Next the mucous covering of the nasal septum is stripped off each side, still working in the same direction, and the bony septum itself eventually resected, bringing the anterior and inferior aspects of the body of the sphenoid bone into full view, which structure then can be easily removed and the roof of the sphenoidal sinuses dealt with as required. The whole operation, says the author, is no more than a submucous nasal resection, except that the approach is *viâ* the mouth, and theoretically could be performed under cocaine and adrenalin, but that it is irksome for the patient to hold the mouth open so long, and with a general anæsthetic it can be opened further. Löwe acknowledges that this procedure is based on the methods of Gussenbauer, König and Hirsch. The buccal wound is subsequently closed with sutures.

(*b*) *Exposure of the Naso-pharynx.*—A short allusion to other methods having been given the author describes his procedure as follows: A transverse incision is made dividing the soft from the hard palate. This in itself may be found sufficient, but if more room is still required an incision is carried though the mucous and periosteal covering of the hard palate on each side, a rectangular flap thus elevated from behind forwards, and the underlying bone removed so that the mucous membrane of the nasal floor is exposed. This latter is then divided as may be necessary and the naso-pharynx thus reached. The bone removed is in a short time reformed.

A section devoted to the topographical anatomy of the pharynx concludes the article. *Alex. R. Tweedie.*

**Baril, G.—Anatomical Study on Regional Anæsthesia of the Superior Maxillary Nerve.** "Rev. Hebdom. de Laryngol., d'Otol., et de Rhinol.," September 2, 1911.

Dr. Baril is of opinion that for operations on the maxillary antrum satisfactory regional anæsthesia may be obtained by the injection of a weak anæsthetic solution *viâ* the posterior palatine canal into the region of Meckel's ganglion and the superior maxillary nerve in the pterygo-maxillary fossa. The buccal orifice of this canal is situated at the base of the third molar tooth. Its line of direction continued forward crosses the neck of the second molar tooth; continued backward it passes through the foramen rotundum at a distance of four and a half centimetres from the neck of the second molar tooth. The technique suggested is as follows: The mouth is opened wide. A platinum needle, not more than five centimetres in length, is introduced into the gum on the inner side of the neck of the second molar tooth. The body of the syringe rests on the lower lip. The needle is pushed on for about one centimetre till its point is opposite the base of the third molar tooth. It now engages the mouth of the posterior palatine canal, along which it is carried for a distance of four and a half centimetres from the point of insertion.

Dr. Baril has carried out this procedure frequently on the cadaver, and considers that it would be of practical use. He has tried the method in one case (radical cure), and was successful in obtaining satisfactory anæsthesia. *John M. Darling.*

## PHARYNX.

**Fraser, J. S.—The Faucial Tonsils, with Special Reference to their Removal by Enucleation.** "Edin. Med. Journ.," July, 1911.

In this paper the author gives a clear account, made all the clearer by some excellent illustrations, of the anatomy of the tonsil and its relations

to adjacent structures, briefly discusses the physiology and the common affections of the tonsil, the indications and contra-indications for operation, and the various operations that are or have been employed. He then gives a full and very lucid description of the operation of enucleation of the tonsil. In adults he prefers operating under local anæsthesia, first spraying the throat with 10 per cent. solution of cocaine, then injecting a very weak solution of cocaine, to which a few drops of adrenalin have been added. The important point in making this injection is to get the solution under the mucous membrane only, but not into the tonsil tissue. If a general anæsthetic has to be used he prefers chloroform, and has the patient's head hanging over the end of the table. If the patient begins to "come to" the operation is stopped, the patient turned almost face downward, and the anæsthetic again administered. (This seems to be a very clumsy procedure. If a tongue-depressor, with a tube for the purpose along its upper surface, is attached to a Junker's inhaler and the chloroform administered through it, the operation need very rarely be interrupted to get the patient under again, and an assistant can be dispensed with also). In 120 cases of enucleation Fraser has had no post-operative sepsis, and only two cases of moderately severe hæmorrhage, both of which were controlled by local pressure with a sponge wrung out of turpentine.

