and KENNETH D. NICHOLS, M.B. (Tor.), New York. *Journ. Amer. Med. Assoc.*, Vol. xc., No. 26, June 30th, 1928, p. 2095.

The authors give a detailed report of five cases observed in the Babies' Hospital and the Willard Parker Hospital in New York. The patients were all boys and the ages ranged from $2\frac{1}{2}$ to 15 months. The principal symptoms were dyspnœa, dysphagia, aphonia, stridor,

fever, and malaise. There was some difficulty in diagnosing between laryngeal diphtheria and thymic enlargement. This was cleared up by a small skin incision through which an aspirating needle was passed. Two cases were intubated more than once, and both developed bronchopneumonia. The laryngoscope offered little for exact elucidation of the condition. In three cases the inflammatory mass was inseparable from the larynx on palpation. After aspiration, external drainage was effective, and all recovered. The pus in two cases showed hæmolytic streptococcus; a third, streptococcus, which was not differentiated; cultures were not made in the other two. In one case there was a previous history of erysipelas, in one of pyæmia, and in two of nasopharyngeal inflammation. It was thought that the pus was not subperichondrial in any case.

ANGUS A. CAMPBELL.

THE PHARYNX

Mixed Tumour of the Nasopharynx. JOHN E. G. M'GIBBON, M.B., B.S., D.L.O. (*Brit. Med. Journ.*, 21st April 1928.)

This is a record of a case of a smooth greyish-pink tumour about the size of a small nut, apparently springing from the lateral wall of the nasopharynx between the left choana and the Eustachian orifice. There was no history of epistaxis or pain, and no involvement of middle ear or lymphatic glands. The tumour was removed with post-nasal forceps without undue hæmorrhage.

Histological examination showed it to consist of cartilage and adenomatous tissue, and the pathologist suggested that it was of congenital origin from some abnormal structure. The author places it as a blastoteratoma. T. RITCHIE RODGER.

Nasal Obstruction in the Infant (Pseudo-Adenoids): Treatment by Nasal Intubation. MARCEL WISNER. (*Archives Internationales de Laryngologie*, June 1928.)

The association of the following symptoms in infants—snoring, difficulty in suckling, restless nights and disturbance of nutrition—lead one to suspect the presence of adenoids. A course of palliative treatment frequently fails to ameliorate the condition. The positive diagnosis of adenoids is not easily made, and curettage of the naso-pharynx is often the only means of establishing definitely that none are present. There may be a slight temporary improvement as the result of local decongestion, but the symptoms soon reappear.

The nasal obstruction is caused by a thickening of the mucous membrane of the nose and nasopharynx. The etiology of the morbid

thickening is due either to a systemic infection with syphilis or tuberculosis, or to a local infection caused by a chronic coryza.

For these cases, the author advises nasal intubation combined with the appropriate treatment for the underlying condition.

Treatment by nasal intubation is carried out by the passage of a rubber tube, closed at one end, into the nasal fossæ. The tube is rhythmically distended with air and gently drawn backwards and forwards.

The author quotes cases typifying the varieties of nasal obstructions in the infant, and concludes with the following practical remarks:—

"When confronted with an infant a few months old suffering from nasal obstruction, often dating from birth, the case should be dealt with as follows:—

"(1) At the first consultation, warn the family (who usually tend to suspect adenoids) that the condition may be due to a systemic infection. The family history should be discretely investigated and, if it is considered suspect, a Wassermann test should be done on the parents and their lungs examined.

"(2) The palliative treatment of the nose should be continued for some time in order to gain the confidence of the parents and to enable the clinical and pathological examinations to be carried out.

"(3) After a time, if tuberculosis or syphilis is present, the nose should be intubated and appropriate general treatment carried out. Or, if the pathological and clinical examinations are negative, the nose should be intubated until such a time when, if no cure results, a gentle curettage of the nasopharynx should be carried out."

MICHAEL VLASTO.

The Guillotine and Ethyl Chloride. C. R. STANIFORD, M.D., Ch.B. Vict., F.R.C.S. Ed., and J. C. CLAYTON, M.R.C.S. and L.R.C.P.

This is a detailed description of the authors' technique for the operation of removing tonsils and adenoids in children, and is very much on the same lines as are followed in many clinics in this country. By using two tables and having good team-work, thirty cases can be dealt with in an hour. The chief points to be attended to as regards the anæsthetic and the operation are well described. Late hæmorrhage is generally from the post-nasal space, and its avoidance in that situation is best secured by using sharp adenoid curettes, just as conversely in the case of the tonsillectomy, the bluntness of the instrument is the best safeguard.

Patients are encouraged to eat and drink on the day following the operation if possible. The throat is cleaned up by the muscular contractions involved thereby far more quickly than by any other method.

T. RITCHIE RODGER.

Abstracts

ENDOSCOPY.

Cardiospasm. H. H. GREENWOOD. (*Brit. Med. Journ.*, 24th November 1928.)

