Pott (Halle).—*On Hyperplasia of the Thymus and its Dangers to Life.* "Jahrb. für Kinderheilk.," Band 34, Heft 1.

In eighteen cases of one hundred and seventy-six of laryngismus stridulus the author has observed sudden death. In four of these cases, which died in the presence of the author, he found an enlarged thymus gland. The author believes that the enlarged thymus may be dangerous by causing compression of the trachea and of the large vessels, especially of the pulmonary artery. The cases observed by the author gave the impression that the children did not die from suffocation, but from disturbance of the circulation and sudden cessation of the action of the heart. Artificial respiration and tracheotomy were without any effect.

Michael.

EAR.

Barr, Thomas (Glasgow).—*Treatment of the Nose and the Throat as a source of Middle-Ear Disease.* "Lancet," Dec. 17, 1892.

DR. BARR points out the now well-known dangers attending the use of the nasal douche. He thinks the entrance of fluid into the middle-ear is a common occurrence, though fortunately not always followed by inflammatory mischief.

He inculcates the necessity in the use of the nasal douche for careful instruction by the medical attendant; the previous examination of the nasal passages, so that in case of one side being narrowed the douche should be injected *into the obstructed side only*; the avoidance of a tight-fitting nozzle; the avoidance of great force; the fall in Weber's douche not to exceed two feet; a comfortable degree of warmth, and the admixture of one per cent. of salt or soda with, in ozæna or other bacterial diseases, a definite antiseptic; avoidance of the act of swallowing (as by protruding the tongue); the avoidance of the douche in the case of infants, young children, and adults with abnormally patent tube, nasal instillations being substituted; abstention from blowing the nose, and if possible from sneezing for at least a quarter of an hour after the douche; performance of the act of swallowing with the nostrils closed if pain in the ears evidence the entrance of fluid; great care, or even avoidance of the douche or syringe, and of exposure to cold or septic influences, for several days after operations or cauterizations on the nose or naso-pharynx; scrupulous cleanliness and asepticity of all instruments—cutting instruments, cautery points, finger-nail, etc. [The editor would like to draw attention to the safety nasal douche exhibited by him before the Laryngological Section of the British Medical Association at Nottingham, and reported in the JOURNAL OF LARYNGOLOGY for September, 1892.] *Dundas Grant.*

Field (London).—*The Pathology and Treatment of Suppurative Diseases of the Ear.* "Brit. Med. Journ.," Dec. 3, 1892.

THE author, after referring to the predisposing causes of suppuration, *i.e.*, any influence inducing a condition of the tympanic mucosa suitable

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for the propagation of pyogenic organisms, enumerates the several pyogenic bacteria found in middle-ear suppuration. The pyogenic bacteria found in the middle ear are enumerated as follows :—

1. Streptococcus pyogenes.
2. Staphylococcus.
3. Pneumococcus of Fraenkel.
4. Pneumo-bacillus of Friedländer.
5. Tubercle bacillus.

To illustrate which, drawings by J. J. Clarke are given. The preponderating frequency of the first in causing suppuration is noted, more especially its being the agent in precipitating cerebral abscess, etc., as a sequel to otitis. To the irritation of staphylococci is attributable the hypertrophy of the pharyngeal tonsil, which so often leads to purulent otitis, while the tubercle bacillus is frequently found in the muco-pus in the tympanum attendant on severe cases of tubercular meningitis. The author further alludes to the extension of suppuration from the tympanum to neighbouring dangerous regions.

Where the free flow of pus from the tympanum is obstructed, facial paralysis leading to wasting of muscles from peripheral neuritis sets in. On the same side as the paralysis there is loss of taste from injury to chorda tympani.