*Arthur J. Hutchison.*

**Levinstein, O. (Berlin).—On the Treatment of Chronic Tonsillitis and Habitual Angina, with especial Reference to the use of the Galvano-cautery.** "Archiv. f. Laryngol.," vol. xxiv, Part II.

A discussion of the physiological function of the tonsils and of the *rôle* played by them in the causation of a large variety of diseases, including pulmonary tuberculosis, appendicitis and nephritis, leads the writer to the conclusion that so long as it has not been proved that the tonsils are without value to the organism the ideal treatment for chronic tonsillitis must be that which brings about permanent cure with the least possible injury to the organ. In mouth-breathers the tonsils are especially exposed to infection by micro-organisms, so that something may be done in these cases by establishing free nasal respiration. Another important measure, and one which is in some cases alone sufficient to put an end to the trouble, is division of the plica triangularis. Of the numerous methods employed for dealing especially with tonsils which, though not enlarged, are diseased and subject to repeated inflammatory attacks, the writer prefers obliteration of the diseased crypts by means of the galvano-cautery point. In carrying out this treatment his aim is to destroy only those crypts in which the presence of a plug indicates a condition of chronic inflammation. In a considerable number of cases, which suffered from almost regularly repeated attacks of acute follicular tonsillitis, he was able to bring about a cure by treatment at one sitting; in some several repetitions were required; in no case had the method failed.

*Thomas Guthrie.*

**Prowse, S. W.—Fatal Case of Quinsy in an Adult.** "Laryngoscope," February, 1911, p. 105.

The case described was a male, aged thirty-eight, His throat had been sore for four days, and he then took a fourteen-hour train journey to his home, but died while leaving the station in a cab. At the *post-mortem* a large double quinsy was found with œdema of the glottis, which had given rise to asphyxia. Neither abscess had burst.

*John Wright.*

**Cline, L. C., M.D.—A Case of Sarcoma of the Tonsil in a young Child.** "Laryngoscope," March, 1911, p. 153.

The patient was a boy, aged twenty-two months. Two months previously he had an abscess of the left tonsil, which ruptured spontaneously. The child now suffered from dyspnœa on lying down and presented a soft, nodular, friable growth from the left tonsil filling the pharynx. The glands at the angle of the jaw were enlarged. A section showed the typical structure of lympho-sarcoma. Urgent dyspnœa was relieved with but slight hæmorrhage by local removal, death occurring two weeks later. *John Wright.*

**Richardson, M. H.—Remarks on a Forbidding Case of Cancer, involving Tongue, Tonsil and Pharynx, permanently Cured by Radical Excision.** "Boston Med. and Surg. Journ.," June 29, 1911, p. 920.

Man, aged sixty-one. The whole growth, together with a chain of glands from the angle of the jaw to the stenio-clavicular joint, was removed through a curved incision, convex downwards, from the mastoid process to the symphysis of the jaw, a second incision passing down from the centre of the first nearly to the sternum. The operation was performed December 12, 1905, and pathological examination showed it to be epithelioma. Patient still alive and healthy, examination on February 11, 1911, showing no recurrence. *Macleod Yearsley.*

**Love, A.—Diphtheritic Paralysis.** "Glasgow Medical Journal," October, 1911.

Paralysis following diphtheria has become rare since the use of antitoxin has become general. Taking eighty-five cases of diphtheritic paralysis it is interesting to note that sixty-five recovered and twenty died. Out of eighty-five cases eight had also nasal implication, seven a combination of faucial and laryngeal paralysis, and in three cases tracheotomy had to be performed; twenty-seven had enlarged cervical glands, in two instances with suppuration. It is interesting also to note that out of these eighty-five cases, fifty-three had paralysis of the palate alone, fifteen of the eyes and palate, three of the eyes alone, twelve of the intercostal muscle and cardiac muscles, one of the lower limbs, and one general. Albuminuria was present in sixty-two cases; in twenty-seven of these there was a large quantity and in others only a trace, but this trace could be detected for many weeks. Thirty-eight out of the eighty-five cases when treated with antitoxin had urticarial rashes. If antitoxin has been injected early in the disease it does not relieve or cure the paralysis by re-administration; the best treatment is to feed the patient and keep up the general physique as far as possible. *Andrew Wylie.*

**McKeen, S. F.—Sudden Death following a Prophylactic Dose of Diphtheria Antitoxin. Autopsy Reveals Status Lymphaticus.** "Boston Med. and Surg. Journ.," April 6, 1911, p. 503.

