Mr. Frank Rose: I think there is severe laryngitis in this case, but the localised lesion on the left cord is, to my mind, highly suggestive of malignant disease. I should watch the lesion very closely, and if there is evidence of increase in size, I would recommend that the cord be removed.

The President: The case is very suspicious.

Abstracts.

PHARYNX.

Hemiplegia after Tonsillectomy.—William A. Scrutan. "The Laryngoscope," February, 1917, p. 96.

Scrutan records a case of a girl, aged eleven, on whom tonsillectomy was performed under general anæsthesia on July 10, 1915. A small portion of the tonsil was left at the lower end of the left fossa, but was removed later by means of the forceps and snare. Hemiplegia on the left side was noted on the following morning, and the patient was reasonably certain that the paralysis existed when she recovered from the anæsthetic. The temperature rose to 101·8° F. during the forty-eight hours following the operation, and the return to normal extended over a number of days. Recovery from the paralysis began within seventy-two hours in the leg, and shortly afterwards in the arm. In two weeks the child began to walk about the ward, and a month later left the hospital without assistance. Scrutan thinks that the hemiplegia was probably due to embolism. The operation was performed under his direction by a man seeking instruction, and lasted twenty-five minutes. The piece of gland left by the tonsillitome had to be fished for repeatedly so that there was considerable traumatism and an unusual amount of vigorous sponging in the fossa which may have caused dislodgment of a clot into the circulation. Six months after operation the leg seemed to have entirely recovered, but a condition of athetosis existed in the foot. The arm also recovered control of all movements, but the execution was slow and athetosis was observed in the hand. The face still showed paralysis at the angle of the mouth. *J. S. Fraser.*

Treatment of Adhesions of the Soft Palate by a Silver Plate Method.—Hazlehurst. "Laryngoscope," July, 1917, p. 574.

Hazlehurst states that tertiary syphilis is the most common cause of adhesions of the soft palate to the posterior wall of the pharynx. The condition is relatively frequent in the hereditary form of the disease. Rhinoscleroma, diphtheria, lupus, and pemphigus are rare causes of the condition. Traumatic adhesion may follow operation for adenoids. Complete adhesion is rare. The nasopharynx may be more or less filled with fibrous bands, which at operation are broken down or cut through with difficulty. The symptoms are largely those of nasal obstruction, and vary according to the extent of the lesion. Treatment is mainly directed, after loosening or cutting through the adhesions, towards preventing re-adhesion. Hazlehurst's technique is as follows: Ether anæsthesia through the peroral intubation tube; division of the adhesions, keeping as close to the posterior wall of the pharynx as possible; separation of adhesions in nasopharynx by means of instruments or the finger. A

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thin silver plate is trimmed with scissors to the required size, approximately 3 cm. square, the sharp corners rounded slightly. Into one of several small holes in the plate a silver wire is attached, and the loose end of the wire then fastened to a rubber catheter passed through the nose into the mouth. Traction was then made on the catheter, and, with the aid of a little manipulation from the pharyngeal side, the plate drawn snugly into the nasopharynx. The wire, holding the plate in position, is fastened to the cheek by adhesive plaster.

The plate was borne by the patient without removal for eighteen days with practically no discomfort. When removed the patient could breathe freely through the nasal passages. This patency still persisted three years later. The patient has, however, a nasal twang in his voice.

J. S. Fraser.

NOSE.

Asthma associated with Ethmoidal Disease.—J. Mackenzie Brown. "Annals of Otology," etc., xxvi, p. 399.

Reports observations on 27 asthmatic cases in which exenteration of the diseased ethmoid labyrinth was done. The ages of the patients ranged from four to sixty-two years. In 13 cases there was marked deviation of the septum. The antrum was involved in 3, the frontal sinus in 2, and the sphenoid in 2. The ethmoids were involved in every case, 22 being hypertrophic and 5 suppurative. Exenteration relieved 6 completely, decidedly improved 12, slightly improved 7, and 2 were unrelieved. Of the last 9, 6 had marked bronchial pathological lesions.

Macleod Yearsley.

Septal Hæmorrhage: Its Cure by Submucous Elevation.—J. Leshure. "Annals of Otology," etc., xxvi, p. 420.

The author finds that the object attained by incision and elevation of the mucoperichondrium is free surgical access to the bleeding area, and the rational treatment of a bleeding vessel is compression. This can be done *en masse* with a flat-bladed forceps. It is most satisfactory in septal hæmorrhage in children. The mucoperichondrium is incised and elevated backward for 1 in. and down to the floor of the nose, and the elevated membrane compressed with forceps. The flap is replaced and packed.

