writings on this subject with the authors' own views thereon, and an account of a case of this character which came under his immediate treatment.

A man of thirty-one was sent to Halasz by his own medical attendant, as he was unable to breathe through his nose, and the eye was swollen.

The patient stated that seven months previously he had noticed some impairment in the vision of the right eye, which, however, at first he had been able to correct with the use of glasses. Once in sneezing he had noticed a bloody discharge from the right nostril, since when that side had always been stopped. Soon after this he commenced to have recurrent attacks of headache, and it seemed to him also that the right eye stood out further than the left. For some months the eye at times had been completely blind, and at times it seemed to him that it was only veiled, so to speak. He had had a purulent discharge from the right nostril for the last month, and the headache, which was chiefly occipital, became unbearable. On the 7th of April the right eye suddenly became much more swollen, since when he had had no idea of vision on that side, and the eyelids were distended with extravasated blood.

On examination a red, slightly movable swelling was found filling the right nostril from the anterior end of the middle turbinal and extending backwards so as to be visible by posterior rhinoscopy, though it did not invade the post-nasal space. The left nostril was not involved. A small piece of this growth about the size of a nut was removed through the anterior nares with a cold snare, any further removal being prohibited at this sitting on account of the excessive hæmorrhage. On the next day under cocaine and adrenalin the remainder of the swelling was removed, together with the whole middle turbinal, in order to determine the origin of the growth. An abnormally large ostium of the sphenoidal sinus then became at once apparent, with issuing from it another portion of the growth. The sinus was thoroughly exposed and curetted, and when cleared active pulsation was visible through the large opening formed by the operation.

In spite of the cocaine, the patient suffered considerable pain during this procedure, which he referred to the suboccipital region, and described as if something were being twisted round in his brain.

The convalescence was uneventful, and four weeks after the operation the swelling of the lids and palpebral suffusion had subsided, and the pain in the head and neck ceased, but the sight had not yet returned. The optic neuritis which was present before the operation was not now visible.

Pressure by the tumour on the ophthalmic vein is the explanation given for this condition. No subsequent history is noted. On examination the growth was found to consist of a round-celled sarcoma.

Alex. R. Tweedie.

LARYNX.

Fränkel (Berlin).—*Diseases of the Upper Air-passages in Typhoid Fever.* "Münch. med. Woch.," January 25, 1910, p. 215.

In the eighties Professor Fränkel had great opportunity of observing cases of typhoid in which there were laryngeal complications. The part most frequently affected was the epiglottis, especially its margins, and in the second place the vocal processes or the arytænoid cartilages. In the latter position there was necrosis of the mucous membrane, the disease

extending to the perichondrium, and leading to a perichondritis with frequently an exfoliation of the cartilage. The writer is of the opinion that typhoid perichondritis, if it occurs apart from an affection of the mucous membrane over it, is extremely rare. With the occurrence of the necrosis in the epiglottis there is sometimes a very considerable degree of œdema. Professor Fränkel has formerly had opportunities of observing the conditions arising in the course of the "week" of the disease with the formation of false membranes, and has been able to convince himself that they are diphtheritic in nature and due to the genuine Loeffler bacillus. He considers those cases in which the vocal processes or arytænoid cartilages undergo exfoliation as particularly dangerous. The continuous wearing of a tracheal cannula is often necessary in these cases, but in a large number of them death ensues from the extreme severity of the typhoid fever. *Dundas Grant.*

EAR.

F. R. Packard.—*The Importance of the Thorough Study of the Naso-pharynx in the Treatment of Diseases of the Ear.* "Laryngoscope," xix, 576.

A good practical paper. The conditions found are classified thus:—1. Adenoids. 2 "Catarrhal affections" (mostly due to nasal conditions). 3. Atrophic, with crusts. 4. Tumours. 5, Adhesions. The treatment advocated for adhesions is—cleansing the naso-pharynx, breaking down with the finger, and the application of solutions of silver nitrate, or of albuminate of silver, to the torn surfaces. *Macleod Yearsley.*

Fallas, A. (Brussels).—*Mastoiditis and Retro-pharyngeal Abscess.* "La Presse Oto-laryngologique Belge," February, 1909.

Besides narrating a case of his own, the author gives abstracts of twenty-six other cases collected from medical literature. In discussing the anatomy of the post-pharyngeal region, attention is directed to the lymphatic glands of the part, which form a chain on either side of the median raphé (Most).

The possible channels of infection are various. In a case noted by Kessel the pus from the ear passed through the tegmen tympani, into the middle cranial fossa, and thence through the foramen ovale, and the foramen rotundum to the back of the pharynx. In a case recorded by Knapp the pus travelled down the canal of the tensor tympani into the cellular tissue round the Eustachian tube, and so on.

A lateral pharyngeal abscess may break through the natural barriers and so reach the retro-pharyngeal space.

Another mode of infection is by extension of caries to the basilar process or the cervical vertebræ, either from abnormally developed mastoid cells or by extension from the apex of the petrous bone. Lastly, there is a possibility, the author thinks, of a metastatic retro-pharyngeal abscess in the course of otitic pyæmia.

Retro-pharyngeal infection may follow chronic, as well as acute, otitis media. Other etiological factors are retention of pus, exacerbation of the virulence of the microbes, a debilitated state of the patient, and particularly tubercular infection.

In discussing treatment, the author prefers to incise the abscess