

ABSTRACTS.

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Authors of Original Communications on Oto-laryngology in other Journals are invited to send a copy, or two reprints, to the JOURNAL OF LARYNGOLOGY. If they are willing, at the same time, to submit their own abstract (in English, French, Italian or German) it will be welcomed.

NOSE.

Treatment of Hay-fever and Paroxysmal Rhinorrhœa.—Morley Agar. "Brit. Med. Journ.," July 24, 1920.

A new method is described which consists in rubbing into the skin of the vestibule of the nose an astringent lotion, namely, argent. nit. gr. xxx to the ounce. In making the application, which must be thoroughly and systematically carried out, particular attention is paid to two spots; the first is high up on the outer wall, and the second is on the floor about half to three-quarters of an inch behind the orifice. The mucosa is not painted.

Before making the application the vestibule should be examined for fissures or sore spots (in order to avoid them?—D. M.).

The author claims to have cured all cases of nasal rhinorrhœa so treated.

In hay-fever the results have not been so good, but some improvement has been obtained.

In this disease he does not use the silver nitrate at first, but applies the following anæsthetic solution "to the vestibule and a wide area around."

℞ Acidi carbolic	℥ijj
Aq. menth. pip.	℥vj
Spt. vin. rect.	ʒiv
Misce.	Fiat pigment.	

After a few minutes lotio calaminæ should be applied "to an even wider area of the face."

Both in paroxysmal rhinorrhœa and in hay-fever the application of the silver nitrate is followed by a definite reaction with sneezing, running from the nose, and sometimes cough and tightness in the chest. It lasts for from half an hour to twelve hours.

In normal people reaction is absent.

D. M.

E.A.R.

The Radical Mastoid Operation.—Morrissette Smith. "The Laryngoscope," August, 1918, p. 584.

According to Morrissette Smith, the first conception of the radical mastoid operation was indicated by Nature when she converted the mastoid process, antrum, middle and external ear into one cavity and lined it with skin. Bacon, Whiting, Dench and Kerrison strongly advocate the procedure, but a number of men not only refuse to commend the operation, but actually condemn it. There are three reasons for this: (a) The operation has been recommended in many cases where it was not indicated; (b) it has been attempted by men who have not taken the trouble to thoroughly familiarise themselves with the technique,

consequently their results have been poor; (c) proper attention has not been given to the after-treatment.

Chronic infections of the middle-ear cleft should be divided into three classes: (1) Those cases of intratympanic [and tubal.—Abs.] infections with little or no involvement of the attic. (2) Those cases involving not only the tympanum, but the attic, antrum, and, to a limited extent, the mastoid. (3) Those cases involving the intratympanic attic, antrum and mastoid structures as well. The infections in Class 1 are mucous membrane infections rather than an implication of the bony tissues, the discharge (usually coming from the Eustachian tube) being of a mucoid character; the hearing is usually good. The condition is in no way a menace to the patient's life. These cases rarely, if ever, require a radical operation. 2. These cases are of the border-line type, and require quite a little study and judgment in deciding whether or not operation should be performed. We must consider the amount, character and duration of the discharge, the evidence of bone destruction, as indicated by polypoid tissue, foul odour of the discharge, roughened bone disclosed by probing, the amount of hearing, the subjective symptoms, as pain, headache, dizziness, and the result of conservative treatment. (3) In Class 3 the radical operation is most frequently indicated. These cases are generally seen in the clinics of the large cities, the otitis having been acquired from some of the infectious diseases of infancy or early childhood and neglected through a number of years. It is in these that we get many of the facial paralyses, intracranial and labyrinthine complications. The hearing is generally very poor, the tympanum filled with foul-smelling pus and granulation-tissue, and the ossicles necrosed. All cases of cholesteatoma, facial paralysis and intracranial complications call for immediate radical operation.

In ten consecutive cases operated on the hearing remained the same as before operation in three, was improved in two, and much improved in five instances.

Technique.—Richards holds that a step in the operation which is of extreme advantage is the shaving down of the convexity of the anterior wall of the bony auditory canal. This widens the antero-posterior diameter of the apex of the cavity and prevents an epithelial septum from later pigeon-holing the apex from the main body of the cavity—an unfortunate and very common occurrence. Further, we secure a splendid view of the region of the tube, and therefore do not have to make an unnecessarily large cartilaginous meatus. The removal of the lip of bone overhanging the mouth of the tube is very important. In addition to this, it has been Richard's practice to evulse the tensor tympani muscle so as to enlarge the tubal opening and permit a thorough view and curetting.

