Naso-pharyngeal Catarrh.—*Cause:* Damp and exhaustion in predisposed persons, chiefly in those of strumous habit. *Treatment:* Chloralum, pure or slightly diluted, applied by a brush; a good dry elevated residence corrects the predisposition.

[It will be seen that the writer's methods of treatment are decidedly old-fashioned. His views upon follicular tonsillitis and naso-pharyngeal catarrh are particularly open to criticism. However, if his treatment is not exactly the means of doing most good, it has at least the merit of probably doing little harm.]

DUNEY, Dr. F.—On a rare Case of Pharyngeal Stenosis from Constitutional Syphilis, and an Anatomo-Pathological Study of Syphilis of the Liver and Spleen. (Sa di un raro Caso di Stenosi Faringea per Sifilide Costituzionale e Contribuzione Anatomo-Pathologica salle Sifilide del Fegato e della Milza.) *Rivista Clinica e Terapeutica, Napoli,* 11 *and* 12. MASSEI.

TURNER.—A Case of Retro-œsophageal Abscess, causing Death by Pressure on the Trachea. *Lancet, January* 1, 1887.

THE patient, a child aged three months, was under treatment for syphilis. After one temporary attack of dyspnœa, the child was seized, a few days later, with more severe dyspnœa, which increased to such an extent that tracheotomy became necessary. The child rallied somewhat for a time, but died a few hours later. Post-mortem was found a large abscess in the areolar tissue behind the œsophagus and lower part of the pharynx. It was bounded behind by the bodies and transverse processes of the vertebræ, which, however, were not diseased. The abscess extended from the level of the cricoid cartilage to within a quarter of an inch of the bifurcation of the trachea, the larynx and trachea being found quite healthy. The abscess probably arose from suppuration of the post-pharyngeal glands. It is worthy of remark that dysphagia, which is supposed to be the most prominent symptom of this condition, was entirely absent in this case.

LARYNX.

WAXHAM, W. E. (Chicago).—**Intubation of the Larynx.** *Phil. Med. News, January* 1, 1887.

REFERRING to the statement that if the trachea be plugged with membrane, and relief fail to follow the removal of the tube, immediate tracheotomy would become necessary, with less hope than if it had been done at first, and that with intubation no attempt can be

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made to remove false membrane, Dr. Waxham mentions the fact that he has devised tracheal forceps for this purpose. He relates the following case :—On December 10 he was called to see a child of seven in the last stage of asphyxia from membranous croup. An intubation tube quickly introduced failed to give relief, no air entering the lungs. The tube was removed and again introduced, with the same result. Being then withdrawn, and the long tracheal forceps introduced by the mouth, a perfect cast of the whole trachea, and of the two large bronchial tubes to the extent of one and a half inches, was removed. The intubation tube now being introduced, respiration was at once established. As this accident will sometimes occur, every one performing intubation should have these forceps at hand. Dr. Waxham contends that intubation will save many lives which *could not be saved* by tracheotomy. He has performed intubation over a hundred times; fifty-two cases have been three years of age or under, a great many of them nursing infants, and he has had thirteen recoveries, or 25 per cent. One was an infant of nine months, another of fourteen, another of eighteen, another of twenty-two months respectively. "If any tracheotomist can show a better record with an equal number of cases at this age, we will then be convinced that intubation will not for the present supersede tracheotomy." One of the chief objections to intubation is the difficulty of nourishing the patient. To remedy this, Dr. Waxham has had tubes connected with very small heads, and uses a rubber collar with an artificial epiglottis attached. The collar prevents the tube slipping into the trachea, and being elastic, fits more perfectly into the larynx than the large metallic head. On swallowing, the epiglottis presses down the artificial epiglottis, and completely covers the opening of the tube.

MASSEI, Prof. F.—Introductory Lecture to the Course of Laryngology. (Prelizione al Corso di Laringoiatria.) *November* 30, 1886. *Riforma Medica*, No. 291.

