He draws special attention to a condition which he terms "thyreoptosis." The larynx is comparatively low, and only the upper tracheal ring covered by the isthmus is palpable over the incisura sterni. The whole lower corner of the thyroid lies within the thorax; when this enlarges, a struma profunda or intrathoracica, without enlargement in the neck, develops. It is characterized by dulness over the manubrium sterni and first intercostal spaces, and must be looked for in unexplained asthmatic attacks or dyspnœa where examination of the larynx and chest is negative. If small, there may be no dulness, and, owing to its position, severe symptoms may be caused. An attempt may be made to map out the thyroid lobes by palpation; when this can be done on one side only, one may be nearly certain that the lower corner is in the thorax. If it is not fixed, it may be protruded on coughing. There is also a form of thyreoptosis where the position of the larynx is normal; where the thyroid is enlarged and movable on deep inspiration, certain parts may be drawn into the thorax. Development of even small nodules cause dyspnœa. Operation should be done before adhesions form.

Amongst five hundred and fifty-six cases of a colloid and cystic nature, only one death due to chloroform occurred. The author considers that, with cocaine and aseptic treatment, operation is absolutely safe. Many of these cases were in weak individuals with marked respiratory and circulatory disturbance.

Six out of eighteen malignant cases died, due to severe, complicated resections, which involved important structures.

Two out of fifteen cases of Basedow's disease died—one due to pneumonia, the other to accelerated action of the heart.

Two deaths occurred in eleven cases of strumitis—one due to tetany, the other to suppuration in a case which had been tapped elsewhere. *Guild.*

## EAR.

**Starr, F. N. G.** (Toronto).—*Epithelioma of the External Ear.* "Canadian Journ. of Med. Surg.," July, 1898.

THE history of two cases are given. First: Male, aged fifty-eight. The cancer had formed in the middle of the outer edge of the helix; it was thickened and ulcerated, presenting everted edges. There was no pain. The operation was V-shaped, pointing down to the bottom of the concha. Two silkworm gut sutures drew the deep cartilages together, and a continuous horsehair suture closed the wound. Union was rapid. One year later there was no recurrence. Second: This case was under the care of Mr. J. H. Cameron; Dr. Starr assisted in the operation. It occurred a week after the first case. In this one, the growth affected the base of the lobale, extending into the fossa of the antihelix, and involving the anti-tragus. This also was unattended by pain. It was removed, and the lobule sutured to the remaining part of the prima. A good recovery ensued, but the case was not traced any farther. *Price Brown.*

**Stillson, J. O.** — *Mastoidectomy involving Lateral Sinus Complications.* "Laryngoscope," June, 1898.

IN this interesting paper the writer records the histories of three cases, in two of which operation followed by recovery took place. In the third operation was refused, and death took place.

In the first case there had been repeated aural abscesses. Two mastoid opera-

tions had taken place. Subsequently necrosis over the sigmoid sinus ensued. A third operation was undertaken, in which the tegmentum of the attic was completely removed. In this case the jugular was not ligated.

In the second case—a case of aural abscess—paracentesis was performed, followed, however, by cessation of discharge and involvement of the lateral sinus. Operation was suggested, but was declined.

In the third case an otitic cerebral abscess was diagnosed and opened, the mastoid at the same time being cleared out and a clot removed from the jugular vein. Recovery took place.

The author sums up his observations by saying that "a bolder and more radical surgery in the light of modern antiseptic measures is destined to replace the former timid conservatism which has cost so many lives. The lateral sinus presents no greater difficulties to operative interference than many other portions of the brain. It should be opened when a clot can be demonstrated with reasonable certainty to exist, and without hesitation when pus is known to be present.

"Ligation of the jugular should be done in certain cases, not for the sake of facilitating the operation, but as a means of preventing at least one source of general infection and sepsis. Like every other valuable surgical procedure, it should be done in time to give the patient the benefit of its value. Procrastination adds to the dangers and diminishes proportionately the hopes for cure which the operation offers." *W. Milligan.*

**Thomas** and **Lartail.**—*Cholesteatoma; Cerebral Abscess; Operations; Death.* "Rev. Hebd. de Lar.," Feb. 25, 1898.

THE case of a boy of seventeen, with pain in the left ear of eight days' duration.

