Abstracts.

MOUTH, FAUCES, Etc.

Fontoynont and **Jourdran**.—*Streptococcal Glossitis and Stomatitis in Madagascar.* "La Presse Méd.," September 16, 1903.

This affection begins on the tongue and may be confined to the tongue, but frequently spreads on to the cheeks and lips. The lesion commences as a series of little red plaques about the size of a pinhead. Each plaque enlarges concentrically till it meets and fuses with its neighbours. Thus large plaques are formed. They are red, smooth, varnished in appearance owing to loss of epithelium, the edges are pale, somewhat raised, and polycyclic in outline, whilst the rest of the tongue is covered with a whitish fur. The condition may spread till the whole surface of the tongue is affected.

The submaxillary glands are always more or less swollen; fever is slight or absent. If left untreated the condition gets well of itself, leaving no trace of its occurrence. It appears to be endemic in Tananarivo amongst the natives. Europeans are liable to be attacked, and at certain seasons of the year little epidemics break out. A streptococcus in long chains and in pure culture is always found in scrapings from the affected parts. *Arthur J. Hutchison.*

NOSE, NASO-PHARYNX, AND ACCESSORY SINUSES.

Dieu.—*Tertiary Lesions in the Naso-pharynx.* "Revue Hebdomad. de Laryng.," etc., September 19, 1903.

Gummata in the naso-pharynx may be divided into two classes: (1) Those beginning in the deep tissues—periosteum, etc. (2) Those beginning in the mucosa. The latter class only is dealt with in this paper. The symptoms are often so slight and so vague that no attention is paid to the condition till it is far advanced. Some obstruction to nasal respiration, frequent desire to clear the throat, and slight, vague pain about the throat or in the back of the head, may be the only symptoms present. When the condition is more marked, the four principal symptoms are nasal obstruction, more or less deafness, which is generally unilateral, dysphagia, and headache with nocturnal exacerbations. The intensity of each symptom will vary greatly with the position of the gumma and the amount of ulceration.

Diagnosis is made by aid of the post-rhinoscopic mirror.

Before the stage of ulceration is reached a gumma of the naso-pharynx has to be differentiated from naso-pharyngeal fibroma, sarcoma, tuberculous abscess, cysts of the vault of the cavum, and acute "adenoiditis."

Fibroma and sarcoma both occur generally at an early age, when tertiary syphilis is rare. The former is often extremely hard and bleeds readily. The latter bleeds readily and grows very quickly. Neither sarcoma nor gumma give rise to adenopathy in the neck—at least, in their earlier stages. Often the diagnosis can be settled only by antisyphilitic treatment. Tuberculous abscess is generally easily dis-

tinguished by the pallor of the mucous membrane surrounding it. A cyst can be diagnosed at once by palpation. As for acute adenoiditis, it occurs only in infancy; sets in with fever; the pharyngeal tonsil is red and covered with muco-pus.

In the ulcerative stage a gumma may resemble cancer, lupus, ulcerative tuberculosis, and ulcerative "adenoiditis." The epitheliomatous ulcer is more irregular; the underlying tissue is much harder than in gumma; it gives rise to ichorous, fœtid discharge, and, lastly, causes glandular swellings. A piece of tissue can always be taken for microscopic examination. A lupous ulcer is always surrounded by pale anæmic mucous membrane, and one can always find other lupous lesions in the nasal fossæ or elsewhere. Tuberculous ulceration is always accompanied by submaxillary glandular swelling. The ulceration commences as discrete small erosions which become confluent. The mucous membrane around the ulcer appears "moth-eaten." Pain on deglutition is very marked. The diagnosis can be made certain by inoculation experiments. Simple ulcerative adenoiditis presents characters similar to those of simple ulcerative tonsillitis. The onset is gradual, without fever, without involvement of glands, the edges of the ulcer are slightly swollen, punched out, with rounded outlines, whilst the surrounding area is normal in appearance. Treatment of naso-pharyngeal gumma, if begun early, is successful, but to be successful must be begun early.

Arthur J. Hutchison.

Hurd, L. M.—*A Case of Paraffin Injection into the Nose followed immediately by Blindness from Embolism of the Central Artery of the Retina.* "Med. Record," July 11, 1903.

In this case the patient had paraffin injected upon three separate occasions. Upon the third occasion a mixture of paraffin and white vaseline having a melting-point of 110° F. was injected, the injection being made from below upwards. At the moment of injection the patient was observed to rub his right eye, and in reply to a question stated that he could not see. A little later ecchymosis appeared about the tip of the nose, indicating that a vein had been punctured. Twenty-five minutes after the injection the eye was examined, and it was found that the main inferior branch of the central artery of the retina was empty and collapsed. Digitalis was at once administered, and later on inhalations of nitrite of amyl were tried. Massage of the eyeball was also tried, with the idea of driving the embolus back into the circulation. No improvement in vision, however, followed.

W. Milligan.

LARYNX AND TRACHEA.

Dupond.—*A Case of Tracheal Ozæna, causing Dyspnœa.* "Revue Hebdomad. de Laryng.," etc., September 26, 1903.

A negro, a sailor, twenty-six years old, had suffered since childhood from ozæna. During a voyage to Bordeaux he fell into the sea, soon afterwards grew hoarse, and had several suffocative attacks. When brought to hospital respiration was noisy, and accompanied by inspiratory retraction. The left cord was fixed in the middle line, but the right moved to a slight extent. The nose and naso-pharynx contained thick green stinking crust, and the inferior and middle