Dench has always been an advocate of the primary skin-graft in the radical operation. He had sent many patients home two or three weeks after a radical operation in which a skin-graft was used. Dench advises that one graft should be made to cover the entire "radical" cavity and the margin of the enlarged meatus. The blood beneath the graft should be withdrawn with a pipette. Dench on occasion uses a little chip of bone to close the tube. In many cases failure to obtain a dry ear was due to the external auditory meatus not being made wide enough to ventilate the cavity. Morrissette Smith does not believe in employing grafts when the dura is exposed; there is a danger to the patient from meningitis when skin is put into such a cavity.

J. S. Fraser.

New Method of Dressing Mastoid Wounds.—Daure. "Presse Medicale," July 23, 1917.

At the time of the operation the wound behind the ear is entirely closed, the meatal plastic having been carried out. The iodoform gauze previously placed in the mastoid cavity is in part drawn out through the meatus. The special treatment employed thereafter is begun between the fifth and eighth days, and consists in daily introduction of sterile ambrine from a five to ten c.c. beaker, previously kept warm on a water-bath. The patient is so placed that the floor of the operation cavity is horizontal, and the meatus spread open with a nasal speculum. Ambrine is now poured in to a depth of two or three millimetres and allowed to solidify. A small cord of sterile gauze, three centimetres long, is then inserted, and a fresh layer of ambrine introduced to a point just so far from the meatus as to permit of packing in a gauze wick to maintain the lumen. The dressing is easily removed merely by traction on the gauze cord embedded in the ambrine. The cavity is cleansed each time with boiled water or saline solution, dried, and dressed as before. These dressings are carried out for a period averaging from fifteen to twenty days. Thereafter daily irrigations with aqueous iodine solution or insufflations of powerful boric acid are employed. *J. S. Fraser.*

End-results of the Radical Mastoid Operation.—Harris. "New York State Journ. Med.," 1917, vol. xvii, p. 17.

Harris has analysed the results of the operation on 24 patients. Concerning the discharge, it was found that 48 per cent. were perfectly dry and 52 per cent. still discharging. Hearing improved in only 8 per cent., unchanged in 70 per cent., and worse in 20 per cent. The ear was found fully epidermised in 14 cases, partly in 3, while granulations were found in 5. Two cases were still under treatment. The tube was closed in 11 cases.

The results are by no means uniformly good, partial or complete failures occurring in a considerable percentage of cases.

J. S. Fraser.

Vertigo and its Treatment by Adrenalin.—Maurice Vernet (Paris). "La Presse Médicale," July 10, 1920, p. 462.

Analysis.—The vertiginous sensation springs from an upset of the labyrinthine equilibrium, whether it occurs in the vestibular apparatus, the vestibular nerve, or in the connections with its centres.

The author is of the opinion that there is at the base of every vertiginous sensation a labyrinthine vasomotor or toxic phenomenon; and therefore a sympathetic or endocrinian phenomenon, of which the cause may be local, central or peripheral.

Adrenalin, the hormone of the chromaffine system, is for this reason a medicinal substance capable of favourably modifying vertigo when the primitive cause allows it.

The vertiginous sensation is, in fact, essentially a phenomenon of the labyrinthine irritation, mobile, and fugitive like the cause by which it is brought on, and like the variations of vasomotor kind in the sphere of the sympathetic and vagus nerves.

All otologists know that vertigo disappears when the labyrinth has been destroyed, and that an irritation of the membranous duct of the semicircular canals is necessary to provoke it.

The ischæmia of a limb brings on anæsthesia; it is the passive or active congestion of the ear which more often induces labyrinthine hyperæsthesia, and through it, vertigo. However, it is not clear whether ischæmia cannot sometimes provoke a hyperexcitability—momentarily at least—of the vestibular nerve.

Vasomotor congestion in the capillary sphere of the vestibular artery may provoke the vertiginous sensation apart from all other manifestation. Vertigo takes, then, all the alternative forms of this type of congestion.

It is well to remember the favourable action obtained on the labyrinthine congestion by ice applied locally, leeches, ergotin, parasyntesis, tepid washings, and intestinal derivatives.

Deafness and tinnitus without vertigo are of frequent occurrence. Vertigo may be associated with them, although it may exist separately, and it is not necessarily dependent on the same cause.