Introducing various clinical cases, Massei endeavours to point out the importance of laryngology for itself, and for clinical medicine in general. The patients brought forward are—one of primary tuberculosis of the larynx, one with laryngeal and pharyngeal syphilis, and a woman with double paralysis of the crico-arytenoidei postici from tabes dorsalis. The Author.

GODET.—Results of Surgical Intervention in some Carcinomas. (Résultats de l'Intervention Chirurgicale dans quelques Carcinomes.) *Thèse, Paris, December*, 1886.

Billroth performed total extirpation of the larynx, in 1873, for a

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cancer; since this time the operation has been frequently done. It was first performed in France by Dr. L. Labbé, who has done it three times. Dr. Pean has also done it twice. It has now become a regular surgical operation, thanks to the introduction of Trendelenberg's canula and the galvano-cautery. Ninety-five cases are up to now recorded of total extirpation; in 12, death occurred within eight days, and in 19 in the eight days following, making a percentage of 33 deaths within the fifteen days following the operation. Adding 7 cases of later deaths, a total mortality is reached of 40 per cent. in this operation. In 22 cases of partial extirpation (generally unilateral), 8 deaths are recorded, of which 2 were after a second operation, for recurrence. JOAL.

ABBE.—Notes on the Operative Closure of a large Laryngeal Fistula. (New York Surgical Society, December 22, 1886.) *Med. News, January* 15, 1887.

IN December, 1885, a man of forty-five came to be treated for an opening into the side of the larynx immediately above the vocal cords, into which the thumb could be thrust. It was caused by a fall upon a cobbler's knife, which cut through the left side of the thyroid cartilage. Attempts to close the fistula by suturing had failed. Eventually, with parings and ulcerations, a good deal of the left lateral half of the thyroid cartilage was sacrificed. The opening through the cartilage proper was $\frac{3}{8}$ths of an inch, and an extraordinary view of the vocal cords in action could be obtained. While the fistula was open, phonation was impossible; when closed, it was perfect. Tracheotomy was first performed, the glottis was then stopped through the fistula by a sponge attached to a string drawn out through the mouth. The edges of the fistula were pared. A broad elliptical space was then included between two incisions, somewhat wider, and extending obliquely downwards on the neck. A part of the included skin below the fistula was dissected up, for a flap to cover the hole, and stitched over the fistula by two rows of fine continuous catgut. The skin on either side of the neck was undermined, and slid over the flap so as to meet directly over its centre. A lateral slash, $1\frac{3}{4}$ inches away, was made to relieve tension and allow insertion of a drainage tube. The patient made a good recovery, the tracheal tube being removed on the fifth day.

LABBÉ, L.—Extirpation of the Larynx. (Extirpation du Larynx.) *Congrès français de Chirurgie*, 1886.

THIS eminent surgeon has been the first to practise extirpation of

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the larynx in France, in three cases in which the diagnosis of sarcoma and epithelioma had been previously made by Dr. Cadier. The operation is easy; it is indicated in cases of tumours relatively benign, sarcoma, and some epitheliomas. Tracheotomy is first performed some months before, in order to accustom the patient to wearing Trendelenberg's canula. JOAL (Mont Dore).

LLOYD, J. (Birmingham).—**Case of Extirpation of the Larynx without preliminary Tracheotomy.** *Lancet, January* 15, 1887.

THE patient, aged fifty-one, was a brass worker, and had suffered from dyspnœa with stridor, cough with expectoration, and attacks of difficulty of breathing for twelve months; great emaciation had now supervened. There was no history of phthisis or cancer, and no syphilis. The laryngoscope revealed a "cauliflower-like growth of the size of half a walnut springing from the left side of the larynx below the false cords." There were no enlarged glands, and the lungs were considered to be sound, nothing being found but "a few bronchial rales." Nothing in the steps of the operation call for comment, except that the trachea was divided with Paquelin's cautery, and instead of Hahn's or Trendelenberg's canula, a curved glass tube was introduced into the trachea for two inches, by which means blood was prevented from entering the wind-pipe. The whole larynx was extirpated, the trachea sutured to the skin, and a tracheotomy tube introduced. The patient died six days after the operation. "Examination of the larynx showed a large intra-laryngeal growth on the left side, probably of tubercular origin, and the necropsy revealed a condition of purulent bronchitis extending into the smallest bronchioles, infundibula, and pulmonary acini. Both lungs were everywhere studded with small miliary tubercles."

