the dry naso-pharynx was practically nil. The exact means by which the treatment takes effect is still a matter for conjecture. Possibly fœtid atrophic rhinitis is a tropho-neurosis which is benefited by the stimulating effect of the electrical current on the part; on the other hand, it may be that the formation of copper salts at the positive pole is the essential factor.

Whilst quite convinced of the relative value of this method of treatment, the author's own small experience leads him to be somewhat diffident of concluding that a permanent cure is to be expected in any but a minority of the cases; and a re-examination, after an interval of several months, of a number of patients who were all too prematurely considered to be cured, has impressed upon him that freedom from symptoms for one, two, or even three months does not insure that a patient shall be free from relapse. At the same time, the benefits of cupric electrolysis appear to be so far superior to those of other procedures that it may be looked upon as the best remedy that has yet been found; and although for the victims of "ozæna" it will not repair the shrunken turbinals or restore intact the sense of smell, it will, in a certain percentage of cases, so reduce, or even banish, the tendency to fœtid crust-formation that a state of wholesome comfort—the *ultima Thule* of these unfortunate sufferers—is safely reached. *StClair Thomson.*

PHARYNX AND BUCCAL CAVITY.

Lermoyez, M., and Gasne, G.—*Acute Gout of the Pharynx.* "Annales des Maladies de l'Oreille, du Larynx, etc.," No. 5, May, 1902.

The authors quote the following interesting case:

M. H——, forty-eight years of age, had acute articular rheumatism at the age of thirteen, had since travelled all over the world, and had had most of the indigenous fevers, also syphilis; during the last fifteen years he has been well, with the exception of neurasthenia.

On the night of May 5 he suddenly developed a swelling and redness on the left tonsil, soft palate, and posterior wall of the pharynx. Skin hot; temperature 101·5°; pulse 120; tongue swollen and covered with fur; urine scanty and dark coloured; swallowing difficult.

On May 8 a saline purge was given, which brought a slight temporary improvement of the pain in swallowing.

On May 10 the voice was nasal, and there was regurgitation of fluids through the nose. On the 11th Dr. Lermoyez was called in. There was no glandular enlargement, and peritonsillar abscess was diagnosed; no operation was permitted. On the 12th the condition was the same. On the 13th the swelling suddenly disappeared, without any fluid discharge, leaving only a general redness. The same night the patient complained of severe pain in his big toe, which developed into an attack of gout with all the classical symptoms. Soda salicylate and colchicum rapidly brought about a cure.

The authors point out the distinguishing symptoms of pharyngeal gout:

1. Sudden onset, acute evolution and sudden disappearance.
2. Sharp febrile symptoms, depression.
3. Very acute pain, out of proportion to local appearances.

4. Tendency of inflammation to diffuse over pharynx and spread towards larynx, ordinary quinsy being more localized.

5. Dark red and œdematous appearance of pillars of fauces, uvula elongated, and posterior wall of pharynx swollen.

6. Absence of exudation.

7. The glands at the angle of jaw not being involved.

When these symptoms are present in patients over middle age the authors suggest the early use of colchicum. *Anthony McCall.*

Pearson, S. V.—*The Acute Retro-pharyngeal Abscess of Infants.* "Lancet," October 26, 1901.

This is not a common complaint, but it is an important one, for an undiagnosed case most frequently ends fatally. Irving Snow,[1] who recently published three cases, makes a similar statement—viz., that retro-pharyngeal abscess unrecognised and untreated usually ends in death. And Blackader[2] says that the notable fact with which one is impressed on reviewing the literature is the frequency with which these cases remain undiagnosed or receive faulty diagnoses. Yet the diagnosis is not as a rule difficult. The disease is frequently overlooked because its occurrence is not thought of. When diagnosed the prognosis is fairly good. The common type of case presents the following picture: An infant under two years of age is brought, the complaint being that during the course of the last few days the child's voice has become gradually muffled, that there has been difficulty in sucking, or apparent pain on swallowing, that the child has been restless, has loss of appetite, and has been constitutionally ill. In addition to this it is remarkable how frequently these troubles have been preceded, or are actually accompanied, by a purulent nasal discharge. Very often at the time that the infant is first seen there is considerable obstruction to respiration, sometimes accompanied by much recession. Such a case may easily be mistaken for laryngeal diphtheria, especially when it is found that some glands in the neck are tender and enlarged, and upon examination of the throat the tonsils appear red and inflamed, and possibly covered with a mucoid secretion. But it will be observed that the voice is different from that in acute laryngitis, and there is not that characteristic croupy cough so often present with laryngitis. Also, on more careful examination it will be noticed that one side of the neck is fuller than the other, and when looking at the throat it may be noticed that one tonsil and the corresponding posterior pharyngeal wall may appear to be pushed slightly forwards. Too much stress cannot be laid upon the importance of making a digital examination in all cases where symptoms suggest such a condition. A very small amount of education is required in order to detect a small swelling, and the most inexperienced can diagnose a well-marked abscess in this region. The only difficulty which arises is the difficulty of making sure that the swelling has true fluctuation. In one of the author's cases the swelling was fairly big and quite elastic to the feel, but subsequent events proved that it did not contain pus. It is said to be very rare for the swelling to become at all large without suppuration having occurred, and this has been the author's experience.

