and just criticism of many medical follies, and he has produced a work the reading of which cannot fail to be of the greatest profit to younger members of the profession, and of equal interest to maturer practitioners. He has chosen a difficult thesis, and skilfully handled it.

R. Norris Wolfenden.

ASSOCIATION MEETINGS.

AMERICAN MEDICAL ASSOCIATION.

A Note on the Etiology of Laryngismus Stridulus.[1] By Dr. JOHN O. ROE, Rochester, New York.

After mentioning the different theories as to the cause of this affection put forth by Kopp, Ley, Marshall Hall, Elsasser, Ledesser, and others, Dr. Roe called attention to the recent theory advanced by Hughlings Jackson, in which he ascribes the affection to the abnormally soft ribs in rachitic children (in whom the affection most often occurs), which renders the action of the diaphragm insufficient, and thus, especially during sleep, when the attacks commonly occur, there is over-stimulation of the respiratory centres by supervenous blood, an excess of the natural stimulant, which results in convulsions.

Since the adductors, as well as the abductors of the vocal cords, are controlled by nerves centring in the medulla, it is readily seen that stimulation of this centre may result in spasmodic adductor disturbance.

Why the nerve centre in the medulla controlling the adductor muscles of the larynx is more susceptible to irritation, or to its normal stimulus than the nerve centre controlling the abductor muscles of the larynx, Dr. Roe explained by the fact that these nerve centres are rendered susceptible by irritation of the larynx itself; and that more or less continued irritation of the larynx has the effect to excite these nerve centres to undue activity. So that an irritation that would itself have no appreciable effect, would, when the nerve centres have become irritable and hyperæsthetic, have the effect of producing abnormal manifestations in the parts under the control of these nerve centres.

Nasal obstruction and irritation combined with oral respiration is an important factor in the production of laryngismus stridulus; in fact, all conditions that tend to cause irritation of the larynx will produce attacks of this affection.

Dr. Roe stated in conclusion that in the causation of laryngismus stridulus there must exist the following conditions :—

1. A chronic irritation of the larynx.

2. An abnormal activity of the motor centres of the medulla, rendering them more susceptible to the normal blood stimulus, and also more

[1] Abstract of a paper read before the Section of Laryngology and Otology of the American Medical Association held in Detroit, Mich., June 7th, 1892.

https://doi.org/10.1017/S1755146300163012 Published online by Cambridge University Press

sensitive to irritants applied to the peripheral nerve fillaments, as a result of irritation of the larynx.

3. An unequal susceptibility of the abductor and adductor muscles to local irritation, and also an unequal stimulation of their nerve centres by the normal blood stimulus. The abductors of the larynx, situated on the outer portion of the laryngeal framework, are not so much subject to local irritation, their motor centre in the brain is less excited and less susceptible to its normal stimulus, and spasm of the abductor muscles is, accordingly, less frequent than spasm of the adductor muscles, and less persistent when it occurs.

THE PARIS SOCIETY OF LARYNGOLOGY, OTOLOGY, AND RHINOLOGY.

Meeting, July 1, 1892.

Researches on the Anatomical Causes of Deviation of the Nasal Septum. Does there exist any relation between this Deviation and the Antero-Posterior Inflexion of the Axis of the Face? By Dr. POTIQUET.

The author has already dealt extensively with the general etiology of deviations of the nasal septum (see JOURNAL OF LARYNGOLOGY, July, 1892). He refers in detail to the conclusions of Schaus from experiments made in the clinic of Prof. Trendelenburg, and to Lissauer's anthropological work. His own researches were conducted on the four hundred skulls in the museum of the amphitheatre of the hospitals, and are very minute. His conclusions are that in the Parisian the osseous nasal septum tends to incurve laterally so much the more as the movement of rotation of the premaxillary around the point of junction of the postero-superior extremity of the vomer with the body of the sphenoid, taken as a centre, is more marked. This conclusion may be regarded as a verification, applied to a very limited group, of a law common to the whole series of primates—to wit, that the nasal septum has so much the greater chance of lateral incurvement as the axis of the face is itself the more inflected in its antero-posterior direction. As this axis is more and more inflected as one rises from the anthropoid to the European male, the nasal septum tends to incurve laterally more and more as one follows this ascending series. Lateral curvature of the septum, therefore, appears to be an evolutionary phenomenon related to the degree of antero-posterior inflexion of the axis of the face.

Over and above this general relation, is it possible to ascertain the proximate cause why the septum is straight in some and curved in others? And may not we seek for the reason of this lateral curvature, at least partly, in the difficulty which the fundamental cartilaginous plate may find in adapting itself to the movement of rotation with retreat which the premaxilla describes, solidly fixed on the one hand, and in the superior maxilla on the other hand. From that, to the consideration of the lateral septal curvature as the result of our imperfect accommodation of the fundamental cartilaginous plate which primitively constitutes it, to the movement of antero-posterior inflexion of the axis of the face, is not a great step. This is only an hypothesis, and, like many hypotheses in science, is incapable of direct verification.

