

destitute children have been saved from perishing in Bruxelles from want of food.

Delsaux had no national prejudices, and was welcome, and made himself welcome in every country he visited. Naturally enough, the affinity of language attracted him to France, where many of us have met him at the annual gatherings of the *Société Française d'Otolaryngologie*. Just before the war he was engaged, in collaboration with Lermoyez, of Paris, and Moure, of Bordeaux, in producing a monumental work on otology and laryngology. I do not know whether his part has been completed, but I hear that his heroic and strenuous character is proved by the fact that, even during the last year, although a prisoner in his own country, he had been able to complete an important "Traité de Laryngologie Pratique."

His affection for England, her ways, and her people is best proved by recalling that outside of Bruxelles, in the Valley of Epinette, on the borders of the lovely forest of Soignes and not very far from the historic field of Waterloo, he had built a country house, which was not only modelled on the style of the timbered cottages of England, but to it he had given the English name of "Firwood." Here the friends of all countries who visited Bruxelles, or attended its scientific gatherings, were always welcome. They were sure of charming hospitality either at Firwood or in the various restaurants which he knew so well in the neighbourhood of the Grande Place. Not that Delsaux was either a *gourmand* or *gourmet*, but he was what the Germans call a "Feinschmecker," and showed his taste in his entertainments as he did in his appreciation of literature, art, music, or travel.

Last winter he was stricken with appendicitis on January 25. He died on February 3, and was followed to his grave by a crowd of mourners on a day of freezing cold, and with the German flag flying over Brussels in a bitter wind.

He lies in the cemetery of Ixelles alongside of his wife, whom he lost in 1891, after a short two years of wedded life. For her memory he always retained a touching devotion.

It is heartrending to think that Belgium, brutally beaten down by "military necessity," should have lost in Delsaux such a gallant son. But it is not only Belgium, it is the science and humanity of the civilised world which share in this loss. Some of us will look forward sadly to visiting that cemetery at Ixelles, when the German flag no longer waves over Belgium.

STCLAIR THOMSON.

## Abstracts.

### LARYNX.

**Heart Failure during an Operation for the Removal of Tonsils and Adenoids; Heart Massage through an Abdominal Incision; Recovery.**—Mollinson, W. M. "Proceedings of Royal Society of Medicine, Section of Anæsthetics," December, 1916, p. 1.

The patient was a boy, aged six. A mixture of chloroform (two parts) and ether (three parts) was administered on an open mask; without any struggling the boy became unconscious, but the corneal reflex was never lost.

The left tonsil was removed successfully; while the right was being removed the boy struggled slightly. It was noted that he did not struggle while the adenoids were curetted, and he remained inert when cold water was poured over the face.

On examination the boy was found to be flaccid, respiration had ceased, the pupil was dilated, and the corneal reflex absent. Examination with a stethoscope revealed absence of heart sounds.

It was now decided to open the abdomen and massage the heart. With the left hand on the chest wall and the fingers of the right hand behind the heart pressure was exerted at about the rate of ninety times a minute; for some moments there was no response, then some respiratory movements began and continued intermittently; still there was no attempt at heart contractions.

Massage was maintained, and after about twenty more squeezes the heart suddenly began beating strongly.

From such time records as it was possible to keep, it is fairly certain that the time during which the heart was stopped cannot have been less than thirteen minutes and not more than twenty-four minutes. During part of this time, however, some slight circulation must have been going on because it was noticed that respiratory movements started while the heart was being massaged.

For seven days the boy was more or less unconscious; consciousness then gradually returned (with relapses). For ten days there was rigidity of the limbs, or choreic movements—at one time both feet and hands were held in the position of tetany. For four days he frequently cried out shrilly meningitic cry; for thirty-six hours the screaming was almost continuous. Shortly expressed he had symptoms of severe cerebral irritation, no doubt due to the damage done to the brain during the cessation of the circulation. He made eventually a perfect recovery.

*Archer Ryland.*

**Aphonics during the War: Our Treatment by Re-education.—G. Liébault and E. Coissard.** "Rev. de Laryngol., d'Otol., et de Rhinol.," February, 1917.