The terminology of this condition is discussed and "cardiospasm" is retained because of its established place in the literature, and because clinical observation bears out its descriptive accuracy. "Achalasia" is rejected as being a premature attempt at generalisation. A case with features of an unusual character is described in detail. The patient, a male, was first seen at the age of 25, but the age of the onset was 16½. The onset was due to the constant hurried swallowing of imperfectly masticated food. During meals relief from the pain and feeling of sickness was obtained by jumping with a curious side-to-side action, first on one leg and then on the other, until he felt a mass slide suddenly through an obstruction. Of the various possible courses of treatment, the patient chose the operation advocated by Walton. After opening the stomach the cardiac orifice was found as a tightly closed dimple-like opening, "resembling an anus spasmodically contracted by a fissura in ano." Stretching by means of the fingers was continued until the hand in the "obstetric position" gained admission. Healing and recovery were uneventful, and the symptoms were completely relieved. After discussing and rejecting the views of Hurst, Rake and Brown Kelly as to the pathology of the condition, the author offers the analogy of the spasm produced at the upper end of the œsophagus by superficial fissures and erosions as a possible explanation. He points out that although no record in any post-mortem reports can be found of cases of cardiospasm in which fissures and erosions were found at or near the cardiac orifice, it is possible that these would not be distinguishable through the œsophagoscope and may readily escape detection at the necropsy unless definitely looked for. The view put forward as to the origin of the disease is that the repeated hurried swallowing of large masses of imperfectly masticated food, too large to pass at once through the cardiac orifice, so that they must remain for long periods in the lower œsophagus, causes a mechanical dilation of that tube. The œsophageal wall, insulted by unduly prolonged contact with disintegrating food, yields grudgingly; the irritation of the contiguous cardiac opening induces a reflex protective spasm.

R. R. SIMPSON.

Congenital Œsophageal Obstruction. A. LAWRENCE ABEL, M.S., F.R.C.S. (*Brit. Med. Journ.*, 14th July 1928.)

Congenital malformations of the œsophagus are by no means uncommon, and usually manifest their presence within a few days of birth. Almost all prove rapidly fatal, but in some life may be

saved by prompt intervention, and the author pleads for a recognition of this fact. He reports a case of membranous stricture about an inch above the cardiac orifice. He saw the case two days after birth, and in the absence of conveniences for X-ray examination, passed a 4 mm. Jackson's œsophagoscope. The membranous stricture, which was complete, was identified and the end of the œsophagoscope was employed to pierce it. X-ray was carried out afterwards and the opaque meal was seen to pass with only slight hindrance. No subsequent dilatation seems to have been necessary, as the child continued feeding well, but four weeks later a pyloric tumour appeared and operation revealed a hypertrophic pyloric stenosis, for which Rammstedt's operation was performed with complete success. After five months the child weighed 11½ lbs. The whole subject of congenital malformations of the œsophagus is treated in detail, with a list of references and an additional bibliography.

T. Ritchie Rodger.

Self-retaining Arrangement for Brüning's Special Electroscope. A. Seiffert (Berlin). (*Zeitschrift für Hals-, Nasen-, und Ohrenheilk.*, Band xix., Heft 3, p. 238.)

This consists essentially of a vertical rod which fixes itself above into the bifurcation of the holder of the bronchoscope. Below it presses by means of movable pads on to the patient's chest and appears to be fixed there by the resistance of the body. It is made by Pfau, Luisenstrasse, Berlin, and is stated to be inexpensive.

James Dundas-Grant.

MISCELLANEOUS

A Case of Intratracheal Thyroid Tumour. Drs Vacher and Denis (Orleans). (*Revue de Laryngologie*, 31st December 1927.)

The authors report a case of this rare form of thyroid tumour. They state that they can find only seven recorded cases, none of which were diagnosed clinically. The patient was a married woman, aged 33, who had suffered from respiratory embarrassment for six years. During that period she had passed through three pregnancies, during each of which the dyspnœa was accentuated. She was more distressed when lying down in bed than during the day-time. On laryngeal examination a sessile tumour was seen in the upper part of the trachea, below the right vocal cord. The tumour was removed through a high tracheotomy opening under local anæsthesia, by "morcellement," it being found impracticable to preserve intact the mucous membrane covering it. It was growing from the right side of the trachea in the neighbourhood of the upper three rings. It was

soft in consistence, and contained several small cysts. The patient made a rapid recovery. Histologically, the tumour had the appearance of a simple goitre. One of the cysts was lined by stratified epithelium, suggesting that the site of origin of the growth was a thyroglossal remnant. G. WILKINSON.

The Treatment of Septic Wounds by Besredka's "Antivirus." R. VILAR FIOL (Valence). (*Revue de Laryngologie*, 31st August 1928.)

This is an enthusiastic article in favour of the "antivirus," which was introduced by Professor Besredka some four or five years ago. The chemical substances which it contains are separated from effete broth cultures of the various organisms, and it is used as a local application to disinfect wounds, and to confer local immunity against the spread of infection by those organisms. The present communication is concerned mostly with pyogenic infections. The author has used these preparations over a period of two years. It is believed that the active principles are definite chemical substances, which neutralise by chemical action the toxins produced by the infecting organisms. The action is purely local. Their action may be usefully supplemented by vaccines. They are used for irrigating septic cavities, or for impregnating dressings either used as packing for wounds or applied superficially to carbuncles, furuncles and other skin infections. The author relates several case histories illustrating the efficacy of the preparations in disinfecting septic cavities, and in protecting operation wounds from the spread of pre-existing infection. He specially lays stress on the immediate relief of pain when the remedies are applied to septic wounds and furuncles. He recommends the antivirus as a dressing after mastoid operations and as an irrigation for infected sinuses. G. WILKINSON.

REVIEWS OF BOOKS

The Extra-Pharmacopœia of Martindale and Westcott, revised by W. HARRISON MARTINDALE, Ph.D., Ph.Ch., F.C.S. Nineteenth Edition. Vol. i. H. K. Lewis & Co.: London, 1928. (27s. 6d. net.)

Wherever one opens Martindale one finds material of such engrossing interest as to keep the attention riveted. There is scarcely a new thing, however obscurely published, that escapes the notice of the editors. Such articles as those on organotherapy, on vaccines and antitoxins and on organic arsenic compounds, will be found full of valuable information in a condensed form. Thyroid treatment is