We may go a little further. In this act of adaptation the special tendencies of the septum are not a negligible quantity, and granted that it is according to the line which unites the premaxilla to the spine of the sphenoid that the septum especially curves, and it is in this line that accommodation seems particularly

https://doi.org/10.1017/S1755146300163012 Published online by Cambridge University Press

imperfect, could not a deviated septum be often considered as a septum too long in an antero-posterior direction? In fact, considering on the skeleton the so frequently incurved upper edge of the vomer, it would seem that this bone in these cases is called upon to develop more amply in an antero-posterior direction than it is really permitted. One step more; is not a septum too long, one which has omitted to accommodate itself to new conditions—in other words, an ancestral septum?

Anomalies explicable by comparative anatomy are, it is true, more common in the nasal cavities, but it is not a region of the body where reversions occur as frequently. But considered as an ancestral septum, and given the extreme frequency of inflexions, it would not be extravagant to say that a man has only exceptionally the septum which belongs to him. An analogy is found in the defect of accommodation of the uterus to adjustment of the spine from the upright position of the human species, which ends in anteversion of that organ. This useless amplitude of the fundamental cartilaginous septum might be compared to the useless simiesque projection of the cartilages of the helix mentioned by Darwin.

Let the Darwinian projection of the helix be more pronounced than usual and the result is of little consequence, since the cartilage of the pavilion can extend at will, but it is not the same for the septal cartilage, and if it happens from some obscure original impulse that it lengthens a little from behind forwards, surrounded by powerful organs which limit it, it is forced to inflect. Comparative anatomy shows the conformation of primitive ancestors tending to reappear in descendants even far removed. Is not the nasal septum especially inclined to these phenomena?

Dr. RUAULT remarked that in lunatics deviations of the septum and even of the vomer exist, and it would be interesting to study the relations existing between these deviations of the septum and cranial asymmetry.

Dr. GOUGUENHEIM called attention to the relation which these deviations of the septum and cranial asymmetry and nasal obstruction had with asymmetry of the face and orbit of the same side, and the influence they could exert on the visual functions, referring to Ziem's work in this direction.

Dr. POTIQUET replied that researches in the direction of Dr. Ruault's suggestion would be interesting but difficult, for the junction of the cerebral cranium with the facial cranium is scarcely accessible to investigation even on the skeleton. Ziem's work does not appear to have led to any conclusions so decisive as Dr. Gouguenheim apparently thinks. A defect of symmetry of the bones constituting the face and the cavities which they limit is indeed the rule. A defect of symmetry of the nasal cavities and of the cavities is, on the same subject, of very frequent occurrence, and it is not possible to establish between the two asymmetries any relation of cause and effect.

The Thickenings of the Antero-Inferior Portion of the Nasal Septum. Rôle of the Subvomerine Bones and the Cartilages of Jacobson. By Dr. POTIQUET.

The great majority of thickenings of the nasal septum—always excepting the septal tubercle—may be divided into two categories according to the region they occupy, namely those of the antero-inferior portion of the septum, and those forming the lateral crest of the vomer. The latter, usually smooth on the concave side and more irregular on the convex, are due to the incurvation of the fundamental cartilaginous plate. Those of the antero-inferior portion depend on the growth of the various elements entering into the composition of the part, which are the crest of the os incisivum, the heads of the two subvomerine bones, the anterior extremity of the quadrilateral cartilage, and the cartilages of Jacobson.

Between the incisive (intermaxillary) bone and the crest of the palatal process of the superior maxilla is interpolated a wedge-shaped bone, with its apex down-

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wards, surmounted by a head which forms part of the general crest. It is higher than the portion behind it, but in early life about the same height as the crest of the os incisivum. The two subvomerine bones form together part of the gutter in which is received the portion of the vomer in front of its horizontal plate. They continue to develop more or less irregularly, and when the part of the floor formed by the os incisivum becomes lowered after the eruption of the permanent middle incisors the subvomerine bones project upwards and form with the Jacobsonian cartilages many of the outgrowths or spurs of the antero-inferior portion of the septum. The anterior point of the vomer abuts on these subvomerine bones, between which and the sphenoid it is fixed. From want of mutual accommodation in developing, the vomer and the subvomerine may press against each other, when sometimes the latter standing fast the vomer has to bend, or sometimes the head of the subvomerine yields and bends outwards so as to form a spur.

The subvomerine bone is the homologue of the median palatine apophysis of the mammalian intermaxillary bone. The forward flexion of the superior maxilla which takes place during growth and is most characteristic of the orthognathous human skull involves an upward extension of the subvomerine bones. This flexion is most pronounced in the highest races, and carries with it a tendency to lateral curvature of the septum.