The author thinks the case interesting from the fact that no preliminary tracheotomy was required by his method of procedure. He also admits that extirpation of the larynx is "a serious surgical experiment." It is exceedingly difficult to understand why this "experiment," admittedly "serious," should have been done at all; or, indeed, why experiments of this nature should ever be undertaken upon the larynx. Where we have to deal with the internal viscera, surgery may come to the aid of medicine in an experimental manner, but with an organ such as the larynx, fully open to inspection, such a method of treatment does not appear to be justifiable. According to Mr. Lloyd the growth was situated above the vocal cords, *i.e.*, in a position favourable for removal *per vias naturales*. It is not easy to comprehend, moreover, why a cauliflower growth should at once be dubbed

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"epithelioma," when it is well known to laryngologists that papillomata, especially if they attain any marked size, commonly assume the cauliflower form. On the other hand, epithelioma of the larynx has quite a different appearance. [Attention should be called to the fact that the growth was described by Mr. Lloyd, after the patient's death, as "probably of tubercular origin." If it was really "tubercular," it assumed an extremely rare, if not unique, form.] To return to the clinical aspect of the case, even if the growth could not have been removed by endo-laryngeal means, a portion could assuredly have been taken away for microscopical examination, when its true character would at once have been evident. But assuming that for some extraordinary and unexplained reason, it was impossible to detach the smallest particle to establish a diagnosis, it is remarkable that Mr. Lloyd did not perform partial, *i.e.*, one-sided extirpation of the larynx, instead of the major operation of total extirpation. In other words, it is in the highest degree remarkable that an operation comparatively safe, and which leaves a useful organ *in situ*, was not preferred to a very dangerous one, which, even if successful, places the patient in a most miserable condition for the rest of his existence. It is possible that Mr. Lloyd may have withheld information which would lead to a different view, but from the facts published we can see nothing whatever to justify the operation either from a medical or surgical point of view.

MASINI, Prof. O.—On a Tracheal Tumour removed *per vias naturales.* **(Di un Tumore Tracheale Extirpato per le vie naturali.)** *La Riforma Medica*, No. 275, 1886.

A FIBRO-MYXOMA from the first ring of the trachea, which during attempts at phonation protruded between the cords, was removed *per vias naturales* at one sitting after several attempts, anæsthesia being induced with cocaine. Some time afterwards there was no sign of recurrence. Masini used forceps specially modelled on the Mackenzie pattern; but the horizontal branch had the curve of Schrötter's forceps, and the vertical portion was longer. MASSEI.

ARIZA, RAFAEL.—Remarks on Tertiary Syphilitic Laryngitis. (Consideraciones Acerca de la Laringitis Sifilitica Terisaria.) *Anal. de Otol., &c.*, 1886, No. XI.

SYPHILITIC hypertrophy, called inflammatory, is extensive, diffuse, without well-marked limits from sound regions, of even surface, and darker red colour than the non-hypertrophied parts of the larynx. Its

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favourite location is the epiglottis, the aryepiglottic ligaments, and the vestibule. Often unilateral, it begins sometimes in the centre of the epiglottis; it suddenly ulcerates in great extent, leaving a purulent, oval, and occasionally serpiginous or irregular form, with red, elevated edges. It may extend very deeply, and reach the perichondrium and the cartilage.

Gummy hypertrophy is well defined. Its size varies from a miliary granulation to a hazel nut; the surface is even if there is a single node, but nodulated if there are several. It is at first of the same, or a little redder, colour than the mucous membrane, but afterwards it turns yellowish; ulceration suddenly supervenes, cavernous and deep, and resembling the hole made by a hollow punch, with perpendicular and excavated edges. Several cases are related by Ariza.

RAMON DE LA SOTA Y LASTRA.