A girl, aged seventeen, was given 500 units and died fifteen minutes later, becoming unconscious, cyanotic and pulseless. The thymus weighed 25 grm., and there were numerous enlarged mesenteric lymph nodes, swollen Peyer's patches, enlarged spleen and small adenoids.

*Macleod Yearsley.*

**Frese, Prof. (Halle a. S).—A Unique Disease of the Buccal and Pharyngeal Mucous Membrane.** "Zeitschr. f. Laryngol., Rhinol., etc.," Bd. iii, Heft 5.

It is only in the early stages that different diseases of the mouth are

characteristic; later on all superficial conditions tend to ulcerate on account of the heat, moisture and friction which are present. So many micro-organisms are present in the mouth that it is difficult to be sure that you have isolated the real causal factor. The oral disease may only be part of a general process and may be observed by a laryngologist, a dermatologist or a physician; for these reasons classification of buccal diseases has hitherto been clinical rather than pathological. All the cases described by Frese came from a single small village. Case 1: Female, aged nineteen, had had small ulcers in mouth and pharynx at intervals since age of seven. The patient's mother had the same trouble; lips and cheek especially affected; each attack lasted three or four weeks. The general health was not affected, and the attacks had no relation to menstruation or to the seasons of the year; never any skin-eruption. Of late the ulcers had shown a tendency to persist, and one had been present on the left tonsil for three months. The trouble began as small red spots, which on account of central necrosis soon became ulcers; no vesicular stage ever observed. The patient complained of pain during chewing and swallowing, and of late had lost weight. The ulcer on the lip had a sharp border and a yellowish-grey surface layer which could only be removed with a sharp spoon; the cheek, tongue and tonsil showed similar ulcers; the edges of the ulcers were red and slightly infiltrated. Teeth and gums appeared to be in good condition, but the tongue was furred and indented; the inner surface of the cheeks showed the scars of old ulcers. Fœtor absent and cervical glands not enlarged. Eight days later some of the ulcers had healed and others had increased in size; one new one had appeared. Three months later the patient complained of pain on swallowing—the pain shot up to the ear—and on laryngoscopy an ulcer was observed in one pyriform sinus. Frese treated the case by the application of tincture of iodine and anæsthesine. Microscopic examination of the tissue showed nothing characteristic—complete loss of epithelium and fibrinous masses and leucocytes with only a few cocci; no fusiform bacilli, spirilla or tubercle bacilli. Wassermann's reaction negative. No cause could be found for the condition in the milk or water supply, though several other people in the village had the complaint.

Frese does not regard the cases as aphthous stomatitis because of the scars left when the ulcers healed. He also rejects herpetic stomatitis because in this there is always a formation of blebs; further, such eruptions occur in groups and do not leave a scar. Pemphigus, erythema exudativum multiforme, sporotrichosis, syphilis and tubercle are all excluded by the author, who names the condition "stomato-pharyngitis ulcerosa disseminata." *J. S. Fraser.*

**Smyth, H. E.—Accessory Thyroid Tumours of the Tongue.** "Annals of Otology, Rhinology, and Laryngology," vol. xx, p. 367.

The author describes three cases, and gives brief particulars of forty-five occurring under the care of others. He concludes that accessory thyroid tumours of the tongue are more common than has been generally supposed, that they result from Nature's effort to supply a physiological need, that they frequently require no treatment, and should be considered simply as a misplaced thyroid gland, and that care should be taken to ascertain the presence of some other source of thyroid secretion before removing them radically. *Macleod Yearsley.*