MOUTH, TONSILS, PHARYNX, &c.

SHEPHERD, F. J. (Montreal). — **Glossitis.** *Medico-Chirurgical Society of Montreal*, May 4, 1888.

DR. SHEPHERD described a case of hemiglossitis recently under his care. The patient, male, aged thirty, had the glossitis limited to the right half of his tongue. The attack was ushered in with fever and malaise, and the case rapidly recovered. **G. W. Major.**

HUNT (Clarksburg, Ont.). — **Idiopathic Glossitis.** *Transactions Ontario Medical Association*, July, 1888.

IN idiopathic glossitis the use of ice in the treatment of the disease was strongly advocated. **G. W. Major.**

HEATH, CHRISTOPHER (London).—**Clinical Lecture on Diseases of the Tongue.** *British Medical Journal*, April 21, 1888.

THE lecturer considers diseases of the tongue under three heads—inflammations, ulcerations, and deposits.

Acute glossitis may be idiopathic, but more often it appears to be connected with the administration of mercury. The treatment is simple—an incision on each side of the middle line of the organ.

Chronic inflammation is most commonly due to smoking. The lecturer has no doubt that tobacco has a deleterious effect upon the mucous membrane of the tongue. The surface is *reddened* during the early stage of chronic glossitis (tobacco), and it is only when this has passed away that the whitened condition ("leucoplakia" or "leucoma") is developed. These white patches may be mistaken for epithelioma; they undoubtedly render the individual liable to epithelioma. They may develop into warts, or into ichthyosis, the latter being very closely related to epithelioma.

The syphilitic affections of the tongue involving a chronic change in the epithelium are chancres and mucous tubercles (rare), and the common specific affection—a variety of chronic glossitis with cracks—which is well recognized as the result of secondary disease. The lecturer strongly advises the use of mercury internally and locally, in the latter case subjecting the tongue to the process of "pickling."

Ulcerations are of three forms—syphilitic, tubercular, and epitheliomatous. The syphilitic ulceration may be superficial or deep; the tubercular ulcer is usually situated at the tip of the tongue; the epitheliomatous ulcer "is not simply an ulcer, but an ulcer with a growth, a growth springing up at the edges of the base, and forming a protrusion."

Deposits in the tongue are of two kinds—the epitheliomatous and the gummatous. The former always follows the ulcer, and extends beneath it, whilst the latter is apt to develop in the central portion of the tongue, and give rise to formidable-looking ulceration.

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The lecturer does not believe in the efficacy of Chian turpentine or other drugs as a remedy for cancer of the tongue. Early operative treatment alone has any prospect of removing the disease.

Hunter Mackenzie.

CASTELO.—Deep Fissure of the Tongue. *Revista de Medicina y Cirugia Practicas*, Madrid, July 22, 1888.

THE condition was an ulceration situated on the superior surface and right side of the tongue; its transverse extent was one centimetre, and its length five. It was of cavernous aspect, had flat borders, and, at the level of the rest of the organ, lightly and irregularly crenated, excavated walls, uneven base of grey-yellow and dark colour, with peripheral plastic infiltration. The patient felt great pain in speaking, drinking, and eating. From the pathological antecedents of the parents and brothers of the patient, and by his own, from the form and objective character of the ulcers, the absence of lancinating pains, of neuralgic irradiations, hæmorrhages, or submaxillary enlargements, and from the odour of the secretion, the author diagnosed ulcerated gumma of the tongue. The treatment showed that the diagnosis was exact, the patient being cured with iodide of potassium internally and locally, along with a good hygienic and dietetic treatment. **Ramon de la Sota.**

RUAULT, A.—Contribution to the Pathology of the Fourth Tonsil. *Archives de Laryngol.*, June 15, 1888.

AFTER an anatomical and histological description of the fourth tonsil, called also the lingual tonsil, Ruault studies also the chronic form of pre-epiglottic tonsillitis, which is rather common. Sometimes the mamillated layer has undergone a uniform thickening, and has reached, or even passed, the level of the free edge of the epiglottis, bending this operculum backwards. Sometimes certain groups of follicles only are hypertrophied, and present the appearance of raspberry-like elevations of variable size—sometimes as large as a nut. The region presents a muriform appearance in others, and seems covered with round grains, resembling currants in form. The cause of the affection is little known. The coincidence, more or less marked, of nasal impermeability noted in a certain number of cases, leads Ruault to suspect that breathing with the mouth open may have some part in producing the disease. The symptoms are of a local or reflex origin: feeling as of a foreign body in the throat, suffocative sensation, affection of the voice, cough, dyspnœic attacks, and dyspeptic troubles. Treatment consists in reducing the hypertrophy by cauterization. **Joal.**

LE DENTU.—Neoplasms of the Hyoid Bone. *Soc. de Chir.*, June 13.

