These two cases seem to indicate some connection or other between ozæna and antral disease. In both it will be noticed the ostia maxillaria were imperforate, and that in both treatment likely to subdue infiltration in the antral mucosa led to patency in one case and is promising the same result in the other, and that with recovered patency increased improvement occurred in the first case. So far I have found treatment per antrum in both cases bring about results immeasurably in advance of the routine at present advocated. Whether more radical and permanent results will follow time alone will show. The question of the connection between ozæna and antrum implication need not be difficult of ascertainment. The light is a handy and ready instrument. If implication of the antrum is indicated few, I imagine, of these unfortunate patients would refuse to undergo the steps suggested.

(To be concluded.)

ANNOTATIONS.

CYCLING AND LARYNGITIS.

DR. RAGONEAU has observed nine cases of young persons, aged from eighteen to twenty-seven, enjoying excellent health, and in eight of whom the lungs were absolutely sound, and presenting no ordinary tendency to catarrhs (in the ninth individual there was a slight degree of pulmonary emphysema), in all of whom a characteristic form of laryngitis has been produced by bicycle or tricycle exercise. The condition is thus described :—"A sore throat which has lasted a very short time, dryness "and irritation, or burning sensation ; later, cough, accompanied with "expectoration of a little mucus, even sometimes tinged with blood ; and "the voice becomes muffled." Laryngoscopically, these patients present a condition of dryness and pronounced congestion of the pharynx ; the mucous membrane is reddened, injected, or dotted with congested granulations ; the vocal cords are pale red, but always discoloured, and covered with more or less viscous mucosities. All these individuals made a daily and often immoderate use of the bicycle or tricycle, and each time, after prolonged or rapid exercise, the laryngeal condition recurred. The inclining of the body forward interfering with respiration, the necessity of inhaling a considerable volume of air during such violent exercise with open mouth, and the penetration of a considerable volume of such air, at a pressure proportionate to the speed, into the larynx and lungs sufficiently explain the origin of the laryngeal catarrh.

The treatment of such cases of laryngitis is obvious.

The unhealthy and unphysiological attitude assumed by the average cyclist, with body bent forward, and chest contracted and head thrown back, when racing along the roads or toiling up hill, is one which must sorely tax the respiratory capacity of the individual ; and, apart from the conditions mentioned above, there must of necessity be, in many instances,

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a considerable amount of congestion of the throat and interference with proper circulation, induced by the abnormal position of the body. Cycling is so universal that many of the less robust individuals who ardently follow this amusement may suffer actual danger. We can well imagine how emphysema or hæmorrhage may be the result of continuous or violent exercise of this kind. Cycle riders should be advised to sit erect upon their machines, with the chest expanded, instead of adopting the ungraceful and unhealthy bent attitude so common, and take due care of their respiratory function, even at the cost of a little less speed of movement.

THE MODE OF CLOSURE OF THE LARYNX.

AT a recent meeting of the Physiological Society, Mr. Anderson Stuart gave a brief outline of his experiments in reference to the above subject, made (1) by observations in a man through a large opening in the side of the neck ; (2) in normal persons by the laryngoscope ; (3) experimentally in animals ; and (4) from a study of the arrangements of the larynges of different animals and the intimate structure of the human larynx. He concludes that the epiglottis does not fold down in a lid fashion, but the entrance to the larynx is closed by the apposition and gliding and inclination forwards of the arytenoid cartilages, the upper parts of which, with the cartilages of Santorini, fit (in man) into the groove formed by the incurved margins of the epiglottic base. The muscles concerned are mainly the external thyro-arytenoidei. The ary-epiglottic folds are rendered tense by the ary-epiglottic muscles, including the oblique arytenoids. A T-shaped fissure is thus caused when the larynx is closed, the transverse limb being bounded anteriorly by the epiglottis, and, posteriorly, by the ary-epiglottic folds ; the antero-posterior limb by the arytenoids and cartilages of Santorini. The cavity of the vestibule is obliterated, the saccule compressed, secretion possibly expressed, the ventricle encroached upon, the glottis lies at a lower level, and thus the vocal apparatus is moistened and protected during deglutition. The upward and forward movement of the whole larynx remains an important factor.

