of the tumour showed it to be a typical adenoma of the strumous gland; it must therefore be regarded as a metastasis of an adenomoid degenerated struma. The goitre was too large for extirpation.

2. A patient, thirty-two years old, had a goitre since his youth. For some years he had a tumour upon the manubrium sterni, which attained the size of a fist. Extirpation was followed by death. The microscopic examination showed the goitre to be an adenoma, and the sternal tumour to be a metastasis.

3. Tumour of the sphenoid bone, showing the nature of a metastasis of an adeno-carcinoma of the thyroid gland, which consisted of adenomoid tumours.

4. Adeno-carcinoma of the thyroid gland, with metastases of colloid tissue in the ribs, the vertebræ, and the lungs.

5. Colossal tumour of the humerus in a patient thirty-nine years old, showing the nature of a metastasis of a colloid carcinoma of the thyroid gland.

6. Malignant goitre, with metastases in the bone of the lower jaw, the glands of the neck, and the mediastinum and lungs.

7. Adeno-carcinoma of the thyroid gland, with metastases in the frontal and occipital bone in the lungs and the liver.

8. Adeno-carcinoma of the thyroid gland, with metastases in the bones of the head, the ribs, and the humerus.

The author concludes that as the primary tumour is often small in such cases, metastases, if they cause symptoms, should be operated upon, contrary to the surgical rule that secondary tumours should never be treated so. *Michael.*

Trumpp (Harscheim-Pfalz).—*On a Case of Angina Ludovici.* "Münchener Med. Woch.," 1893, No. 38.

A SEVERE case of swelling and inflammation of the cervical tissue, in which incision was followed by cure. *Michael.*

EAR.

Conners.—*A Foreign Body in the Ear for Thirty-nine Years.* "Med. News," Aug. 26, 1893.

THIS consisted of a white bean, and after removal hearing was almost completely restored. *B. J. Baron.*

Toeplitz, Max.—*Clinical Contribution to the Study of Aural Syphilis.* "New York Med. Journ.," Oct. 7, 1893.

AURAL syphilis may appear during the secondary and tertiary stages, and a few rare cases of primary induration of the auricle have been recorded. Secondary affections are usually transmitted from the pharynx or naso-pharynx, or may appear in the external meatus as condylomata

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or ulcers. Tertiary affections are characterized by chronic inflammation of the periosteum of the labyrinth, with subsequent hyperostosis or exostosis of the petrous bone, or of the cavities of the labyrinth, leading to stenosis, or even occlusion of the latter.

The following case is remarkable from the fact that the labyrinth was affected primarily in the course of a freshly-acquired case of syphilis, and that the aural affection began simultaneously with the appearance of roseola.

The patient, a medical man, aged forty-one, consulted the author, complaining of deafness in the left ear. Moderate congestion of Shrapnell's membrane was found. Politzerization used for diagnostic purposes did not improve the hearing. On the fourth day the right ear became affected also. Examination with the tuning-fork at this stage pointed to implication of the internal ear. A chancre (contracted during gynæcological examinations) was found upon the middle finger of the patient's left hand. At the same time pharyngeal mucous patches and a commencing roseola were found. Energetic antisyphilitic treatment was at once adopted, and injections of pilocarpin were also made.

The special features of the case were :—(1) The affection of the labyrinth occurred after the appearance of the pharyngeal mucous patches, and simultaneously with the appearance of roseola. (2) The aural lesion took place during the secondary stage without attacking the middle ear. (3) The diagnosis of syphilis was made from the ear.

W. Milligan.

Politzer, Professor Adam.—*A Clinical Lecture on the Treatment of Chronic Suppuration of the Middle Ear.* Reported by ST. CLAIR THOMSON, M.D. "Lancet," Aug. 19, 1893.

IN the treatment of chronic suppurative middle-ear disease the remedies to be applied must depend upon the quality and quantity of the secretion, the situation and size of the perforation in the membrane, the local changes consequent upon the suppuration, and the previous state of health of the general organism. Thorough removal of secretion from the tympanum is all-important. It is advisable in commencing the treatment to examine the discharge microscopically for the different micro-organisms. The streptococcus, when present, is the most unfavourable from a prognostic point of view. For thorough removal of secretion, the middle ear should be inflated by the author's process, or the Eustachian catheter should be passed, and, if necessary, the contents of the middle ear may be aspirated with Siegle's instrument. The lotions the author usually employs for syringing are solutions of lysol (ten to fifteen drops to a quarter of a litre of boiled water), two per cent. carbolic acid, one to two per cent. resorcin, or one per cent. solutions of salol. Regarding the use of corrosive sublimate solutions (one to two thousand), the following points should be borne in mind: (1) never to use it in the case of children, (2) or when the Eustachian tube is very patent, as it might then run into the pharynx and be swallowed in small, but frequently repeated doses; (3) discontinue its use at the end of a week or sooner, if all fœtor has disappeared. The author constantly employs

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insufflations of boracic acid and has never seen any bad effects due to caking of the acid, but advises that only a fine coating should be insufflated. In employing powdered iodoform as an insufflation, the disagreeable smell may be disguised by the addition of Tonga bean. Small bougies made of iodoform, gum arabic, glycerine, and tincture of Tonga, and about the thickness of a Eustachian catheter, have been found useful. A small piece (about a quarter of an inch) is broken off, introduced as far as the membrane with forceps, and kept *in situ* by means of a cotton plug. As melting takes place gradually, a fresh antiseptic solution is formed.