Macleod Yearsley.

Nasal Refracture.—L. L. Stanley. "The Laryngoscope," January, 1917, p. 49.

L. L. Stanley remarks that in almost any fistic encounter the nose is the most accessible point of attack. As a result it may be more or less injured. In some cases the blow is not sufficient to fracture the nasal process of the superior maxilla or the nasal bones, but there is force enough to dislocate the cartilage of the septum along with the mesethmoid and vomer, so that permanent nasal obstruction results. In other cases the bones are broken and the nose is deformed. If this condition is recognised soon after the accident and the fracture reduced, there may be no permanent deformity. Without attention, however, the result is disfigurement.

Stanley advises operation under ether anæsthesia. As soon as the

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patient is relaxed, the operator places against the convex side of the nose a round piece of wood, or buffer, 6 in. long and 1 in. in diameter. The end placed against the nose is heavily padded; then with several strokes to a mallet against this buffer, each stroke being progressively heavier, the nose is refractured and is quickly set in proper position. There is usually some ecchymosis following very soon, but by holding the nose firmly with the thumb and finger undue swelling is prevented.

As soon as the nose is in proper position, the nasal cavity is quickly packed with strips of gauze previously boiled in petrolatum. This is packed in rather tightly, and soon the bleeding from the nose is stopped.

When the intranasal packing is in place, pieces of gauze, cut to fit over the nose, cheeks, and forehead, are saturated with liquid collodion and are then placed over the nose in layers, each one being allowed to harden by means of a current of air which evaporates the ether before the next layer is applied. In a short time the splint is dry and the nose is held in normal position. On the second day the intranasal packing is removed, and on the fifth day the collodion gauze splint is taken off. The nose is usually found to be straight and to functionate better than before, though Stanley remarks that it may be necessary to do a subsequent submucous resection of the septum. After operation there is usually a "black eye," which persists for several days.

J. S. Fraser.

The Use of the Turbinals and the Septum in the Repair of Injuries and Defects of the Wall of the Nasal Cavity.—G. Seccombe Hett. "Lancet," December 15, 1917, p. 892.

The author has found the middle and inferior turbinals very useful for the repair of damage to the nose due to war injuries. His conclusions are as follows: (1) Turbinals and septum are capable of being advanced into new positions to form fresh attachments and continue to live. (2) Advancement of the turbinals is a useful procedure in cases of loss of the whole or part of the nose. (3) The upper septal swing is useful as an aid for supporting the new bridge of the nose. (4) The lower septal swing is often required in the pug-nose type. (5) The septal cartilage after removal by submucous resection may be used as a free autogenous graft for increasing the prominence of the sunken bridge or for a nasal support. Heterogeneous septal cartilage graft may be used in the same way.

Macleod Yearsley.

Nævus treated by X-rays.—E. P. Cumberbatch "Proceedings of the Royal Society of Medicine" (Section of Electro-therapeutics), January, 1918, p. 13.

The case is that of a girl, aged nineteen. At the age of five a nævus formed on her nose. Slight bleeding was occasionally noticed from the nose, but it was not profuse till she was aged fourteen. On examination, at this time, it was found that the nævus occupied the anterior cartilaginous part of the nose and vestibule, spreading to the cheek and upper lip on the right side. The nævus pulsated strongly.

The facial artery was tied, but severe hæmorrhage recurred later. The external carotid was then tied, but with no more success.

X-ray treatment was commenced in November, 1910. Hæmorrhage persisted at intervals until March, 1912, when the bleeding became less frequent and less severe. The X-ray treatment was left off in the summer of 1912.

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Towards the end of the same year the bleeding began to be more frequent and severe, and a second course of X-ray treatment was commenced. It had the same beneficial effect. It was discontinued in the summer of 1913. In 1914 there was a severe attack of bleeding, and the patient appeared to be quite blanched. It was found that it took place from an artery in the septum. The vessel was obliterated by means of diathermy. Since then there has been no hæmorrhage.

Archer Ryland.

EAR.

Is a Modified Radical, or Heath, Operation a Justifiable Procedure? —A. S. Kaufman. "Annals of Otology," xxvi, p. 543.

An attempt to reduce the Heath operation from a universal panacea for all oto-suppurative ills to its proper level.