There exist as many causes of vertigo as there are causes of labyrinthine vasomotor modification, causes of toxic or endocrine modifications—local causes acting by reflex vaso-congestions; general causes—organic, neuro-glandular, central, acting equally by the sympathetic system medium.

It is so, for instance, if we consider the endocrine disorders which seem to be at the base of every diathesis, and if we consider the connections of the sympathetic system with those internal secretion glands.

Vertigo due to the menopause, to chlorosis, Graves's disease, arthritis and gout is a congestive vertigo through active or passive vasomotor disorders, dependent on the alteration of internal secretion glands.

Regarding central causes we have congestive vasomotor disorders of the paralysed regions (rising of local temperature, exaggeration of sudoral secretion, ecchymosis, œdema, etc.).

The collateral phenomena associated with the vertigo are essentially those of the sympathetic or the vagus system (nausea, vomiting, perspiration, mydriasis, vasomotor disorders). They are also met with in the painful syndromes of intestinal irritation.

The author wonders what are the relations between the labyrinthine vasomotor disorders, the general arterial tension, and the tension of the endolymphatic liquid.

Instability of the vasomotor system in the capillaries, or the remarkable variations from one moment to another of its effects, show how difficult it is to discover a rigorous rule in its connections. In short, something must be remembered: the rupture of the vasotonic equilibrium of the capillaries seems to be wonderfully influenced by adrenalin, the effect of which is exclusively vascular.

This rupture seems, in fact, to be more frequently a passive vasodilatation.

It is possible to battle against vertigo by means of adrenalin without any appreciable modification of the general arterial tension.

The author puts aside the various causal treatments of which a successful result is undeniable (such, for instance, as the removal of a cerumen plug, the expulsion of *tænia*, etc.). He looks only upon vertigo "without any obvious material cause."

He recognises the excellence of the sedative and non-intoxicative medications, but he refuses to adopt the quinine medication, of which the sad result is injury to the hearing. It is also the same with the sedative medications.

Adrenalin, on the contrary, has a triple function, which allows a struggle against the labyrinthine vasomotor disturbance: elective excitation of the endings of the sympathetic nervous system, regularisation of the blood-pressure and antitoxic function.

For the last four years a great number of vertiginous patients have been successfully treated by the author. He employs Clin's solution at 1 to 1000, by giving 5 to 20 drops twice a day by the mouth, interrupting this treatment every ten days. Doses must be administered progressively. Vertigo generally quite disappears in a few days under this treatment.

Author's abstract.

REVIEW.

THE PLASTIC SURGERY OF THE FACE.

Plastic Surgery of the Face, based on Selected Cases of War Injuries of the Face, including Burns. With original Illustrations by H. D. GILLIES, C.B.E., F.R.C.S., Major R.A.M.C.; with chapter on the "Prosthetic Problems of Plastic Surgery," by Capt. W. KELSEY FRY, and "Remarks on Anæsthesia," by Capt. R. WADE. London: Henry Frowde, Oxford University Press, and Hodder & Stoughton, Warwick Square, E.C., 1920. Price £3 3s. net.

MAJOR H. D. GILLIES has now crowned his work on the plastic surgery of the face with a book which is in every way worthy of that work.

As everyone knows, and as most have personally experienced, the late war brought with it many new and strange problems for our solving, and while there were departments of national activity in which our efforts did not reach so completely and rapidly as they might have done, the high level of success we had hoped for, it will on the other hand be generally conceded that in the realm of medicine, with one or two exceptions, the results attained by British workers were unsurpassed either by our allies or by our enemies. And in the book now before us we have the record of one of our successes, the reading of which amply explains how it came about that the Queen's Hospital, Sidcup, was eminently one of the things to see in England during the war. Here Major Gillies and an enthusiastic band of coadjutors and assistants were reconstituting with extraordinary and unlooked-for success the features of those unfortunate men whose faces had been so torn asunder by the cruel wounds of modern warfare as, in many cases, almost entirely to lose the semblance of the human countenance. The problem of building these ruins up again was a new one, because never before were so many soldiers deformed in this way, since, apart from the overwhelming increase in numbers, in former wars most wounds of this severe shattering character must necessarily have been fatal.

At first sight, surely, no type of deformity could have appeared to the novice in plastic surgery to have been so hopeless of remedy with the slender means formerly at his disposal. And in 1914 even the experienced rhinoplastic surgeon was a novice. Now, thanks to Gillies and his fellow-workers, he knows that much more can be done than he ever dreamt of, and, what is more, he knows how to do it in such a way