THE TREATMENT OF DIPHTHERIA.

A VERY interesting "letter from Paris" to the *Archives of Pediatrics* reviews the latest methods employed by several French physicians in the treatment of diphtheria, which is worth reproduction in these columns.

Dr. JULES SIMON first cleanses the throat with a wad of antiseptic cotton, wrapped in Péan's long forceps, avoiding any wounding of the mucous membrane, after which the following solution is applied on a wad in another pair of Péan's forceps.

℞. Salicylic acid..... 0·60 centigrammes.
Infusion of eucalyptus ..... 60 grammes.
Glycerine..... 40 „
Alcohol ..... 15 „ M.

This treatment is carried out every two hours. All cotton used is burned,

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and the instruments are disinfected by washing in boiling water. Dr. Simon uses no carbolic acid.

In the intervals of using this application a four per cent. solution of borax in hot water is employed freely for irrigating the throat, or for gargling, if the child is old enough to perform it. The atmosphere of the room is kept moist with a spray of thymol. The child is, where possible, changed into another room during the day, or, if impossible, inhalations of oxygen gas are employed. Alcohol, either as port or sherry, or in some other form, is frequently given, and three to six drops of the perchloride of iron in a little water is administered internally. No milk, mucilaginous solutions, or metal spoons are employed when the iron is given. To a child of five or six years of age Dr. Simon adds a preparation of cubebs and copaiba, but never prescribes opium in any form.

Dr. GAUCHER removes the false membrane with a rough brush holding the following solution :

℞. Camphor..... 20 grammes.
Olive oil ..... 15 „
Alcohol (90°) ..... 10 „
Crystallized carbolic acid... 5 „
Tartaric acid ..... 1 „ M.

This is applied every night and morning, care being exercised that none of the solution drops into the mouth or larynx. In the intervals, irrigation of the throat with one per cent. solution of carbolic acid every two hours is made. This treatment is said to be very painful.

Dr. LEGROUX, at the Trousseau Hospital, uses twice a day brush applications of—

℞. Glycerine ..... 20 grammes.
Alcohol ..... 10 „
Creosote ..... 1 „ M.

and prescribes a spray of creosote, 100 parts in alcohol 1000 parts, to be kept going all the day. In serious cases he uses hypodermic injections of—

℞. Aseptic olive oil .....150 grammes.
Creosote ..... 20 „

and claims that this has a preventive action upon the broncho-pneumonias which may succeed tracheotomy.

Dr. LEGENDRE uses the following solution in a cotton wad several times a day—

℞. Napthol..... 5 grammes.
Alcohol ..... 5 „
Glycerine .....100 „ M.

and irrigates the throat in the interval with—

℞. Napthol..... 0·20.
Water ..... 1000.

Dr. HUTINEL, at the Children's Hospital, uses wad applications of—

℞. Terpine hydrate ..... 8 grammes.
Bichloride of mercury.....0·30 centigrammes.
Ess. mint .....100 grammes.
Alcohol .....100 „
Ess. thym..... a few drops. M.

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Irrigations are also made every two hours with hot borax water, and from 3 to 12 grammes per diem are given internally of benzoate of soda. Several physicians (Drs. Gaucher, Cadet de Gassicourt, and d'Heilly) are also trying sulforicinated carbolic acid as a local application.

℞. Carbolic acid ..... 10 grammes.
Sulforicinated soda ..... 90 „ M.

applied on wads to the throat. It is not washed off by gargles or irrigations, but adheres to the mucous membrane, and is allowed to penetrate as much as possible. The application is also free from pain or irritation. The following is being used in the Children's Hospital at Nice, as an application to the throat and membrane every three hours—

R. Sulforicinated soda ..... 80 grammes.
Salol ..... 10 „
Creosote (or terpine)..... 2 „ M.

and the following is also employed there as a local application :

R. Glycerine ..... 30 grammes.
Salicylic acid.....
Terpine or creosote ..... } āā 0·60 centigrammes.
Alcohol q. s. to dissolve. M.