Most of the patients who lose their voices from neuropathic causes in the war have no disability of these muscles of the lips, tongue, or palate. But there exists another class of case where these muscles are affected by a functional paresis. In such patients the above muscles may display inco-ordinate and bizarre movements. And—a point to be emphasised in reviewing the authors' report—the movements of the diaphragm are jerky, and the thoracic expansion and capacity subnormal.

After these introductory remarks a schedule of exercises follows, such as protrusion and retraction of the tongue, pouting of the lips, and so on. The movements should be practised before a mirror. As soon as co-ordinated movements have been reacquired, the projection of the voice into the upper resonance cavities may be cultivated.

The authors next proceed to give striking curves, plotted on charts, of the results of treatment; these show a notable parallelism between the increase in respiratory expansion, thoracimetry, and voice-power. Moreover, any of their pupils who, having re-attained speech, subsequently lose it momentarily (without any inflammatory cause), show a simultaneous temporary reduction in respiratory capacity as obtained by thoracimetry. Any soldier who has remained aphonic for two weeks without signs of acute laryngitis, should at once be sent to a phonetic re-education establishment. At present they are found, on search, at

depôts, convalescent hospitals, and even temporarily discharged for "chronic laryngitis." (This last is not necessarily, as it might seem, a mistaken diagnosis. I have repeatedly noticed that men who can only whisper, through inability to adduct due to shell-shock, do, after about ten days, develop a subacute or even chronic laryngitis as the result of trying to speak aloud. These would justifiably be diagnosed as the authors suggest. Abstract.)

Among seven cases described *in extenso*, it is noteworthy that one patient, treated elsewhere for chronic laryngitis for several months, recovered, after orthophonic re-education, in a few weeks.

The authors submit that no case, however long neglected, is hopeless; but that *timely* treatment is the keynote of success.

This paper has an undoubted military value. *H. Lawson Whale.*

## NOSE.

### Non-operative Treatment of the Accessory Sinuses.—L. A. Coffin.

"Laryngoscope," 1915, December, p. 833.

Coffin states that he has ceased to think of the cure of disease of the accessory cavities whether operation is performed or not. He is satisfied he can arrest the trouble. He finds that most radical operations have been followed by recurrence, while a sinus once diseased seems more liable to reinfection. Coffin advocates the employment of negative pressure in conjunction with autogenous vaccines. After the vacuum has been produced he forces medicated air into the nose and accessory sinuses by means of a special apparatus attached to the vacuum instrument. The apparatus consists of a connecting tube ending in an olivary nozzle. To this connecting tube two bottles are attached (1) the vacuum bottle and (2) the medicating bottle. The physician can either apply suction by means of a vacuum pump and bottle (1), or he can shut off the vacuum and force in medicated air through bottle (2) by using a force pump. Coffin gives a history of five illustrative cases.

*J. S. Fraser.*

### Isolated Nasal Diphtheria.—J. D. Rolleston. "Brit. Journ. Child. Dis.," vol. xiv, p. 21.

An instructive and exhaustive paper, giving bibliography and then proceeding to fifty-five cases occurring at the Grove Hospital, Tooting, between 1902 and 1915. With the exception of two patients (aged twenty-six and fifty-one), the disease was confined to children of from five weeks to sixteen years, and preponderates during the cold months of the year. The author summarises thus: (1) Isolated nasal diphtheria, *i. e.* diphtheria originating in and confined to the nose, occurred in ninety-five out of 3000 cases of diphtheria (1.5 per cent.) admitted to hospital. (2) It is most frequent in young children and in the cold months of the year. Congenital syphilis is a predisposing cause. (3) The great majority of cases run a mild course, but rare examples of toxæmic diphtheria confined to the nose undoubtedly do occur. (4) The habitually mild course of isolated nasal diphtheria has been proved to be due to auto-immunisation. (5) Chronicity is a characteristic feature of isolated nasal diphtheria, the persistence of the bacilli being explained on anatomical grounds. (6) Sequelæ occasionally occur, but are rare. (7) Treatment by antitoxin is indicated (this is contrary to the declaration of StClair Thomson that antitoxin is useless in these cases).

Local treatment should be avoided (owing to risk of infecting the middle ear). (8) The term "fibrinous rhinitis" should be reserved for those comparatively rare cases in which this form of rhinitis is due to other causes than the diphtheria bacillus (such causes being staphylococcus, streptococcus, and pneumococcus). (9) The practical significance of isolated nasal diphtheria consists in its epidemiological importance.

