incision made here three quarters of an inch deep. With the help of the fingers of the left hand in the sulcus between the middle and lower lobes, a finger in the incision felt the pin, which was easily extracted by sinus forceps. A little foul pus followed it out of the wound in the lung. There was very little hæmorrhage. A small drainage-tube was inserted down to the incision in the lung. Morphia gr. $\frac{1}{6}$ was administered. The pin was one and a half inches long, with a glass head one eighth of an inch in diameter. The child was very restless for a few days (temp. 101°–102°, pulse 150–160, respirations 44–50), and began to improve on the seventh. Now the chest moves well, there is no scoliosis, and air enters the greater part of the lung. *Raymond Verel.*

NOSE.

Whale, Harold.—Spasmodic Rhinorrhœa cured by Irrigation of the Maxillary Antra, which were infected by B. Coli. "Lancet," October 12, 1912, p. 1012.

A healthy athlete of twenty-five "Hay fever" four years. Both antra dark to transillumination. Both were tapped, and pus found, yielding a pure culture of *B. coli*. An autogenous vaccine was made. Cure was remarkably rapid. *Macleod Yearsley.*

Sluder, G.—Vacuum Nasal Headaches with Ocular Symptoms only. "Annals of Otol., Rhinol., and Laryngol.," xxi, p. 160.

Refers to a class of nasal headache due to closing of the frontal sinuses or of the anterior ethmoidal labyrinth. The eye disturbance is of the nature of asthenopia. Headache is usually frontal, growing worse on using the eyes. Nasal symptoms are usually absent, but the nasal origin is revealed by tenderness of the upper inner angle of the orbit at the point of attachment of the pulley of the superior oblique and internal and posterior to it. Sluder details six ways in which the frontal sinus may become closed: (1) Enlargement of the tubercle of the septum; (2) lapping down of the middle turbinate; (3) hypertrophy of the middle turbinate; (4) œdema of soft tissues of vault of middle meatus; (5) in normal noses by bony narrowing, the uncinate process and bulla being in contact; (6) empyemas or coryzas which have got well but left some swelling. As regards treatment, applications of such astringents as 2 per cent. silver nitrate are often sufficient, but operation, according to the condition found, is sometimes required. *Macleod Yearsley.*

Wishart, D. J. Gibb.—The Relation of Accessory Sinus Disease to General Medicine. "The Canadian Practitioner," March, 1912.

This paper, which indicates much care in preparation, and contains a *résumé* of the author's personal experience in observation of diseases of the sinuses, covers a wide field. Mention is made of the facts that Ziem, only a quarter of a century ago, opened up the subject of the sinuses for observation; that Morell Mackenzie, in his work of 1882, does not mention the subject at all; that Hyrtl the same year stated that the sphenoidal sinus was outside the field of observation; and that in 1885 Schoffer was the first surgeon to operate on the sphenoidal sinus upon the living subject.

In dealing with the minute anatomy of the sinuses the writer dwells particularly upon the importance of the venous and lymphatic drainage as indicating the possible direction of absorption processes. He also

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refers to the peculiarities of formation of the sinuses. In 10 per cent. of maxillary sinuses there is an accessory ostium below the uncinate process and behind the common ostium. Also large anterior ethmoidal cells may occupy the place of the frontal sinus, and when present they may interfere with the fronto-nasal duct.

The interesting relationship of the sphenoidal sinus to the olfactory, optic and spheno-palatine nerves and the reflex infra-orbital neuralgia which is often associated with sphenoidal sinusitis do not escape the author's attention.

The paper is intended to deal with suppurative diseases of the sinuses only, and closes with a *resumé* of forty-three cases which have passed under the writer's observation in private practice. Of these, eight are noted as frontal, nine as maxillary, twelve as ethmoidal, one as sphenoidal, and the remaining thirteen as a combination of diseased conditions in two or more of the sinuses.

The last case, No. 43, the writer makes a special note upon. The patient, male, aged twenty-nine, had suffered for years from terrible headaches in both frontal regions. During this period his physician had frequently given him injections of morphine when the pain became unbearable. The attacks were intermittent, formerly every four or six weeks, latterly two or three times a week, lasting for many hours until relieved by natural or acquired sleep.

The nasal discharge was thick and yellow, but free from odour. There was very slight optical defect. When first examined by the writer there was no discharge, and the nose was remarkably free from obstruction. The right middle turbinal was rather close to the septum and slightly coated. Transillumination showed right antrum and frontal sinus darker than the left. On washing, a teaspoonful of odourless pus was washed from right antrum, but none from the left or from the frontal sinus. Several days later patient had a burst of blood and pus from his nose. On washing antrum again no pus was obtained. While discharge was free the headache was relieved, but pain returned on cessation of the flow.

It was then decided to remove the entire middle turbinal and some of the posterior ethmoid cells. A week later the patient felt much better. A further curetting was done, but no pus found. This time the cure of the headache was complete. *Price-Brown.*

EAR.

Frey, Hugo.—The Auditory Apparatus in relation to Syphilis and Anti-syphilitic Therapy. "Die Heilkunde," Jahrg. 1911, No. 11.

Primary sores in relation to the ear are not so rare as might be imagined. That most commonly met with is in the neighbourhood of the pharyngeal orifice of the Eustachian tube, the virus having been transmitted by an infected catheter. Though macules and papules may occasionally be observed in the external auditory meatus or on the membrana tympani, secondary syphilitic manifestations in the ear are usually of a catarrhal nature and secondary to a specific lesion in the nose or naso-pharynx. The same applies to tertiary lesions in these regions. Early treatment will prevent such sequelæ. Syphilitic affections of the inner ear may be either labyrinthine or retro-labyrinthine, and may manifest themselves at an early or late period of the disease. The accompanying symptoms and a functional examination of the internal ear will indicate whether the vestibular or cochlear branch of the nerve

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