Under "Treatment of Otorrhœa with Perforation," thorough washing of the tympanum with antiseptics three or four times daily is commended, along with politzerization, which of itself in children may prevent an otorrhœa if carried out in the earlier stages of inflammation. [The use of cocaine at this stage is an important adjunct. Peroxide of hydrogen, fifteen volume solution, is recommended (more especially where cholesteatomatous masses are met with) in chronic otorrhœa.] For eczema auris, dilute mercury ointment is to be tried, taking care to free the meatus from discharge [as an unfailing remedy for this affection might well be mentioned glycer. acid. tannici. *Rep.*].—For furunculosis, an alcoholic solution of boracic acid is recommended, making incisions to relieve tension. For exostoses, the drill is the favourite instrument of the author. [It must be admitted that drilling is a most tedious process, and not to be compared for celerity and effectiveness to the alternative of detaching the auricle and lifting the cutaneous meatal wall out of the way and detaching the exostosis with hammer and chisel.—*Rep.*]

Wm. Robertson.

Clutton, H. H. (London).—*A successful Case of Ligature of the Internal Jugular Vein, and Trephining of the Lateral Sinus in an Ear Case where the symptoms of Pyæmia were well pronounced.* "Brit. Med. Journ.," April 19, 1892.

THAT of a boy aged ten, complaining of pain in the head and right ear, from which previously a discharge had been noticed. Swelling in the neck at angle of jaw and rigors followed, with temperatures ranging from 103-105° Fahr. No optic neuritis or mastoid tenderness. The jugular was exposed, and divided between two ligatures, the vein being found to contain a thrombus. The lateral sinus was next opened, and found to contain pus, and this was washed out by syringing through the distal

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opening in the vein. Metastatic suppuration took place over the left ulna and the left ankle, and was duly treated, after which the boy gradually recovered, with the exception of a few granulations in the tympanum. Primary emboli in the lung were not noticed, and were effectually stopped by the ligature of the vein, which is the first step to be adopted in such cases (supposing, of course, that the case is not met with when mischief is brewing in the mastoid antrum). *Wm. Robertson.*

Parker, Rushton (Liverpool).—*Aural Pyæmia successfully treated by Removing Putrid Thrombus of Jugular Vein and Lateral Sinus.* "Brit. Med. Journ.," May 21, 1892.

THE patient, who had been kicked over the left ear at the age of fourteen, and had had discharge from it ever since, was admitted, having suffered from pain for a week in the ear; for three days had had rigors, vomiting, restlessness, and giddiness. There was swelling and tenderness of the neck over the upper part of the left jugular, but no mastoid swelling. There was double optic neuritis. The jugular was first exposed and ligatured, then the mastoid and lateral sinus were opened, and, as in Clutton's case, through drainage effected. A subsequent relapse was found to be due to some antrum mischief, remedied by appropriate treatment. The patient made a good recovery. *Wm. Robertson.*

Field (London).—*Intra-Cranial Abscess.* "Brit. Med. Journ.," Dec. 17, 1892.

FOR the most part a review of the literature of the subject. In his reference to the complications of suppuration of the middle ear, Mr. Field refers (1) to facial paralysis from cerebral or peripheral implication, meningitis, or abscess. 2. Suppuration of the mastoid cells and sometimes also of the deeper tissues of the neck, more commonly sub-periosteal abscess, and necrosis, and sclerosis of the mastoid. [A reference might here have been made to Bezold's form of mastoiditis, which is liable to be complicated with facial paralysis and notoriously with phlegmon and abscess of the soft parts inferior to the mastoid apex. Perforation of the mastoid mesial by and into the posterior wall of the meatus takes place in this form of mastoiditis.] 3. Extra-dural abscess. 4. Meningitis. 5. Cerebral abscess from direct extension of septic inflammation along veins or lymphatics from the roof of the tympanum, mastoid antrum, or lateral sinus. 6. Thrombosis of the lateral sinus and internal jugular vein. 7. General pyæmia. 8. Marasmus.

Mr. Field further states that intra-cranial lesion is usually associated with at least one other complication; that, provided there is free exit for pus, the patient's general health remains good; and that caries and necrosis of the temporal bone may be extensive without causing cerebral mischief. In dealing with the symptoms of cerebral implication the author refers to pain over the mastoid region and racking headache as symptoms of actively inflammatory brain lesion from aural suppuration; vertigo is another well-marked symptom in chronic cerebral irritation. Oscillations of temperature and rigors are indicative of pyæmia.