*Macleod Yearsley.*

### ŒSOPHAGUS.

**Post-typhoid Ulceration and Stricture of the Œsophagus.**—R. K. Moorhead. "The Laryngoscope," December, 1915, p. 848.

Moorhead begins with a review of the literature. No case of typhoid ulceration with perforation of the œsophagus has so far been found at *post-mortem*. Most of the patients have first noticed difficulty in swallowing during convalescence though dysphagia during the disease itself may be produced by ulceration of the pharynx or larynx. Only seventeen cases of post-typhoid stricture are on record, and in only two of these was there a stricture in the upper part of the gullet. Moorhead's patient was a man, aged twenty, who suffered from a typical attack of typhoid in February, 1914. At the end of the fourth week he noticed difficulty in swallowing soft toast. By the middle of April he could take no solids whatever, and in June a radiogram showed a tight stricture at the level of the eighth dorsal vertebra with a large dilatation above. Direct examination showed a tight stricture which only admitted a probe with difficulty. In three weeks the stricture was dilated sufficiently to permit the introduction of a Lerche dilater, after which it rapidly expanded to normal size. Four months later he was able to swallow any kind of food, but occasionally noticed slight hesitation due to the fact that the dilated upper portion of the œsophagus had not got the ordinary propelling power. Moorhead gives short extracts of seventeen cases by other writers. In this series gastrostomy was performed upon six patients, while eight were dilated with bougies (one death). Three other patients died without either operation or dilatation. Practically all occurred before the days of œsophagoscopy.

*J. S. Fraser.*

### EAR.

**The Treatment of the Deafness in Chronic Catarrh of the Middle-Ear.**—Sophus Bentzen. "Nord. Tidskr. f. Oto. Rhino. Laryng.," Bd. 1, nos. 2, 3, and 4, p. 175.

The novelty recommended by the author is vibratory massage of the external meatus under negative atmospheric pressure, for which a special apparatus is required.

*Dan McKenzie.*

**The Labyrinth Operation.**—Edward B. Dench. "The Laryngoscope," August, 1915, p. 556.

Dench gives it as his opinion that during the past few years the labyrinth operation has been less frequently undertaken than formerly. From 1904 to 1915 the cases of acute purulent otitis media treated at the New York Eye and Ear Infirmary numbered 17,726, while the chronic cases numbered 18,859, and the acute catarrhal cases 9613, giving a total of 45,998. During this period 45 operations on the labyrinth were

performed, or less than one-tenth of 1 per cent. Dench's own records during the same period show 659 cases of acute and secondary mastoiditis, 533 of chronic middle-ear suppuration subjected to the radical operation, 23 cases of brain abscess, 39 of meningitis, and 37 of sinus thrombosis. From 1907 to the end of 1914 Dench has operated on 22 labyrinths, so that in all cases of middle-ear suppuration the labyrinth operation was performed in only 2 per cent. Of the 22 cases the labyrinth operation was partial in 10 and complete in 12. Of the former 7 were cured and 3 died (2 from meningitis), and of the latter 7 were cured and 5 died (in 2 of these meningitis was already present before operation). Dench believes that, given a dead labyrinth, in a case of acute suppurative otitis media, where no labyrinthine symptoms are present, *i. e.* no disturbance of equilibrium, no fever, and no signs of meningitis, it is unwise to do a complete labyrinth operation. Such patients should be carefully watched as regards temperature, vertigo, nystagmus, and headache. If these symptoms arise the complete labyrinth operation should be at once performed. In three of Dench's cases, where this plan was followed, the patients made a complete recovery. According to the statistics of the New York Eye and Ear Infirmary, labyrinthine involvement in acute or chronic middle-ear suppuration occurs even less frequently than brain abscess or meningitis. In none of Dench's cases of cerebellar abscess was this condition secondary to labyrinthitis, though many of his meningitis cases were due to labyrinthine involvement.