Almost all French physicians use irrigations of hot borated water, and keep the atmosphere moist with steam sprays. In Nice a common earthenware pot is kept on the fire with thymol in water, or leaves of the eucalyptus tree kept boiling in water, the steam being allowed to pass into the room constantly.

For general treatment, tonics such as kola, cinchona, &c., and good wine are freely given ; fluid foods are prescribed, and where food is not taken rectal alimentation with peptonized foods is resorted to at once. Careful antisepsis is employed, all linen and dejections, as well as the closets, being treated with bichloride of mercury. Each member of the household, as well as the nurses, and those in attendance upon the patient, uses borated solutions, with which they wash the face and hands frequently, which is also done for the patient.

It will be observed that intelligent French physicians are no more agreed upon a common method of therapeutics for diphtheria than others, their efforts being based, however, upon the generally accepted propositions that the microbes in the membranes develop the toxines which poison the system, that these microbes develop on an inflamed surface only, or on one which is denuded of epithelial covering, and that the microbes preserve their vitality for a long time. The focus of infection must therefore be controlled by antiseptics, the mucous membrane be preserved from injury and be protected from the entrance of the bacillus, and enabled to eliminate the toxines, which are formed by the micro-organisms.

AT the meeting of the British Laryngological and Rhinological Association, held on Friday, March 25th, 1892, the following notes and cases were presented :

By Mr. LENNOX BROWNE :—1 "A Case of Hypertrophic Rhinitis,

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with old history of Lupus." 2. "A Case of Lupus of the Mouth, Fauces, and Larynx." (With microscopic specimens by Mr. WYATT WINGRAVE.)

By Dr. W. MILLIGAN :—1. "The Notes of a Case of Primary Nasal Syphilis." 2. "The Notes of a Case of Primary Abscess of the Larynx."

By Mr. WARD COUSINS :—"Notes of a Case of Deep Abscess of the Neck, followed by Acute Laryngeal Symptoms—Tracheotomy—Recovery."

By Dr. SANDFORD :—1. "Case of Bulbar Paralysis." 2. "Case of Paralysis of Left Vocal Cord, etc., from Injury."

By Mr. WYATT WINGRAVE :—1. "Some Points concerning the Pharyngo-Glossus and Lingual Tonsil." 2. "On some Characteristics (Histological) of Laryngeal Epithelioma." He also demonstrated the following microscopic specimens, etc. :—1. "Lingual Tonsil." 2. "Epitheliomata." 3. Recent specimen. "Membranous Laryngitis" (from a Case of Mr. JAKINS).

A Discussion on "The Necessity for Systematic Voice-Training in Preparing for Public Speaking" was introduced by Dr. SANDFORD, in which the following gentlemen took part :—The President (Mr. LENNOX BROWNE), Dr. FARQUHAR MATHESON, and Dr. DUNDAS GRANT. Mr. BEHNKE made a few remarks. The official report of this meeting will be published in the May number of this Journal.

Dr. DUNDAS GRANT has been appointed Otologist and Laryngologist to the West End Hospital for Nervous Diseases, London.

NOSE AND NASO-PHARYNX, &c.

Bull (New York).—*Tumours of the Orbit, secondary or consecutive to Tumours of the neighbouring bony cavities.* "New York Med. Journ.," Dec. 19, 1891.

THESE tumours are either fluid or solid. The former almost always arise in the frontal sinus or ethmoid cells and contain pus or mucus ; the latter are either solid or densely gelatinous, are always malignant, and arise in the maxillary, sphenoid or ethmoid antrums. Finally, a by no means uncommon growth in this locality is a bony tumour, or real ivory exostosis, arising from the bones surrounding the orbit.

Referring to the diagnosis of abscess of frontal sinus, the author has seen cases where there was never any pain during the development of the abscess. If with local pain there is coryza, ozæna, or purulent discharge from one nostril and the frontal boss is painful and protruding, and if the eye is displaced downwards and outwards, the lesion is almost certainly in the sinus, but may not be abscess.

The incision for the tapping of a frontal abscess should start from the inner canthus, immediately beneath the superior orbital arch, be carried

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