

sent out his circular letter asking for suggestions concerning this meeting, he thought it wise to have several papers concerning the treatment of the diseases of the upper air-passages. Dr. Beck agreed to discuss the scientific side, while he took the therapeutic side of the question. He had endeavoured to discuss the matter from the point of view of everyday practice. The most important point, and one which he would reiterate, was expressed in the opening sentence of his paper: "One half of all the diseases it is our daily work to treat, are curable by medicinal means alone."

(*To be continued.*)

Abstracts.

PHARYNX.

Richardson, Charles W.—Indiscriminate Tonsillectomies for Remote Infections. "The Laryngoscope," 1915, p. 293.

Richardson says that it has been thoroughly ingrained during the past decade that the tonsils are the portal of systemic infection. The small-sized, buried tonsils, we are told, are the greatest offenders. It has even been stated that no adult should possess tonsils, nor even the site from which the tonsils had been removed. Richardson thinks that it is incumbent upon us to consider some of the indications for tonsillectomy. Even the layman nowadays considers himself competent to judge of the advisability of operation, and frequently says he has come to have his tonsils removed.

Independent of the tonsils there are many points which may be the origin of general infection. Richardson mentions the accessory nasal cavities, the mastoid antrum, the teeth, gall-bladder, appendix, and seminal vesicles. The writer allows that it is permissible to remove hypertrophied tonsils or those which are the seat of chronic lacunar infections, or of follicular tonsillitis, or abscess formation; he even admits tonsils which are painful on swallowing or tender on pressure. What seems to Richardson objectionable, however, is the frequent removal of tonsils which show no macroscopic evidence of disease. That the possessor of this type of tonsil may be the subject of an infection that cannot be accounted for does not justify the removal of the tonsil. Numerous instances can be enumerated of acute and chronic rheumatism and rheumatoid arthritis where tonsillar enucleation has been followed by total failure to obtain relief. Some practitioners send patients with the statement that they have expressed pus from the tonsil, but in the great majority of cases Richardson fails to confirm their findings. On the other hand, he meets with many cases in which patients come to him in the hope of being relieved of the faucial dryness due to tonsillectomy. The article concludes with the report of several illustrative cases.

J. S. Fraser.

Figdor, P.—Pericarditis in Diphtheria. "Proceedings of Royal Society of Medicine, Section of Disease in Children," June, 1915, p. 89.

The author reports the case of a boy, aged three, who was admitted to hospital for laryngeal diphtheria. Tracheotomy was performed shortly after admission, with instant relief.

The cardiac rhythm afterwards became irregular. Cyanosis developed, and also a rapidly increasing cardiac dulness.

Post mortem: The parietal and visceral layers of the pericardium showed recent pericarditis. There was about ten ounces of serous pericardial fluid. Great oedema of pericardium and of tissues at the root of the neck, including the thymus. No tubercle; no evidence of consolidation.

Archer Ryland.

NOSE.

Onodi, Ladislaus (Budapest).—Congenital Teratoma of the Septum Narium.

Onodi observed in a new-born infant, four days old, with hare lip and cleft palate, two congenital tumours of the septum narium, which microscopically show the character of the teratomas. The anterior tumour was a myxoma covered with skin, pavement epithelium, hair follicles, sweat glands. The posterior tumour contained a large tooth. He has not found in the literature a similar case. The teratomata of the septum narium are very rare. The macroscopical and microscopical photographs were demonstrated.¹

Author's Abstract of Case.

EAR.

Maurice (Paris).—Auditory Re-education: Chronic Deafness and Acoustic Exercises. "Arch. Internat. de Laryng.," etc., 1914.

The author's remarks refer not to absolute deafness, nor to deaf-mutism, but to deafness with some vestige of hearing, deafness which has been acquired post-natally, after the sufferer had acquired speech. We have learned that the older clinicians were wrong in assuming that the degree of deafness varies directly with the degree of the anatomical lesion. Indeed, Zimmerman and Frey have shown that the ossicles subserve only sound-accommodation, not conduction. In agreement with this, the author has found that, as regards the prognosis in re-educating the deaf, Gelle's sign is valueless and stapes-ankylosis immaterial.

Urbantschitsch noted that unilateral deafness reduces the hearing-power of the opposite ear. And the author, in the course of treatment of the worse ear, has remarked an improvement in the hearing of the better ear. This must be a sympathetic or reflex action. From a psychical standpoint, we may have to deal with *aboulia*, in which the patient, often a neurasthenic, is too lazy to try to fix his attention for hearing. Or *phobia*, in which the patient is so frightened by increasing deafness that he fears entering into a conversation, just as an agrophobic fears crossing a road.

