

Theobald, S.—*Reflex Aural Neuroses from Eye-strain.* "Journ. Amer. Med. Assoc.," July 10, 1909.

The author has observed three distinct varieties of tinnitus due to eye-strain, the more usual or vascular type, the relatively low-pitched whirling or fluttering sound caused by irregular contractions of the tensor tympani, and the high-pitched, almost musical, intermittent tinkling produced by contractions of the stapedius. The evidence in favour of the ocular origin of the aural sensations mentioned is their disappearance after the relief of the eye-strain, their greater intensity when the eye-strain is most troublesome, or their appearance or aggravation by use of the eyes. The ocular fault most often present is astigmatism. The tinnitus is probably explained by vaso-motor disturbance of the intralabyrinthine vessels.
Macleod Yearsley.

MISCELLANEOUS.

Stepinski (Paris).—*Lactic Acid in the Treatment of Ozæna and Otorrhœa.* "Arch. Internat. de Laryngol., d'Otol., et de Rhinol.," July-August, 1910.

The author mentions several cases in which dry lactic acid ferment on gauze was used in his clinic with gratifying results in the above cases. He cleanses the parts of all scabs and other foreign material, and then makes daily application of the ferment.

He believes this treatment is applicable to several other conditions, such as sinus suppurations, pyorrhœa alveolaris, stomatitis, fœtid breath, etc.
Anthony McCall.

Hunt, J. Ramsay (New York).—*The Symptom-Complex of the Acute Posterior Poliomyelitis of the Genuiculate, Auditory, Glosso-pharyngeal and Pneumogastric Ganglia.* "The Archives of Internal Medicine," vol. v, June 15, 1910.

A study of the symptomatology, complications and various clinical combinations of acute posterior poliomyelitis (herpes zoster) of the peripheral root ganglia of the facial, auditory, glosso-pharyngeal and vagus nerves. The ganglionic structures concerned are the genuiculate of the seventh, the ganglion of Corti and the ganglion of Scarpa of the eighth, the ganglion petrosum (Andersch) and the ganglion of Ehrenritter of the ninth, the ganglion jugulari and the ganglion plexiforme of the tenth. All these structures originate from the neural ridge, in common with the posterior spinal ganglionic chain, and are, therefore, susceptible to the specific inflammatory reactions of herpes zoster (herpetic ganglionitis or posterior poliomyelitis).

The subject-matter is considered under the following general headings :

(1) Report of personal cases of herpes zoster oticus. Clinical abstracts of nine cases with herpes zoster oticus, in which the eruption was distributed in the genuiculate area in seven, and in the vagal zone in two. Facial palsy was present in six of the cases, and a unilateral paresis of the soft palate in two.

(2) The zoster zones of the genuiculate, glosso-pharyngeal and vagal ganglia on the external ear (herpes zoster oticus). An attempt is made to differentiate the zoster zones on the external ear by the herpes zoster method.

(3) The paralytic complications of herpes zoster oticus. These consist of facial palsy, auditory symptoms (deafness and Ménière's

syndrome), paresis of the soft palate and symptoms indicating irritation of the pneumogastric nerve.

(4) The zoster zones of the glosso-pharyngeal and vagal ganglia within the buccal cavity (herpes zoster pharyngis and herpes zoster laryngis).

(5) The complications of herpes zoster pharyngis and herpes zoster laryngis. Among these are facial and palatal palsies, auditory and pneumogastric symptoms.

(6) Herpes zoster of the tongue with facial palsy.

(7) Posterior poliomyelitis of the auditory ganglia. A consideration of the auditory symptoms complicating herpes zoster of the cephalic extremity, also of the posterior poliomyelitis of the auditory ganglia *without herpes zoster*.

(8) The paralytic complications of herpes zoster facialis and herpes zoster occipito-collaris.

(9) Concluding remarks.

From the evidence which has been presented I believe that we are justified in isolating a large and varied group of cases, characterised by herpes zoster of the cephalic extremity, associated with facial palsy, auditory, glosso-pharyngeal and pneumogastric symptoms, and in regarding them as constituting a well-defined clinical picture. A number of syndromes are thus united in a symptom-complex, having a common ætiology and pathology.