*J. S. Fraser.*

**Massage of the Eustachian Tube.—Andrew Lewy.** "Annals of Otolaryngology," xxv, 898.

The method is one described originally by Mink. A nasal applicator is curved to about the same degree as an Eustachian catheter, but a shorter segment of the curve is used. A number of different lengths of curve are necessary to fit septal deviations and various anatomical conditions. The cotton is wound so as to form a thick ball. The region of the tube-mouth is cocaineized and the cotton armed applicator is passed back to the posterior pharyngeal wall, swept upward in the fossa of Rosemüller, brought forward over the mouth of the tube and immediately downward and back under the mouth of the tube. The motion is repeated about twenty times. Several cases are reported, with the usual marked improvement, except to tinnitus. As usual, also, it is noteworthy that other methods (*as inflation*) are used in conjunction.

*Macleod Yearsley.*

**The Radical Mastoid Operation.—Thos. J. Harris.**—"Annals of Otolaryngology," xxv., 835.

From a review, historical and personal, of the radical mastoid operation, Harris concludes: (1) That it is an operation of undoubted merit. (2) That it has been in the past and is to-day being performed often when not called for. (3) That the results are by no means uniformly good, partial or complete failures occurring in a considerable percentage of cases. (4) That improvement in hearing cannot be promised. The most that can be offered is that the hearing will not be altered; but there is sufficient risk of lowering or destroying it to warrant reluctance or refusal to operate in case the hearing in the other ear is destroyed. (5) That while accidents are met with in the course of the operation they are not of sufficient frequency or significance to have any bearing on a decision in regard to operation.

*Macleod Yearsley.*

## MISCELLANEOUS.

**Anatomic Relations of the Cavernous Sinus to other Structures, with Consideration of Various Pathologic Processes by which it may become involved.**—Langworthy, H. G. "Annals of Otology, etc.," xxv, 554.

Presents a fairly clear picture of its subject and indexes the scattered data of pathological affections available in the literature of the past fifteen years.  
*Macleod Yearsley.*

**Epidemic Cerebro-spinal Meningitis. Craniotomy.**—Nils Arnoldson. "Nord. Tids. f. Oto-Rhino-Laryngologi," Bd. 1, nos. 2, 3, and 4, p. 149.

Two cases reported: (1) Man, aged twenty. Very acute case with loss of consciousness on the first day of the disease. The posterior cranial fossa was opened and the lateral cisterna at the angle of the pons drained. Six hours later consciousness was regained, but, in spite of free administration of "serum" both intra-cranially through the cranial wound and intra-spinally, the case ended fatally.

(2) Woman, aged twenty-eight. Illness lasted about a month. Lumbar puncture and intra-spinal injections of serum repeatedly performed. Craniotomy and drainage as above, but without any evacuation of fluid from the cisterna. Death.  
*Dan McKenzie.*

**Further Observations on the Relation of Autointoxications to Acute Membrane Disturbances.**—Sargent F. Snow. "Annals of Otology," xxv, 972.

The author has already written six papers on this important subject, and in the present (seventh) one draws conclusions from a twenty-five years' practice. He points out that his views are largely personal and not authoritative, but that they help to clarify the situation as to the fundamental principles involved in handling common colds and allied inflammations of the accessory sinuses, ear, mastoid, pharynx, and larynx. Whilst a balance is kept between the inhibitory intestinal juices of the upper bowel and the bacteria of the lower bowel, there is no need for common membrane congestions. Autointoxication means self-poisoning from bacteria originating within the body, which may be active ("bilious attacks") or passive. Overeating and constipation lead to these conditions. In such cases the author believes in calomel, 2 to 4 gr., in  $\frac{1}{4}$  gr. doses.  
*Macleod Yearsley.*

**Epidemic Meningitis: On the Presence of an Accessory Food Factor in the Nasal Secretion.**—C. Shearer. "Lancet," 1917, i, p. 59.

The author discusses the action of this accessory food factor on the growth of the meningococcus and other pathogenic bacteria. In this preliminary communication he concludes from experiment that there is in the nasal secretion some body which greatly accelerates the growth of the meningococcus on an artificial culture medium. Alone it is incapable of acting as a food or stimulant to the growth of this germ. It is soluble in water, less so in alcohol, and very insoluble in ether. It has great heat-resisting power, being able to resist prolonged boiling for many hours. It is not destroyed by boiling in the presence of strong hydrochloric acid for twelve hours. In addition to the meningococcus it also stimulates the growth of many other pathogenic germs.

*Macleod Yearsley.*