ARIZA, RAFAEL.—On Partial Laryngeal Paralyses. (De las Paralisis Laringeas Frustrados.) *Mem. Leidas en la Socied. Espanola de Laring., Ot., y Rhinol.* Tomo I., 1886.

THE author studies those cases in which, with apparently sound larynx, the voice is feeble, lost, or aphonic momentarily. It is sometimes dependent upon one-sided contraction of the adductors, through loss of their tonicity. This condition is revealed by the slight deviation at the anterior end to the right or left side, from the straight line formed by approximation of the vocal cords during phonation. At other times it is due to diminished force of contraction of the abductor muscles of one side, as is shown by the arytenoid cartilage of one side retiring from the mid-line more slowly than the other, after phonation; or by its remaining stationary for a moment, or by its arrest midway, arriving at complete abduction only when the patient has taken deep inspirations. If there is a partial paralysis of the tensor muscles, the vocal cords appear lax; if of the thyro-arytenoidei, a separation is seen, now in one, now in another portion of the glottic line. In all these cases there is not true paralysis, since the conditions are not stable and constant; but that it is not a transitory accident is shown by the obstinacy of the affections.

RAMON DE LA SOTA Y LASTRA.

HALL, DE HAVILLAND.—A Case of Aneurism of the Aorta. *Proc. Med. Society*, Vol. IX., 1886.

THE left cord was motionless in the cadaveric position. Eight months before, patient could hardly speak at all, due probably to pressure on the left recurrent leading to immobility of the cord, and on phonation

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the right cord coming to the median line, leaving a gap. Compensation took place afterwards, and the right cord passing the median line, the voice improved. The pressure in this case seems to have affected both abductor and adductor fibres, the cord at once assuming the cadaveric position. Thus, there was no cough, stridor, or dyspnœa, and the voice was falsetto. In three cases examined successively, the author found cadaveric position in two, and partial adduction of the cords in one.

MASINI, Prof. O.—Anatomo-Pathological Observations on a Case of Primary Cancer of the Larynx. (Su di un Caso di Cancro Primitivo del Laringe Osservazione Anatomo-patologico.) *Archiv. &c., Anno. VII., fasc. I.*

THE anatomical specimen, which the author investigated in the Laboratory of General Pathology in Genoa, belonged to the Anatomo-Pathological Museum of that University. It was the larynx of an adult man who had died two years previously with symptoms of laryngeal stenosis. It presented at first sight an enormous tumour, in relation with the *rima glottidis*. Macroscopical examination did not reveal anything further than a certain thickening of the inter-arytenoid fold, and a superficial irregularity about the wide base of the tumour. Microscopically, the following were the prominent points: in some places a covering of cylindrical epithelium; in others, infiltration of young cells towards the centre, characteristic cylinders scattered here and there, and collections of epithelial cells, smaller at the periphery than the centre, and disposed concentrically; lastly, a fibro-cellular stroma, in many spots infiltrated with round cells, as though from the proliferation of the same connective stroma. Not only was the examination of the two laryngeal nerves negative, but also that of the lymphatics. MASSEI.

JURASZ (Heidelberg).—**Splint of Bone in the Larynx of a Twenty-two-months-old Child found by Laryngoscopy and removed. (Knochenstück in der Kehlkopfhöhle eines 22 monate alten Kindes laryngoscopisch nachgewiesen und entfernt.)** *Monatschrift für Ohrenheilkunde, &c.* 1886, No. 12.

AFTER aspiration of a splint of bone the child became hoarse, had an attack of dyspnœa, cough, and difficulty of swallowing. Laryngoscopy was not possible without narcosis. Under chloroform the Whitehead speculum was applied, but it was impossible to see anything in deep narcosis. But as the child half recovered from the narcosis, laryngoscopy became easy while it was crying. The splint could

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be seen between the right arytænoid and the left ligamentum vocale. The bone was now extracted with forceps. It is the first case of extraction of a foreign body in a child younger than three years. This operation can only be performed during semi-narcosis.

MICHAEL (Hamburg).