Either of these two psychical states creates a vicious circle. The existence of a psychical element may be suspected from paradoxical hearing, as in the case of a man who heard the watch at 35 cm., but a whisper at only 8 cm.; or when words are heard much better than sustained sounds.

¹ For a somewhat similar case, reported by Mr. A. R. Tweedie, see JOURN. OF LARYNGOL., RHINOL., AND OTOL., vol. xxvi, 1911, p. 80.

Re-education is not intended to supplant other local or general treatment.

All the special senses, when feeble, can be re-educated, in the same way as the muscular sense of the ataxic, or the writing-power of the agraphic. In any such re-education one employs the normal physiological stimulus. And the natural stimulus for an incompetent hearing-apparatus is the sound-wave.

Science, like Nature, proceeds by slow degrees, never by bounds. In the first century, A. D., Archigène recommended noise to stimulate a jaded sense of hearing.

The author passes in review various aurists since then who have recommended various instruments. Urbantschitsch employs the human voice and an accordion.

Re-education is of two types. (1) Passive: By means of waves of large amplitude, *i. e.*, loud sounds, which must be of pitch and timbre similar to the human voice. The sound is so loud as to force itself on the patient's attention. Acquired deafness should be treated by this passive re-education. (2) Active: The sound-wave, however produced, is of very small amplitude; the sound is so faint as to be barely perceptible to the patient, who must exert a great effort of concentration to hear it at all. Active re-education, supplemented by lip-reading and making the patient feel digitally the vibrations of the speaking larynx, should be used for congenital deafness which is not quite absolute; that is, for deaf-mutes with a slight perception for vowel-sounds.

H. L. Whale.

Collier, James.—Pontine Polio-encephalitis. "Proceedings of Royal Society of Medicine, Neurological Section," June, 1915, p. 71.

The case is one of a child, aged eight, who was taken suddenly ill with headache and fever. During the following two days he had a series of convulsions, vomited repeatedly, and was subconscious. Subsequently he was noisy and restless for a few days, and then seemed quickly to recover, except that he was completely deaf, and was very unsteady upon his legs.

He was completely deaf when examined a month after admission. Ears normal; vibration sense present; nystagmus; bilateral ataxy; titubation; cerebellar gait. Lumbar puncture normal. Wassermann reaction negative.

Under observation the cerebellar signs practically disappeared, leaving complete deafness as the feature of the case. *Archer Ryland.*

Holmes, E. M.—Aural Complications of Typhoid Fever. "Annals of Otology," xxiii, p. 555.

The writer has had exceptional opportunities for a study of this subject, and, in this paper, pays special attention to the difficulties of diagnosis in lateral sinus thrombosis occurring during typhoid fever.

Macleod Yearsley.

Young, H. B.—The Sociologic Aspect of Deafness, Congenital or Acquired, in Early Life, with a Suggestion for a Betterment through Indirect Effort. "Annals of Otology," xxiii, p. 827.

A most retrogressive paper, advocating the use of the sign-language generally among the deaf and hearing. Owing to the inability to hold water of its arguments, the publication of such a paper is strongly to be deprecated. *Macleod Yearsley.*

Keiper, George F.—Mastoiditis a Probable Cause of Acute Nephritis.
“The Laryngoscope,” 1915, p. 287.

Case 1.—Female, aged six, suffered from acute suppurative otitis media (right). Temperature 103° F., pulse 130. R.M.T. bulging and red. Paracentesis under local anaesthesia; very little pus. Next day patient no better. Urine showed a trace of albumin and many granular and hyaline casts. Right mastoid very tender. Patient treated for nephritis: diaphoresis, saline per rectum, purgatives, etc. Four days later temperature normal. As kidneys resumed their normal function the discharge from the right ear increased and the tenderness over the mastoid began to disappear. (Staphylococcus infection.) Patient recovered. The author remarks: “It is well known that nephritis may be caused by tonsillitis and peritonsillar abscess. Why not by mastoiditis?”

Case 2.—Female, aged fifty-two, had had acute suppurative otitis media for ten days; tenderness over right mastoid. Temperature suddenly rose to 103.8° F.; pulse 128. Severe headache. Patient admitted to hospital. In the evening temperature rose to 105.2° F. “Patient more stupid than ever”; sagging of meatal wall; pupils hardly reacting; patient semi-conscious. Immediate operation: large mastoid, cortex firm, little pus in the antrum but a considerable quantity in the posterior cells; sinus healthy. Urine was found to contain a large amount of albumin with casts. In spite of general treatment for nephritis, temperature continued high. Wound surface covered with false membrane. Odour of necrosis well marked. Haematuria present. Temperature rose to 107° F. just before death. No mention of *post-mortem*.