THIS was a case in which a tumour developed in a woman aged seventy-one, which was movable in a lateral direction, and presented so great a development that the whole region was invaded. The skin was healthy; one single gland was enlarged to the right side above the carotid; the buccal mucous membrane was quite intact; also the tongue and the salivary glands. No alteration was observed of the pharynx or larynx.

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After having performed ablation of this tumour, which was independent of the larynx and easily removed, it was quickly ascertained that it had developed at the expense of the posterior part of the hyoid bone. This was removed at the same time. **Joal.**

VERNEUIL.—Adeno-phlegmon (Sub-hyoidean) and Periostitis of the inferior Maxilla. *Bull. Méd.*, May 2, 1888.

THE differential diagnosis of the two affections is deduced from—

1. The previous history. If the patient has had amygdalitis, periostitis may be eliminated.

2. The objective characteristics of the tumour. In periostitis the greatest degree of tumefaction is on the face; in phlegmon the chin is exempt, and the tumefaction is chiefly situated below the inferior edge of the jaw. The prognosis is different in the two cases. Adeno-phlegmon is rapidly cured; in periostitis prolonged osteo-myelitis must be feared. **Joal.**

CHAMPIONNIÈRE, J.—Guttural Reflex observed after Utero-ovarian Operations. *Journ. de Méd.*, Paris, May, 1888.

AFTER operations in the region of the ovaries or uterus, a guttural reflex is often observed, which the author calls "crachotement" (expectoration). Patients have an incessant desire to spit. In bad cases, this insupportable desire incessantly torments the patients, and the effort of spitting is followed by vomiting. In less grave cases this desire, though less frequent, is often very painful. Besides utero-ovarian operations, this spitting is very frequently met with in a marked degree at the commencement of pregnancy. **Joal.**

PONCET, A.—Voluminous Adeno-chondroma of the Palatine Arch. Death from Asphyxia. *Gaz. des Hôp.*, June 14, 1888.

THE case of a man, aged fifty-seven, who had a tumour weighing 150 grammes, and who died some hours after his admission to the hospital. It is rare to find an adenoma of the palatine vault terminate in such an accident. The volume of these tumours generally varies from a nut to a hen's egg. **Joal.**

TRÉLAT.—Ribbon Ligature in Palato-plastic Operations. *Journ. de Ruault*, April 15, 1888.

IT is well known that Dudon has proposed to employ a ribbon, and to include the two flaps in this ribbon, and by this means to draw them near to each other. Trélat says that this method offers no advantage, for the following reasons:—The time taken in the cure is longer, duration of the operation at least as long, and there is no chloroform used. **Joal.**

ROUSSEAU.—Contribution to the Study of Acute Infectious Amygdalitis. *Thèse Paris*, 1888.

AFTER dealing with the history and description of these tumours, the author gives the differential diagnosis with acute and cold abscesses,

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hæmatoma, hydatid cysts, erectile tumours, and finally publishes an original observation, and summarizes fourteen cases related by other authors. **Joal.**

DU CASTEL.—Early Syphilitic Angina. *Soc. Méd. des Hôp.*, June 8, 1888.

EARLY syphilitic angina, which generally coincides with the appearance of roseola, is not admitted by all authors. Its existence appears, however, to be indisputable. It commences, as Lasègue has pointed out, on the arch of the palate, and is characterized by hypertrophy of the glands of the palatine mucous membrane, and notable injection of the vessels of this region. The arch of the palate appears to be dotted over with grains of semolina. The mucous membrane then becomes thickened, infiltrated, and œdematous in patches. The evolution of this symptomatological process requires several days. **Joal.**

JAMISON, ARTHUR (London). — **Hæmorrhagic Pharyngitis.** *British Medical Journal*, April 21, 1888.

THE author states that "the diagnosis of all these cases rests on the fact of the entire absence of lung mischief, and on the microscopical characters of the sputum. The clear portion of the secretion consisted of large squamous epithelium from the mouth, and many small round cells from the entrance to the larynx, and a few pus corpuscles, the yellow portion of pus and fat cells, a few blood corpuscles, and in great abundance the large spheroidal cells from the pharynx. There were no elastic fibres, nor any distinct epithelium from the alveoli or bronchial tubes." In two cases in which tubercle bacilli were looked for, they could not be found. The author is inclined to think the condition is of hepatic origin.