Wm. Robertson.

https://doi.org/10.1017/S1755146300149790 Published online by Cambridge University Press

Barr (Glasgow).—*Case of Aural Exostosis causing Purulent Retention in the deep parts of the Ear, removed with the Electric Snare.* "Brit. Med. Journ.," July 2, 1892.

THE patient, a female aged twenty-four, with history of discharge from left ear for eight years. On admission she complained of pain in the ear and the same side of the head, and also of giddiness, tinnitus, and rigors. Examination showed a white, firm, rounded body just inside the meatus, evidently springing from the posterior wall of the same, near the junction of the bone and cartilage. With the electric snare, under chloroform, it was readily removed, from the fact that it was found pedunculated. Marked disease of the middle ear was now observed. With the removal of the exostosis the aural symptoms disappeared. The growth was found to be constituted of dense bone covered by a thin layer of cartilage. The author in dealing with the etiology of those growths refers to gout and syphilis as probable factors, but insists on an origin arising from irritative processes in the meatus, *e.g.*, chronic otitis media purulenta, or entrance of water into the meatus. Cassells referred such growths to ossification of granulations sprouting from an abscess cavity. Note is made of their growth invariably taking place from the mastoid wall of the meatus, the site most often affected by inflammatory processes. *Wm. Robertson.*

Laker.—*On Internal Massage of the Mucous Membrane, and its Relation to Aural Disease.* Verhandlungen des Deutschen Otologischen Gesellschaft, Frankfort-a-Main, April 16, 1892.

BY systematic massage of the nasal and pharyngeal mucous membrane the author has often observed improvements of chronic catarrhs of the middle ear. *Michael.*

Charazac (Toulouse).—*Notes on Syphilitic Internal Otitis.* "Journal of Laryngology and Ophthalmology," Oct., 1892.

THE labyrinth and the auditory nerve may be attacked by syphilis in the different stages of its evolution, either primarily, outside of any other lesion of the auditory apparatus, or, secondarily, by propagation of the affection from the middle ear to the internal ear. In the "isolated" internal otitis either the nerve is attacked or the disturbances are produced by osseous or congestive lesions of the walls of the labyrinth. In the other mode of attack the direct vascular communications that exist between the vessels of the tympanum and those of the cochlea are the channel for the mischief. Intense tinnitus, troublesome vertigo, cephalalgia, and, in some cases, facial paralysis accompany the disturbances of hearing. The tympanum and drumhead are often found to be normal. The cranial perception of the watch is abolished or markedly diminished, even when there still exists a very good degree of hearing. In all cases the fork is heard much longer by the cranial than by the aerial passage. Very rarely the auricular lesions and the deafness follow suddenly after the appearance of a chancre, and before any secondary manifestations of syphilis are noticeable. The author advances the hypothesis that where the primary lesion is in the throat, tonsil, lip, or maxilla, the cerebral lesion is more to be feared than if it is in the genitalia. *B. J. Baron.*

https://doi.org/10.1017/S1755146300149790 Published online by Cambridge University Press

Cheatle, Arthur H. (Vienna).—*The Mastoid Antrum in Children.* "Lancet," Dec. 3, 1892.

In a number of children varying in age from one to twelve years, the condition of the antrum was pretty uniform. It was conical with the apex, externally and below, the base being internal and above. The diameter of the base, and the length from base to apex, were both from a quarter to three-eighths of an inch. The sides are external, antero-internal and postero-internal, the entrance being at the upper and anterior angle. The apex abuts on the base of the mastoid process. He objects to the antrum being dubbed mastoid, as it is really part of the petrous bone, and suggests a better name would be "tympanic receptaculum." [Why not "petrous antrum" or "tympanic antrum," so as to retain the well-established term without outraging anatomical accuracy?] *Dundas Grant.*

Black (Edinburgh).—*Note on Perforation of the Mastoid for Middle-Ear Disease.* "Brit. Med. Journ." April 9, 1892.

Relates as to the use of a gimlet and cone-shaped burr, a suggestion by Dr. Hunter Mackenzie, to perforate the mastoid antrum, which, in the hands of Dr. Black, has given satisfaction. *Wm. Robertson.*

Politzer, Adam (Vienna).—*On Perforation of the Mastoid Process in Cases of Acute Otitis Media due to Influenza.* "Brit. Med. Journ.," Dec. 31, 1892.