It seems to be generally admitted now that the cause of the abscess is acute post-pharyngeal suppurative adenitis. If the constitutional symptoms are slight and the swelling is small an expectant line of

[1] *Archives of Pediatrics*, January, 1901. [2] *Ibid.*, 1889, p. 80.

treatment should be followed. Under these circumstances the swelling may soon disappear, any local condition, such as rhinitis, having been attended to and a mild purge given. In all other cases, however, operative measures are indicated. Except in the worst cases immediate operation is not necessary. Very often an infant will be in a much better condition for operation by waiting for a short time, during which the swelling can be re-examined to see whether there is any chance of its being non-suppurative and subsiding. The only danger associated with this postponement is the possibility of an increase in the dyspnœa. Infants are liable to a sudden increase of any obstructive dyspnœa, and probably this is due to some spasm added to the primary cause. The actual operation in the case of opening the abscess externally is often quite easy, and is generally not very difficult. Moreover, the after-treatment of cases treated by the external method is entirely satisfactory.

The position of the incision should be immediately behind, and parallel to, the sterno-mastoid; its centre should be as nearly as possible on the same level as the centre of the swelling behind the pharynx, or a little below this. Towards the bottom of the wound the spinal accessory nerve must be avoided. Having used a knife to cut through skin and fascia, the posterior edge of the sterno-mastoid being carefully exposed and the muscle pulled slightly forwards, the knife should be abandoned in favour of a blunt dissector and a pair of dissecting forceps. By the time this stage of the operation has been reached it may have been necessary to remove one or two slightly enlarged glands situated behind the sterno-mastoid. From this time onward the operation consists in a careful separation of the structures until the prevertebral region is reached. The landmarks are the transverse processes and the plane of the anterior surface of the vertebral bodies. Keep well back, feel with the finger for these landmarks, and there will then be no danger of injuring the jugular vein or cervical sympathetic, the only two structures likely to be interfered with. The patient should never be at all deeply under. Then matters are much facilitated by introducing one finger into the mouth and a finger of the other hand into the wound. By this means the exact limits of the abscess-cavity can be made out. Then a fairly fine-pointed blunt dissector, or similar instrument, can be passed along the front of the finger in the wound and the abscess-sac pierced. The pus flows out readily when the opening is made larger by means of a pair of sinus forceps guided into the cavity by the instrument already introduced. Irrigate the cavity once or twice with some antiseptic solution. Then a very small drainage-tube should be introduced right to the greatest depth of the wound, and perhaps a small strip of gauze around this superficially. One or two stitches are then put in to bring the edges together above and below the tube, and an ordinary antiseptic dressing is applied. With regard to after-treatment, there is nothing very much of importance. It is best to leave the small drainage-tube in for about forty-eight hours or three days, to irrigate the wound by gently syringing it with 1 in 4,000 perchloride or biniodide solution for the first few days, and after that with a weak solution of iodide. It is best to dress it twice within the first twenty-four hours of the operation, but after that once daily is sufficient. After the tube has been removed a very thin plug of gauze should be introduced, and every other day slightly shortened. Some discretion is required in carrying out this detail; the point is to strike a mean result between getting a

reaccumulation of pus and a long-lasting callous sinus. Some indication as to the rate of healing of the sinus is given by stating that in about three weeks from the time of the operation the wound should be healed. *StClair Thomson.*

Pick (Vienna).—*Chorea Pharyngis.* "Monatschrift für Ohrenheilkunde," April, 1902. (Case from Practice.)

A delicate, neurasthenic joiner, aged forty, complained of dryness of the throat and intolerable cracking noises in the ears, like the ticking of a loud watch. The sound was audible through the otoscope, and was due to contractions of the pharyngeal muscles which could be plainly seen through the wasted nasal passages. The soft palate rose and moved backwards, the lateral bands stood out, and the tubal swellings moved about 2 centimetres towards the middle line. There were crusts in the nose, formed by the dried secretions from a deeply-furrowed mass of adenoids—the so-called Tornwaldt's disease. The muscular contractions were no doubt in the first instance voluntary—hawking to dislodge troublesome crusts—and afterwards passed beyond the control of the will. Removal of the adenoids, attention to the state of the mucous membrane, and tonics produced a rapid cure.
William Lamb.

LARYNX AND TRACHEA.

Bronner, Adolph.—*A Case of nearly fatal Intra-laryngeal Hæmorrhage from Papillomata of the Larynx.* "Lancet," April 26, 1902.

Cases of dangerous hæmorrhage from laryngeal papillomata are extremely rare. The notes of the following case may therefore be of some interest:

A strong, healthy man, aged forty-eight years, was seen in June, 1896. He had been hoarse off and on for nearly two years, and was getting worse. There were a large number of papillomata growing from the vocal cords (edges and upper surface) and the ventricular bands. These were removed at intervals of from two to three months. On December 18, 1897, the patient was running to catch a train when he began to cough and to feel choky and had to walk slowly. He spat up small quantities of bright blood. In the train he gradually became worse, the cough was more violent, and he was continually spitting up small lumps of blood, and he felt as if he were going to suffocate. When he arrived at Bradford, twenty minutes after entering the train, he had to be lifted out of the carriage, and was unconscious for from fifteen to twenty minutes. During this time he was violently shaken and brandy was poured down his throat. He coughed up lumps and threads of coagulated blood and froth. He gradually came round, and was taken to a private hospital. He was then breathing rapidly and perspiring freely, and was coughing up frothy mucus and small lumps and threads of coagulated blood; some of the latter were ramified and evidently came from the smaller bronchi. The pulse was 125. There was slight dulness of the base of the left lung and numerous rales and sonorous rhonchi were heard over the bases of both lungs. The upper parts of the lungs were normal. The symptoms gradually cleared up in two days. There were not, and never had been, any symptoms of tuberculosis of the lungs. He said that both lungs felt heavy, especially the left, as though a large piece of lead were pressing on them. For the next