In regard to treatment, he "treated the throat less, the general condition more." He thinks the profession nowadays pays too little attention to the liver.

(We agree with the author in the value he attaches to the microscopical examination of the sputum, and to the advisability of every practitioner making it a part of his routine work. An important defect in the paper is the entire omission of any description of the appearances of the pharynx in these cases. Had the sources of the hæmorrhage been carefully looked for and detected, local treatment (*e.g.*, the galvano-cautery) might have proved more successful.—REP.) **Hunter Mackenzie.**

KIDD, PERCY.—Hæmorrhages from the Pharynx and Larynx, and other Hæmorrhages that simulate these. *Brit. Med. Journ.*, September 15, 1888.

A TENDENCY exists now to speak frequently of bleeding from the throat. The causes of hæmorrhage from the pharynx and larynx may be general and local. Of the former are diseases characterized by changes in the blood, and possibly in small vessels, *e.g.*, purpura, hæmophilia, leucæmia, pernicious anæmia, &c. The second group comprises ulcerations, *e.g.*, suppuration, traumatism, the so-called hæmorrhagic laryngitis, and perhaps

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a varicose or dilated condition of veins. An actual discharge of blood from the pharynx or larynx, such as in diseases of the first group, is quite exceptional. Submucous extravasations are less uncommon. Serious bleeding from local affections of the pharynx or larynx is very uncommon. Dilated veins in the pharynx may possibly streak the saliva or expectoration, but this is not important. Under the term hæmorrhagic laryngitis several conditions are included. Some are instances of purpura or hæmophilia. In these cases there is seldom more than a staining of the secretions. Such cases, in which the hæmorrhage is often submucous, occur oftenest after strain of the voice. The detachment of dry crusts in laryngitis sicca may give rise to slight bleeding.

The causes of serious bleeding from the larynx and pharynx are three in number, viz., ulceration, suppuration, traumatism. Cancerous ulceration is most likely to give rise to bleeding; syphilitic ulcers occasionally perforate vessels of large size. Bleeding from tuberculous ulceration must be very rare. The author's great experience of these cases has not given him a single instance.

Isolated instances occur where persistent blood-spitting has been traced to a bleeding point in the larynx, without obvious disease of the mucous membrane, supposed to be due to rupture of capillary vessels. The pathology of these cases is very obscure. In the great majority of cases in which bleeding is attributed to the throat, the blood comes from below the glottis, nearly always from the lung, less frequently from the nose, gums, or mouth. Most throat hæmorrhages occur in persons with early pulmonary phthisis, and are really from the lung. It is a mistake to conclude that because there are no physical signs in the chest, phthisis must therefore be excluded, and the hæmorrhage be referred to the throat.

Every hæmoptysis must not be attributed to serious disease of the lung.

Bleeding from the nose, especially if occurring during sleep, may be mistaken for pharyngeal or laryngeal hæmorrhage. Epistaxes are much more common in women after puberty. The erectile tissue of the nose is the immediate cause of the bleeding. Bleeding is common in anæmic girls, the blood having oozed from the gums, mouth, &c. Bleeding is obtained in some hysterical girls by wounding. **R. Norris Wolfenden.**

MILLS, T. WESLEY (Montreal).—**Case of Profound Lightning Shock, with Recovery.** *Montreal Medical Journal*, August, 1888.

DR. MILLS observed, among other symptoms, difficulty in getting rid of saliva and excessive secretion of it for some time after the accident. Loss of speech, after consciousness had been regained, he considers points to paralysis of pharynx and adjacent parts. **G. W. Major.**

SCHAEFFER (Bremen).—**The Pharyngeal Bursa and Tonsil.** *Monatss. für Ohrenheilk.*, 1888, No. 8.

THE author concludes a paper upon this subject with the following theses :—

1. The "bursa pharyngea" is in rare cases congenital, or develops later as the result of pathological processes.

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2. Most of Tornwaldt's cases are pathological, produced by diseases of the pharyngeal tonsil.

3. There is no reason to call this condition "bursitis."

4. The treatment often gives negative results.

The author then relates cases of disease of the pharyngeal tonsil, and their treatment. In one case he observed a cyst of the bursa as large as an apple, which he removed with Michael's forceps. **Michael.**

MOLLER (Aalborg, Denmark).—**A Case of Pharingotomia Subhyoidea—Recovery.** *Ugeskrift for Laeger*, July 21, 1888.