*History.*—Pain in the left ear from time to time. Otorrhœa on the right side since childhood.

*State.*—August 27th. Axillary temperature, 39°; pulse, 68. Painful stiffness of the neck. Fixed headache in the frontal and left occipital regions. Mind clear. No paralysis. Dilatation of the veins of both optic discs. Mastoid region apparently healthy. Tympanic membrane natural in position and colour, with the exception of the postero-superior region, where a small granulation was to be seen.

*Treatment.*—After cocainization the granulation was removed and the posterior half of the membrane removed. Syringing brought away some *débris* of a cholesteatomatous character.

August 28th. State unchanged, and the diagnosis of cerebral abscess made.

August 29th. Commencement of facial paralysis.

September 1st. Fall of temperature to 36°-37°.

September 7th. The lateral sinus, occupying the centre of the mastoid region, opened and packed. A cholesteatoma, the size of a nut kernel, removed from the aditus. Curettement without perforation of the cranium. Chiselling of the anterior attic wall, which was eburnated, and removal from that cavity of a second cholesteatoma, the size of a nut. The roof of the attic trephined laying bare a square centimètre of dura mater which appeared normal. Incision of the dura and escape of cerebro-spinal fluid. Resection of the superior wall of the cartilaginous meatus.

September 10th. Less headache and stiffness of neck.

September 14th. First dressing of the wound. Some vomiting.

September 17th. The cranial opening enlarged anteriorly to the central point of the tegmen tympani. Granulations discovered which had reached the inner table through a small perforation.

September 22nd. Absence of pressure symptoms.

October 6th. Return of pressure symptoms. The exposed dura was freely

incised and the brain appeared normal. Luc's bistouri was passed, to the depth of three centimètres, upwards, forwards and backwards, into the tempero-sphenoidal lobe, but no pus was detected. Cessation of pressure symptoms and pain.

October 10th. No vomiting, but hiccough after food. Respiration slow; pulse rapid, with attacks of tachycardia. Commencement of pneumogastric compression.

October 12th. Temperature, 36·5°; pulse, 120; respiration, 14.

October 15th. A fit, which ceased abruptly on the discharge of a quantity of cerebro-spinal fluid.

October 16th. Appearance of a hernia cerebri, the size of a chestnut, filling the upper part of the operation wound.

October 17th. Return of occiptal pain.

October 20th. Increase of pain. Mind clear.

At the patient's desire he was placed on the night-stool, and at the first effort suddenly carried his hand to the left occipital region, cried out with pain, and fell dead. Bursting of the abscess and inundation of the medullary region.

No *post-mortem* examination was allowed. The author supposes the abscess to have been in the occipital lobe. *Waggett.*

# REVIEWS.

**Holmes.**—*Benjamin Brodie* (Masters of Medicine). By TIMOTHY HOLMES. Price 3s. 6d. T. Fisher Unwin, 11, Paternoster Buildings, London, E.C.

IT is, we trust, not needful to remind our readers that this is the fifth number of the series. The four already gone, or, rather, come, have left a craving for more, and we turn to this volume with high hopes.

We are sorry that we omitted to tell both our readers and thank the publisher that the last two issued had needed less paper-knife, this one none, for which we are grateful.

Brodie is another example of the eminence to which the Scotch have so frequently risen outside their native land as well as within, a fact amply exemplified by the earlier numbers of this series.

He, like his countryman Hunter, became attached to St. George's Hospital, and, like him, saw and determined to obviate, the inefficiency of the teaching as then carried out; his methods, and to what an extent he succeeded, we must leave the reader to find out for himself.

Brodie was admitted a F.R.S. in March, 1810, at the early age of twenty-seven, and, as Mr. Holmes most truly says, most of his after life becomes the history of his work at the Royal Society. His varied attainments, noble character, and great success are told in the clear and forcible style possessed in so marked a degree by the editor.

**The Journal of Tropical Medicine.** A Monthly Journal. 17s. per annum. Edited by J. CAULLIE and W. J. SIMPSON. Published by J. Bale, 83, Great Titchfield Street, London.

THIS journal will be welcomed by many, to give us an insight into the changes which occur in the blood in malaria and in quinine poisoning, and such like general topics, which have a direct bearing on otology.