The neural complications may occur singly or in various combinations, depending on the degree of the infection and the localisation of the inflammatory process. Because of the tendency to invasion of more than one ganglion in cephalic zona neural complications may occur, even when the eruption is situated in the distribution of a ganglion situated above or below that causing the paralysis. In this event the nerve complication is caused by an inflammatory reaction in the ganglion of the affected nerve sufficient to cause a transient palsy, but not to produce an eruption.

The general symptoms may be very mild or they may reach a high degree of severity, in consequence of which a considerable variation in the clinical picture results.

The neural symptoms are often singularly transient in their duration, all trace disappearing within a few days or a fortnight. Not infrequently permanent structural changes take place with persistent disturbance of function.

As is well known, paralytic complications may occur in other parts of the body in zona, notably of the ocular nerves, but also in the distribution of the spinal nerves. These are comparatively rare, probably because the inflammatory lesions are limited by the capsule of the ganglion, and in order to reach the motor nerves of the eye in Gasserian involvement or the anterior root in that of the spinal ganglia the inflammation must first break through this fibrous wall or travel for some distance along the course of the sensory nerve. The capsule of the ganglion therefore forms a natural barrier and protection against the extension of the inflammatory process.

Anatomical conditions are different, however, in the ganglia under consideration. Here the fibres of the seventh, eighth, ninth and tenth nerves are in more immediate relation to the cell-structures of their respective ganglia and are not separated by an intervening fibrous wall.

For this reason very slight inflammatory reactions within these ganglia jeopardise their respective nerve-fibres. This intimate association of ganglionic structure and nerve-fibres would account, not only for those

cases with light and transient symptoms, but also for those of a more severe grade, with lasting impairment of function.

In my study of this group of cases I have encountered none in which a fatal issue could be attributed directly to the disease itself. It is well known that a unilateral lesion or section of the vagus is not necessarily dangerous to life; and as herpes zoster is usually unilateral pneumogastric involvement on one side would not be fatal. If, however, bilateral zona of the cephalic extremity should occur, involving the ganglia of the pneumogastric nerves on both sides, dangerous symptoms, or even a fatal termination, might result. It is perhaps significant in this connection to recall the wide-spread belief among the laity of the fatal tendency of bilateral shingles. Possibly we have here an explanation for a tradition which is common to all nations.

I would also emphasise the fact that in my study of this subject I have found no cases with facial, auditory, glosso-pharyngeal or pneumogastric nerve complications accompanying an eruption of herpes zoster, except when situated on the cephalic extremity of the body, *i. e.* herpes facialis, oticus, pharyngis, laryngis, lingualis, and occipito-collaris. That such neural complications do not accompany an eruption in the lower segments of the body is readily understood from the tendency of the posterior poliomyelitis to limit itself to a small series of ganglia, usually only one or two. In severe forms of infection, however, with extensive involvement of the cerebro-spinal chain or ganglia, there is no reason theoretically why cranial nerve-palsies may not occur.

It is my firm conviction that cases belonging to the group which I have just described are of much more frequent occurrence than might be inferred from the study of our literature, the reasons for which are to be found in the smallness and inaccessibility of the eruptive areas, making their detection difficult, or all traces of the eruption may have disappeared before the case comes under observation, when a retrospective diagnosis might be difficult or impossible.

It also seems probable that some cases which are interpreted as rheumatic palsies of the face, palate, and even the larynx, may belong to this group, as well as toxic unilateral palsies of obscure origin. This, I believe, is also true of unilateral affections of the auditory nerve.

Author's Abstract.

REVIEW.

A Practical Guide to the Newer Remedies. By J. M. FORTESCUE-BRICKDALE, M.A., M.D. Bristol: John Wright & Sons, Ltd. London: Simpkin, Marshall, Hamilton, Kent & Co., Ltd., 1910.

Dr. Fortescue-Brickdale's "Guide to the Newer Remedies," although intended chiefly for the general physician, contains much matter of interest to the specialist, as, for instance, the discussion of the various iodoform substitutes, the vaso-constrictors, the direct local anæsthetics, and the specific remedies for phthisis, as also for functional disorders. The index occupies six and a half double-column pages made up of little else than the names of these newer remedies, and it would be strange if any reader failed to find in this list some with which he was unacquainted.

Among the vaso-constrictors we note the pituitary extract, and among the hypnotics we see isopral, a remedy which will sometimes relieve otherwise intractable tinnitus, classified as among the most dangerous,