A GROWTH, consisting of four divisions, each being the size of a small hazel nut (according to the description it seems to have been an adenoma), originating with a broad base from the left edge of the epiglottis, was removed through a five centimetre long transverse incision in the thyro-hyoid space, in a man aged thirty-two, in whom attempts to remove the growth *per vias naturales* had previously failed. The operation was preceded by tracheotomy, and the tracheotomy wound was afterwards sewn up, but the development of a considerable emphysema after the operation forced the operator to re-open the tracheotomy wound. The patient recovered speedily; only a very slight hoarseness was left when he was seen last, about a month after the operation.

Holger Mygind.

MORENO Y DESVERNINE.—Foreign Body in the Gullet· External Œsophagotomy. *Cronica Medico-Quirurg. de la Habana*, June, 1888.

MORENO was called to see a man who was choking through an artificial set of teeth having, during his sleep, fallen into his throat. Being unable to extract the foreign body, Moreno caused it to change its position, with which the patient was relieved. Desvernine saw the case in consultation, and he tried to extract the set of teeth by the mouth, but, not succeeding, eight days after he performed without any accident external œsophagotomy and extracted the foreign body. The patient had some hæmorrhage and was in a critical condition for some days, but a month after the operation there was only a small fistula in the neck. Desvernine reproduces Fisher's statistics upon external œsophagotomy, completing it with the two cases of Sota and the present case. **Ramon de la Sota.**

PLICQUE (Paris).—**Critical Study on the Treatment of Cancerous Strictures of the Œsophagus.** *Ann. des Mal. du Larynx, &c.*, August, 1888.

THE author passes in review four methods of treatment:—

1. *Dilatation by Catheterism.*—This method is both ineffective and dangerous. The results are not permanent; spasm and inflammation are apt to follow the introduction of large sounds, and there are dangers of penetrating the aorta, bronchi, and mediastinum. Non-cancerous strictures are those which benefit most by this method.

2. *Gastrostomy* is less successful in malignant than in ordinary strictures. When the operation is performed late on, mortality is excessive.

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Early gastrostomy, so often performed in England, is rarely done in France. Of 145 cases of gastrostomy collected by Lagrange the mean duration of life has only been nineteen days. The operation is useless and unnecessary if performed early, and too late if held over till the condition is advanced.

3. *The Employment of Permanent Catheters* (short and long).—These have remained in the œsophagus five months (Boyer), 305 days (Krishaber), three months, fifty-five days (Kirmisson). Long sounds may produce ulceration at the level of the cricoid cartilage, and they prevent the patient from swallowing directly. Morell Mackenzie tried to overcome this by employing a short sound. Symonds introduced sounds of variable diameters (Nos. 10, 13, and 16), of seventeen centimetres in length. Renvers modified them by making them of soft material, and latterly by employing canulas of horn or caoutchouc in the form of a cone, five centimetres high, twelve to fourteen millimetres at the open, and six to nine millimetres at the narrow part. The canulas are flattened from before backwards, to pass more easily over the region of the cricoid cartilage. The sound is introduced into place by a conducting bougie, and kept in place by threads passed out through the mouth. Liquid alimentation must be employed. Renvers' canula acts as a dilator, and in a few days many patients find they can swallow naturally, though only temporarily. A great point in favour of Renvers' tubes is that patients can satisfy their thirst. Patients can wear their canulas also better than long sounds. Certain cases—when there are broncho-œsophageal perforations—require the use of the long sound. The objection to these short canulas is that the thread to hold them in place has to pass out through the mouth, and is thus insecure. The tubes have slipped into the stomach, but so far have not been shown to do any harm. If the tubes get blocked with food, a fine sound must be passed through them. **R. Norris Wolfenden.**

NOSE AND NASO-PHARYNX.

BOSWORTH, F. H.—The Physiology of the Nose. *Med. News*, August 4, 1888.

THE author maintains the thesis that the functions of the nose are mainly respiratory, the olfactory and phonatory functions being quite secondary, this respiratory function consisting in yielding up to inspired air about 5,000 grains of water, none of which can come from the bronchi or air cells. This water comes by transudation from the blood-vessels underlying the mucous membrane of the turbinated bodies, "the so-called erectile tissue." The physiological proof of Bosworth's ideas (which are founded on clinical observations) is found in Aschenbrandt's and Kayser's experiments, which are quoted by the author at great length. The "erectile tissue" of the nose is designed to subserve serous

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