tion of fluid between the condyle and socket. This condition may be secondary to a throat lesion or may result from a focus of infection in some other part of the body. The patients usually refer the trouble to the ear, but this can be excluded by otoscopic examination.

Ankylosis of the lower jaw joint may vary in degree. According to Blair, trauma is the most common single cause and accounts for 50 per cent. of cases which were usually due to a blow or fall on the chin. Suppuration following scarlatina accounts for 20 per cent., and other cases are due to otitis media, dento-alveolar abscess, typhoid fever, pneumonia, measles, variola, diphtheria, and rheumatoid arthritis. Congenital ankylosis is very rare and is due to trauma during delivery. The obstetrical forceps may cause fracture of the base of the skull or of the mandible, and this may be followed by ankylosis. The writers record three cases: (1) Bilateral complete bony ankylosis of congenital origin cured by operation; (2) fracture of the body of the mandible, in which a fairly good result was obtained; and (3) bilateral forward dislocation of the lower jaw cured by operation.

J. S. Fraser.

CORRESPONDENCE.

To the Editor of The Journal of Laryngology, Rhinology, and Otology.

Sir,—I feel that Dr. W. H. Kelson's criticisms of my paper must be answered in detail, in order that the objections which he raises may be met before they deter others from using a method which I believe to be of great value to all those who aim at the rational (and not the rule-of-thumb) treatment of deafness.

Some of Dr. Kelson's objections are well put, some of them are mere "bogies"; to be disposed of, like a certain other "Bogey," by care in play.

I must, therefore, beg you to allow me a little of your valuable space for as short a reply as I can make.

(1) Is endo-rhinoscopy all plain sailing, and do the results obtained point to its great practical utility? To these I would reply "No" and "Yes." It is no more plain sailing, especially to the beginner, than is laryngoscopy or posterior rhinoscopy. I say unhesitatingly "Yes" to the second half of the question, and I should say it (on the same grounds as the "one sinner that repenteth") if I could only point to one case in which its use had been instrumental in saving hearing—and I could point to several.

(2) "It is practically useless in children." No, this is by no means the case. Granting that in its present form the instrument is a little too large (of which more anon), I have found it in some cases most valuable. In the cases quoted in my paper, one was a girl aged twelve, one a boy aged ten. With these children I had no difficulty whatever. And they were by no means solitary instances. But it is seldom that the instrument is needed in children. I have had one or two cases in which the instrument, used under an anæsthetic before operation, has yielded information most useful in character. I have had no difficulty in children younger than those mentioned. Personally, I believe that one can carry out with success in a majority of children most forms of examination, *provided* one is gentle, treats them as reasonable beings, takes them into

https://doi.org/10.1017/S1755146300018163 Published online by Cambridge University Press

extremely difficult, but these belong to a minority and the majority can be "got round" by perseverance. But this applies as much to other methods of examination as to endo-rhinoscopy.

(3) There are, it is true, certain noses in which the instrument cannot be passed, but these are very few. As to the alteration of appearance caused by cocaine, surely the experienced rhinologist knows what allowances to make for these! In some cases such alterations are a positive help, as enabling one to see things that would otherwise have remained hidden. This was the case in one of my patients who had a small polypus at the opening of the frontal sinus.

(4) The washing out of the nose, before passage of the instrument, on account of pus, blood, or thick mucus getting on to the prism is quite a minor consideration. I did not mention this in my paper because I considered it too obvious and I was writing for trained rhinologists. Why should it make more difference to wash out the nasal passages before using the endo-rhinoscope than it does before practising posterior rhinoscopy, or before testing an antrum by putting the patient into the draining position?

A point that I ought not to have omitted in my paper is that the instrument should be warmed before introduction; also it is useful to rub a little oil over the prism, to avoid the obscuring effect of moisture.

I would ask Dr. Kelson whether any method of examination has ever yet been introduced which did not entail modification and improvement? Did Lannaec throw away his stethoscope because of the contemptuous opposition with which some of his professional brethren regarded it? Were the X rays abandoned because it was not always easy to locate a needle by their aid? The essence of progressive medicine is invention, and the stimulus to invention is not merely criticism, but *constructive* criticism.

I would suggest that two material improvements in the endo-rhinoscope would be: (1) Its reduction in calibre, (2) the abandonment of the curved for the straight instrument. Both these improvements have been carried out by Dr. Dan McKenzie in his instrument.

Dr. Kelson says that "no doubt the method will score occasionally." I suggest that it will score in the majority of cases and that this majority will grow with time. It is not the drawbacks of a method that keep it out of the text-books, it is the fear that so many authors seem to possess of what they are apt to style "innovations."

I thank Dr. Kelson for his criticisms, which have enabled me to add further to what I have already written on the subject, but still more for his calling me a "progressive otologist." In these semi-stagnant days of hesitation between the roads of palliation and prevention, the title is one to be proud of.

Faithfully yours,

MACLEOD YEARSLEY.

NOTES AND QUERIES.

PROF. GRADENIGO.

Prof. Gradenigo, we are interested to observe, on January 15 last, delivered the first of his course of lectures at the Oto-Laryngological Clinic of the Royal University of Naples. We wish our distinguished colleague every success in his

https://doi.org/10.1017/S1755146300018163 Published online by Cambridge University Press