McCOY, A. (Philadelphia).—**The Galvano-cautery in the Treatment of Papilloma of the Larynx.** *Med. News, January* 1, 1887.

THE author employs a finely pointed electrode, insulated well down to the point, and made of copper to obtain flexibility. With this instrument he has been able to destroy growths very difficult of access with ordinary forceps, and even to extirpate subglottic growths only coming into view on deep inspiration. The cautery point must be heated to white heat, and in this manner reaction is avoided and contact only momentary. The author relates a case of laryngeal growth extirpated by him in this manner.

SOTA, RAMON.—On Crico-Arytenoid Arthritis. (De la Artritis Crico-Aritenoidea.) *Mem. leidas du la Sociedad Española de Laring., Otol., y Rhinol.* Tomo I., 1886.

A MAN of twenty-six, after drinking cold water while sweating, felt pain on speaking, coughing, and swallowing. The voice was hoarse, the palatal and laryngeal mucosa were red and granular, the base of the right arytenoid cartilage tumid and red, its movements on the cricoid cartilage very limited, and during inspiration it hardly separated from the mid-line, whilst during phonation it remained in front of the left arytenoid, this latter going further over than natural. The right vocal cord was relaxed, the internal edge undulated, and its vibrations abolished. There were no constitutional symptoms, and no history of disease. Dr. Sota diagnosed arthritic crico-arytenoid inflammation. The patient recovered in a month by rest, sudorific drugs, and the application to the larynx of a solution of chloride of zinc. The author discussed the causes, symptoms, prognosis, and treatment of this class of affection.

RAMON DE LA SOTA Y LASTRA.

TISSIER.—Glottic Stenoses in the Tubercular. (Sténoses Glottiques chez les Tuberculeux.) *Annal. Mel. Oreilles Larynx. January,* 1887.

THESE are stenoses due to the approximation of the vocal cords to the median line. The explanation of this condition is either: 1st, paralyses of the dilators; 2nd, spasm of the adductors. Tissier thinks that the recurrent is affected by peripheral neuritis, or gang-

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lionic compression. This nerve is composed of pneumogastric and spinal accessory fibres. The former fibres are smaller in quantity, their excitability is lost sooner than the spinal fibres, and it is not irrational to suppose that they submit first to the "*contrecoup*" of ganglionic compression, or of neuritis, and that they may be damaged, while the spinal filaments preserve their action. The influence of these latter predominating, the glottis will be closed and the cords approximated. JOAL (Mont Dore).

NECK, &c.

WEIR.—Tumour of Thyroid removed by Socin's Method. *New York Surgical Society, December* 8, 1886 (*Med. News, January* 25, 1886).

SOCIN'S operation of enucleating the thyroid tumour now embraces over fifty cases, without any cachexia strumapriva following. In Dr. Weir's case the patient was a dwarf of twenty-one, mentally defective, and with an appearance of commencing myxœdema. The thyroid gland was exposed, cut through, and the tumour enucleated with the end of a scalpel and the finger nail, the venous oozing being checked by clamps and ligatures, and the cut gland edges sewed together except at the lower end, to allow the insertion of a drainage tube. Secondary union followed. The tumour was friable, and divided into lobes, like a compound racemose gland, with tubes and ducts lined with cylindrical epithelium, and the whole enclosed in a delicate fibrous capsule. The diagnosis was adenoma.

DE BURINE.—Considerations on Goître, dependent on Pregnancy and Accouchement. (Considerations sur le Goître, dependant de la Grossesse et de l'Accouchement). *Thèse. Paris, December*, 1886.

THE author relates nineteen observations, of which three are original. The thyroid gland is related to the female genital organs sympathetically. Uterine excitements are reflected in this organ so greatly that a sign of virginity has even been sought for in the volume of the neck. Thyroid hypertrophy has been noticed at the time of puberty, or the menopause. Goîtres have even appeared at each monthly period, disappearing on its cessation. Pregnancy is analogous. We can imagine that with the uterus, the vagina, the round ligaments, and the breasts, the thyroid gland acquires an

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