J. S. Fraser.

Bonner, H., and Dutrow, H. V.—Primary Mastoiditis. “The Laryngoscope,” 1915, p. 244.

Male, aged sixty-five, suffered from influenza in January, 1915. One week later his doctor noticed slight oedema over the right mastoid process, and there was tenderness on pressure at the tip. The tympanic membrane showed slight congestion, which cleared up in a few days. The mastoid swelling slowly decreased, but the patient complained of fulness in the ear and dull pain in the mastoid. Otoscopic examination showed loss of gloss of the right drumhead, with slight congestion; tube patent; air and bone conduction normal; slight tenderness at mastoid tip; temperature and pulse normal. Next day the patient complained of noises in the ear, and there was slight sagging of meatal wall. Two hours later the patient had a sudden attack of dizziness and fell to the floor. An hour later he had a second similar attack. For a week the patient refused operation. *Mastoid operation*: Bone sclerosed; superficial cells contained viscid fluid, and, deeper, a large amount of thick yellow pus was evacuated. Extensive disease. Apparently the lateral sinus was opened accidentally, but this did not hinder an uneventful recovery. (It is a pity that the bacteriology is not mentioned, as the case appears to correspond very closely with the type of middle-ear inflammation associated with the presence of the *Streptococcus mucosus*.)

J. S. Fraser.

MISCELLANEOUS.

Whale, G. H. Lawson.—Perithelioma of the Superior Maxilla and Ethmoid.¹ "Lancet," May 15, 1915, p. 1013.

Patient, a female, aged fifty-two. Duration of disease, two and a half years. At the first operation only a portion could be removed. A second operation was undertaken some three months later, when the whole right upper jaw, palate bone, nasal bone, and part of the malar were removed, together with the right half of the ethmoid up to the cribriform plate. Save for an abscess in front of the right ear, recovery was uneventful.

Macleod Yearsley.

REVIEW.

Operative Surgery of the Nose, Throat, and Ear, for Laryngologists, Rhinologists, Otolologists, and Surgeons. By HANAU W. LOEB, A.M., M.D., Professor of Ear, Nose, and Throat Diseases in St. Louis University, in collaboration with JOSEPH C. BECK, M.D., R. BISHOP CANFIELD, M.D., GEORGE W. CRILE, M.D., EUGENE A. CROCKETT, M.D., WILLIAM H. HASKIN, M.D., ROBERT LEVY, M.D., HARRIS P. MOSHER, M.D., GEORGE L. RICHARDS, M.D., GEORGE E. SHAMBAUGH, M.D., and GEORGE B. WOOD, M.D. In two volumes. Vol. I. 409 illustrations. London: Henry Kimpton. Glasgow: Alexander Stenhouse, 1914. Two volumes price £2 10s. net.

This is the kind of book that everyone who handles wishes to possess.

The surgical anatomy of the nose is dealt with by Dr. H. Loeb, and those who know the uncompromising way in which he has gone to nature in making his reconstructions of the accessory sinuses will expect from him an exceptional degree of thoroughness and accuracy. In this they will not be disappointed. The more or less stereotyped anatomy of the part is given with great detail, while the points of more especial importance to the rhinologist are emphasised by words and by illustrations. Almost every possible aspect of the sinuses and other parts of the nose is shown and amply delineated. A specially good bit of work is the study of the relation of the optic chiasma and nerve to the nose and accessory sinuses. The nasolacrimal duct and the hypophysis also receive the fullest attention from the nasal aspect.

Dr. Wood, of Philadelphia, is responsible for the surgical anatomy of the pharynx, larynx, and neck, which has all the minuteness of the descriptive anatomist with very special consideration of the parts and relations of the parts in which the laryngologist is peculiarly interested. The discussion of the region of the palatal tonsil from the outside gives a very striking idea of the arterial supply of that organ. There are some beautiful illustrations of the lymphatic glands of the neck taken obviously from diseased subjects, and the relations of the facial nerve and the venous structures in the carotid triangle are particularly good.

It would be difficult to find an author with a more distinguished name than Dr. Shambaugh as an authority on the anatomy of the ear, and

¹See JOURNAL OF LARYNGOL., RHINOL., AND OTOL., August, 1915, p. 315.