Paralysis." In reference to the latter it is stated that "imperfect closure of the eyes causes epiphora, conjunctivitis, corneal ulceration and *atrophic rhinitis* on the same side."

The book terminates with brief epitomes of seventeen cases—mainly examples of the intracranial complications of ear disease which should prove very useful to the student.

The illustrations number 100, and, excepting those of instruments, have all been drawn by the author. They are simple, diagrammatic, and for the most part adequate, although some, especially in the anatomical section, would be improved by the introduction of a little more shading to indicate differences of level. There is a good index.

THOMAS GUTHRIE.

LETTERS TO THE EDITORS

TO THE EDITORS,

The Journal of Laryngology.

SIRS,—In his letter regarding the "Blood-Clot Method of Closing the Mastoid" in the November (1922) issue of your *Journal*, I notice that Mr Tilley states that he regards two "indispensable factors" as necessary to obtain a successful result, and that one of those indispensable factors is "the complete removal of all infected areas."

I am wondering whether Mr Tilley has not forgotten one rather important infected area, the complete removal of which would, I fear, present some little difficulty, and the retention of which must (one would think) prejudice the asepticity of the closed mastoid wound. I refer of course to the middle ear.

It is true that experiment and experience, not logic, are what rules the surgeon's practice, and were this point merely one of debating value I should have let it pass. But my experience with early mastoid operations, as well as with the ordinary operation for manifest mastoid suppuration, has led me to practise and to teach that it is safer, and at the same time free from any drawback, to drain the mastoid wound, and with it the middle ear, for several days at least after operation.

DAN M'KENZIE.

LONDON.

THE EDITORS,

The Journal of Laryngology.

SIRS,—I observe a letter from Mr MacGibbon in the October number of the *Journal* (1922) *re* "The Blood Clot Method of Closing the Mastoid," and take it that this is in the nature of a reply to Mr H. Tilley's letter which appeared in May, where my

name was mentioned as having carried out the method fairly extensively; it is only in justice to Mr Tilley that I should give my experience.

I have performed approximately 400 operations for acute and subacute mastoiditis by the blood clot method. Previous to March 1919, when Mr Tilley's modified method appeared in the *Journal*, I had carried out the original blood clot method on 100 of the 400 cases, *i.e.*, flushing the wound with normal saline, allowing the cavity to fill with blood, and primarily stitching without drainage. I regret to say that this in my hands was an entire failure as only 25 per cent. healed with dry ears, etc.; the remaining 75 per cent. became inflamed and broke down, requiring reopening with subsequent drainage. Still the patient was in no worse a position than if the cavity had been primarily packed and drained.

Since March 1919, in all acute and subacute mastoiditis, both in hospital and private practice (most of my private work is done in hospital), I have carried out Mr Tilley's modified method, that is, flushing the cavity with saline, alcohol, B.I.P., and finally allowing the entire cavity to fill with blood and stitching the wound completely; the results have been excellent. Out of 300 cases, in 95 per cent. ten days was the average stay in hospital; the middle ear became dry and hearing returned to normal; of these 95 per cent. 60 per cent. could have left the hospital on the eighth day, but acting on Mr Hunter Tod's valuable experience that should sinus thrombosis occur as the result of traumatism, it invariably occurs not later than the tenth day, and in these acute cases of mastoiditis, 50 per cent. at least have their sinus exposed, so that the tenth day was precautionary; the remaining 5 per cent. showed redness of the wound with serous discharge at the lower extremity requiring reopening to the extent of 1 mm.; these cases were rapidly put right by the application of dry heat (the electric box); in only one was there free suppuration which recovered with the usual three weeks' packing.

The exposure of dura mater and the sinus does not in the least interfere with primary closure.

Out of the 400 cases 5 were admitted with a fulminating meningitis and died, while 3 entered the hospital with cerebro-spinal meningitis (diplococcus intracellularis) and recovered.

The method has many advantages and, to my mind, no disadvantage; the primary dressing is removed on the third day, when the stitches are taken out (the only time the patient suffers any inconvenience) followed by the application of spirit gauze which remains on for another forty-eight hours, then finally collodion wool, which is allowed to separate of its own accord.

It would be invidious for me to detail my technic, but it closely

follows in every respect that carried out by Sir W. Arbuthnot Lane in the fixation (plating) of fractures by the open method, and those who have seen him operate in such cases will fully appreciate what I mean. However, as the method I carry out on closure of the post-auricular wound is entirely different from anything I saw in Europe last year, I trust it will not be looked upon as presumption on my part if I detail it.

The whole thickness of the lips of the wound is approximated by two on end or vertical mattress sutures of silkworm-gut, taken out of hot saline (needle and suture being sterilised together). I mention particularly that the wound is only approximated, in many cases the lips being left apart 1 to 2 mm., while the accurate adjustment of the skin is carried out with the Michel's clips or Herff's metallic sutures.

I am aware that Mr Tilley's modified method has not become general either in England or America, but having once given it a fair trial, no one would consider carrying out any other.

Many modifications have appeared recently, such as removing the tube or other drainage in twenty-four or forty-eight hours, followed by hot applications; but if heat is considered necessary in any aural condition either before or after operation, there is nothing to compare with dry heat from electric light enclosed in a box sufficiently large to contain the patient's head and face while the eyes are protected with asbestos pads.

In conclusion, it is self-evident from the results of my 300 cases that all Mr Tilley claims for his method has been fully justified.

JAS. C. G. MACNAB, M.D., F.R.C.S.

JOHANNESBURG.

THE EDITORS,

The Journal of Laryngology.

SIRS,—I am impelled, by the perusal of the Abstract on Cocaine Poisoning in the issue of the *Journal* of last November, to place on record the following occurrence. It will "point a moral" as well as "adorn a tale."

In an annexe to the operating theatre, an assistant was preparing a woman for the removal of tonsils under local anæsthesia. By mischance he injected, instead of the usual ½ or 1 per cent. solution of cocaine, a 20 per cent. solution with adrenalin. In two minutes the woman collapsed and he recognised his mistake. He called to me and I said, "put her on the table." The tonsils were immediately enucleated by the dissection method and the throat mopped. At the same time the house-surgeon was requested to ask Professor Stockman, who was in the hospital, to come. This he did at once. Hot bottles were placed around the patient. Respiration had ceased but the