In Dr. Politzer's Viennese experience influenza in attacking the ear gives rise with exceptional frequency to purulent inflammation of the middle ear, attributable to the passage of germs from the pharynx, and commonly complicated with mastoid abscess, rendering perforation of the bone unavoidable. In considering the classification of mastoid suppurations it is pointed out that the mastoid process presents three varieties of structure:—

1. Mostly made up of cellular spaces:
2. Entirely of diploe;
3. Air spaces and diploe.

The first is most prone to abscess formation, the pus in ordinary cases being absorbable, but in influenza the special organism of the disease exercising a destructive effect on the bony tissue prevents absorption, and renders operation necessary. Caries of the bone limiting the pus is observed. In diploetic mastoids abscess of the bone was also met with, rarely evacuating spontaneously. The symptoms relied upon (indicating abscess formation) were spontaneous pain in mastoid, with tenderness on pressure over middle and lower part, increased temperature over the region, and generally no notable cutaneous infiltration unless where there is superficial periostitis. Temperature slightly raised, and worst at night. The course of the affection was as follows: Mastoid and tympanic abscesses proceeded *pari passu* (without perforation of latter), necessitating perforation of both; more often the membrana tympani was perforated. While the mastoid abscess remained, otorrhœa continued, but sometimes the abscess was absorbed, and cure resulted spontaneously as an ordinary otitis media.

As a rule the morbid state continued, leading to caries, etc., and demanded operation, antiphlogistic measures proving inadequate. In one

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case Politzer found the lateral sinus exposed in a large cavity which, being opened in time, saved the patient.

Treatment.—Iodine, Leiter's coil, and washing out tympanum, etc., may subdue the symptoms, and lead after a week or two, to cure; if however, the febrile condition and local symptoms have continued for more than eight days, or if the antiphlogistic measures afford no relief, opening the mastoid must be thought of. The incision, four to five centimètres long, curved, through the skin, half-a-centimetre behind the concha, reaching to the upper limit of the bone, is effected, and the periosteum cleared to expose the middle and lower part of the process. The cortex is removed to the depth of from a half to one centimetre by means of a gouge, six millimètres in breadth, held obliquely to the surface. In the course of section pus is met with. Several small abscesses, separate or in communication, are sometimes met with. The abscess may now be scraped out. In only one case operated on was there communication of abscess with antrum.

Results.—Only one fatality. Fever soon disappears and discharge from the ear decreases in a few days, but not less than fourteen days. Wound heals (under iodoform gauze) in from three to four weeks.

Dr. Politzer wisely commends a more precise knowledge of operations on the mastoid amongst surgeons, more especially those in country practice, as in some cases delay is fraught with danger, and justly remarks that aural surgery should be rendered an obligatory subject of examination for the student in order that this branch of medicine should become the common property of all practitioners. *Wm. Robertson.*

REVIEWS.

Halbeis (Salzburg). — *Die adenoiden Vegetationen des Nasenrachenraumes Hyperplasie der Tonsilla Pharyngea bei Kindern und Erwachsenen und ihre Behandlung.* München and Leipzig: J. F. Lehmann. 52 pages. 1892. ("Adenoid Vegetations of the Naso-Pharynx; Hyperplasia of the Pharyngeal Tonsil in Children and Adults, and their Treatment.")

In a well-written treatise, read before the Medical Association of Salzburg, the author describes the pathology, etiology, and treatment of adenoid vegetations, and concludes with a table of five hundred and forty-two cases collected from his own practice. Naturally the greater portion of the facts communicated are well known to specialists, but some of the remarks of the author may be of interest. He agrees with Michael, Mackenzie and Schech that the disease is not scrofulous, and is often observed in patients without any other signs of scrofula, but sometimes both affections are combined. Adenoid vegetations also never contain tubercle bacilli. Complications such as coryza, eczema, and swollen glands are always cured by operation upon the tonsil. In some cases laryngismus stridulus can be cured by removing the pharyngeal tonsil. Discharge of pus from a recessus media, as described by Tornwaldt, the author has observed in forty-seven cases; aprosexia in two cases;

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