In those patients where arrest of suppuration has taken place without, however, cicatrization of the membrane, there is a tendency for the epithelial lining of the meatus to grow inwards, and tend to the formation of cholesteatomatous masses. The best treatment for the prevention of such masses is the use of pure alcoholic instillations from time to time. Where such masses have already formed, they should be softened by using solutions of glycerine and bicarbonate of soda, and then washed out. Cases which do not yield to this treatment require the employment of astringents. Nitrate of silver is the drug principally used for this purpose. A ten per cent. solution should be warmed, and poured into the ear, and allowed to remain from ten to fifteen minutes *in situ*. The author does not recommend neutralizing this solution with solutions of common salt. The resulting clots of chloride of silver form insoluble deposits, and act as foreign bodies within the tympanic cavity. In cases of suppuration, through Shrapnell's membrane, from suppuration in the external attic, or cavity of Prussak, finely-pointed canulæ (*e.g.*, those of Hartmann) should be used. If the perforation in the membrane is very small, and obviously insufficient to maintain free drainage, it should be enlarged. The ossicles should be removed only when they are carious, or when the membrane is destroyed and they are of no further use. Regarding the exact method of action of many of the remedies employed in the treatment of chronic suppurative middle-ear disease, no very definite explanation can be given. Many remedies, especially alcohol and powders, withdraw water from diseased tissues. Others have a strong caustic action, and set up strong reaction and speedy alteration in the circulation and nourishment of the mucous membrane. Also the chemical and mechanical irritation, caused by certain agents, sets up a disintegration and re-absorption of round-celled infiltration, and finally the antiseptic treatment prevents putridity and decomposition, and exercises a good influence (through its germicidal properties) on the progress of the suppurative process. *W. Milligan.*

Burnett, C. H.—*The Surgical Treatment of Chronic Tympanic Vertigo, often miscalled Ménière's Disease.* "Med. News," Sept. 30, 1893.

CHRONIC tympanic vertigo, the most frequent form of aural vertigo, is one of the results of chronic catarrhal otitis media. This form of vertigo is paroxysmal in character and attended with tinnitus and deafness in the affected ear. It is caused by the inward pressure exerted upon the labyrinthine fluid by the retracted and anchylosed ossicles. The irrita-

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tion in the labyrinth being communicated to the motor filaments of the auditory nerve is reflected by them to the cerebellum, and disturbed equilibration is the result. The author formerly excised the membrana tympani and the malleus in such cases, but having found that more or less inflammatory reaction followed he determined to remove the incus alone, or incus and stapes, the membrana tympani and malleus being allowed to remain in position in the hope that less inflammatory reaction would ensue. The experience of ten such operations leads him to the following conclusions: (1) That removal of the retractive force of the sound-conductors upon the stapes is the efficient means of relieving the tinnitus, deafness and vertigo due to the lesions of chronic catarrh of the middle ear; (2) that the removal of the retractive force upon the stapes can be accomplished efficiently and simply by removal of the incus alone, and even by resection of its long process; (3) That the improvement in these cases is due to the liberation of the stapes from the retractive power of the tensor tympani muscle, and the consequent unimpeded action of the stapedius muscle, which, relieved of the antagonism of the tensor tympani, tends all the more to draw the stapes from the oval window, thus aiding in the isolation and improved mobility of the bonelet, as well as in removing its undue pressure inward upon the labyrinthine fluid; (4) it would seem wiser, therefore, in most cases of chronic catarrhal deafness, tinnitus and vertigo, not to sever the stapedius tendon and remove the stapes, but to be content with removal of the incus only; (5) the progressive improvement in hearing, noted in many cases, must be due to the passive motion exerted upon the anchylosed stapes by sound waves, which are enabled to reach this bonelet more freely after removal of the incus. *W. Milligan.*

Coues, W. P.—*Mastoid Measurements.* "Boston Med. and Surg. Journ.," Sept. 21, 1893.

THE author examined 400 crania in order to determine (1) the relative frequency of asymmetric mastoid processes; (2) whether the mastoid process being small, or the digastric fossa deep, made any difference in the depth and direction of the lateral sinus.

Out of the 400 crania examined, 13, or 3·25 per cent., had asymmetric mastoid processes. One hundred and sixty-four had either a small mastoid or a deep digastric fossa. Of these 164, 136, or about 83·3 per cent., had a very deep lateral sinus coming up towards the mastoid antrum. Therefore, where the digastric fossa is deep, or where there is a small mastoid process, the lateral sinus is almost invariably deep, coming up towards the mastoid antrum and encroaching upon the mastoid cells, so that in operating upon the process, if it is small, or the digastric fossa deep, great care must be taken lest the lateral sinus be wounded. *W. Milligan.*

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