The author concludes that it is a justifiable operation in (1) chronic mastoiditis when there is only partial destruction of the tympanic membrane and the ossicles are in position. (2) In cases of acute mastoiditis with an unusual amount of destruction of the tympanic membrane and loss of hearing. (3) In cases of acute mastoiditis with extensive necrosis of the bony portion of the external auditory canal. It should never be attempted where there are cholesteatomatous masses found in the antrum, which indicate the radical operation; and it should never be done until all non surgical methods, including vaccines, have been tried.

Macleod Yearsley.

Vertigo: Its Causes and Methods of Diagnosis.—Lewis Fisher. "Annals of Otology," xxvi, p. 511.

The author emphasises the following points:

(1) There can be no vertigo unless there is a disturbance of the vestibular apparatus. When diseases of remote organs are accompanied by vertigo, it is because those states affect the vestibular apparatus.

(2) Vertigo may be due to some simple irritation of the vestibular tracts. In such a case they are temporary and fleeting in character, leaving the apparatus itself intact, and the tests will therefore show normal responses.

(3) There may be a lesion of the internal ear itself.

(4) There may be a lesion situated within the brain along some pathway in association with the ear.

Disturbance of the vestibular apparatus with vertigo can be definitely analysed and diagnosed only by means of the ear tests.

Macleod Yearsley.

Experimental and Histological Researches on Labyrinthine "Commotion."—Prenant and A. Castex. "Rev. de Laryng., d'Otol., et de Rhinol.," September 15, 1917.

Rabbits and guinea-pigs were made deaf by explosions. In checking the clinical results, hearing was tested by whistles and the barking of dogs; vestibular function by Bárány's tests and galvanism. At autopsy the middle ear and brain were examined, and sections of the internal ear cut in paraffin wax. Thus the authors' investigations were very thorough, and their findings may be epitomised as follows: (1) Dislocation of supporting-cells and hair-cells of Corti's organ, chiefly in the

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basal coils of the cochlea. (2) Hæmorrhage into the scala tympani. (3) Shrivelling of the cells of the ganglion spirale. (4) Ascending degeneration of the cochlear nerve. (5) None of the above effects are produced if the cochlea be previously subjected to trauma. Finally, there is usually no macroscopic lesion produced in the middle ear or in the brain. Moreover, the cochlea appears to bear the brunt, leaving the vestibule unaffected. *H. Lawson Whale.*

MISCELLANEOUS.

The Nature and Symptoms of Cardiac Infection in Childhood.—F. J. Poynton. "Brit. Med. Journ.," March 2, 1918.

It is nearly twenty years since the writer and Dr. Paine isolated from the tonsils of a patient suffering from acute rheumatism and tonsillitis a strepto-diplococcus identical with that which they had already found in the blood, heart-valves, and joints of cases of rheumatism. The fact that rheumatic infection may enter the body by way of the tonsils was thus established.

There are, of course, other avenues of infection, and this must be borne in mind when considering the question of tonsillectomy in the treatment of rheumatism.

The important practical lesson is that "acute tonsillitis in a child should always call for a careful examination of the heart." There is no condition of the tonsils which may be described as "rheumatic." It is probable that the specific micrococci are present in the healthy tonsil, and only acquire their pathogenic qualities when the resistance is lowered. The organisms may also be present in adenoid vegetations, and the nasal mucosa itself may well be a portal of infection. Poynton is convinced that certain cases of acute otitis are of "rheumatic" origin. Enlarged cervical glands are common in rheumatic children and afford proof of the entrance of the infection into the system. *Douglas Guthrie.*

The Complement-fixation Test in the Diagnosis of Tuberculosis with a Study of 135 Cases.—G. W. McCaskey (Fort Wayne, Indiana). "Amer. Journ. Med. Sci.," November, 1917.

The early diagnosis of active tuberculosis is one of the most difficult and most important problems of clinical medicine. The subcutaneous tuberculin test, while absolutely prohibited by universal consent in a large group of cases, has in it an element of possible danger difficult to estimate because of the possible or even probable remoteness of effect.

Specific complement-binding bodies are present in the blood of patients suffering from tuberculosis. They are not constantly present even in clinically active cases, and may be present in cases which have no clinical manifestations. A positive result, however, proves the existence of a tubercular focus, which is, at least, pathologically active. Its clinical importance and its relationship to any co-existing syndrome can only be decided by correlating it with all available clinical data, precisely as in the case of a positive Wassermann reaction in an obscure case. A negative fixation test does not absolutely exclude clinically active tuberculosis any more than a single negative Wassermann reaction excludes clinically active syphilis.

With due regard to its obvious limitations, the tuberculosis complement-fixation test is a valuable addition to our diagnostic methods.

Thomas Guthrie.

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