The quadrilateral cartilage is found on section to be much thinned at a little distance above its lower border, and along a line parallel with this. Higher up, again, at the "tubercle" it is thicker. Owing to this peculiarity of structure we find deviations of the septum marked on one side by a deep furrow, and on the other by a flat, or only slightly convex, surface. The cartilages of Jacobson, vestiges of Jacobson's organ, can usually be found, in the young child at least, as two small lamellæ or rods of gristle, flanking the inferior border of the quadrilateral cartilage. They have, according to Sappey, "the form of an elliptical tongue, "with the long axis directed from before backwards, describing a curve with the "concavity turned upwards. Their length varies from six to twelve or fifteen "millimètres." Occasionally they are partly or entirely wedged in below the quadrilateral cartilage, partially covering the side of the apophyses of Steno (subvomerine bone), and the anterior part of the vomer, and in one instance simulating a dislocation of the quadrilateral cartilage.

Dr. POTIQUET concluded by referring to the necessity of studying in lower animals the nature of the deformities of the nasal septum. The lateral curvatures are the outcome of the antero-posterior flexion of the axis of the face (transition from prognathism to orthognathism). The thickenings sometimes result from duplicatures caused by the above-mentioned flexion, and sometimes from overgrowth of the median palatine apophysis to one side or the other. Others are the result of defective involution, and result from the persistence of Jacobson's cartilages, which—like the vermiform appendix—are a useless and often injurious inheritance.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, October 20th, 1892

("Medical Record," November 5th, 1892).

ALFRED L. LOOMIS, M.D. *(President), in the Chair.*

THE meeting was held under the auspices of the Surgical Section, Dr. JOSEPH D. BRYANT, Chairman.

https://doi.org/10.1017/S1755146300163012 Published online by Cambridge University Press

Intubation versus Tracheotomy for Acute Laryngeal Stenosis in Children —To what Extent, if at all, has Intubation supplanted Tracheotomy ?

Dr. JOSEPH O'DWYER read a paper, opening the discussion on this subject. He said that while it would have been very easy to prepare a long paper upon it, he had found it difficult to prepare a short one. By acute stenosis of the larynx was meant the stenosis which occurred in fibrinous, diphtheritic, or membranous croup. If unrelieved by mechanical means this would prove fatal. The disease still continued one of the most fatal of early life. An illustrative case was related in which, in spite of intubation, which gave complete relief for about twelve hours, the temperature, pulse, and respiration increased, the latter to about eighty, and thirty hours after intubation the child died. Some would say there must have been broncho-pneumonia, yet the autopsy showed none, death having resulted from blocking of the bronchial tubes with pseudo-membrane as far as could be traced.

Not uncommon causes of death were catarrhal pneumonia, nephritis, and paralysis. If mechanical obstruction from membrane in the larynx alone were the only question in these cases, intubation would certainly be a most efficient method and should have scarcely a failure.

As it would be impossible in a brief paper to answer all the charges that had been made against intubation, especially the accidents and dangers, he would confine his remarks upon this part of the subject to a consideration of criticisms in a paper by Dr. Lovett, of Boston, in which was recited the experience with intubation in the Boston City Hospital. The principal, if not the only, cause of the bad results obtained at that institution was that the operations were performed by a number of different men, more or less inexperienced, who appeared on the staff by rotation. The only difficulty met with by experienced operators was the tendency of the tube in a few cases to engage in the sub-glottic fold, and yet the experienced operator meeting with such difficulty knew how to overcome it. An analysis of the accidents cited by Dr. Lovett showed clearly that they were in almost all instances due to the operation having been done by inexperienced men or to carelessness. Sudden death occurring while the tube was in the larynx must be due either to obstructing membrane or to heart paralysis, but more frequently did pushing of membrane before the tube give relief than cause stenosis.

One of the gravest objections which had been offered to intubation was the difficulty afterwards of feeding. When, however, the tube was introduced with care and skill this difficulty existed only exceptionally. If the parts were injured by clumsy efforts to pass the tube, it would be remarkable if the little ones did not suffer during deglutition afterwards. When the operation was really called for the patient was getting but little air, and this little could be cut off only a very short time without endangering life; even ten seconds was not safe. To pass the tube, then, as speedily as should be done and cause no injury required practice, which should be gained on the cadaver and in different subjects, for some subjects were more difficult to intubate than others. Tracheotomy implied no such danger. No great amount of surgical skill was required

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to do tracheotomy, but subsequent intelligent nursing was almost an absolute necessity. One practice, therefore, called for trained nurses, the other for a trained operator.

It appeared that at the Boston City Hospital intubation had been followed by about twenty per cent. recoveries, and tracheotomy by about twenty-nine per cent. One could hardly believe that the smaller number of recoveries following intubation could have been due to the operation so much as to the manner in which it was performed, for the percentage of recoveries at the Willard Parker Hospital had been thirty-eight, and another operator had had thirty-four per cent. of recoveries in over one hundred cases. In fact, the percentage of recoveries at the Boston City Hospital had been lower than any individual results that he knew of, and there were sufficient reasons for it.

Of the factors which influenced the prognosis in intubation and tracheotomy, age was the most important. The results of intubation in the first year of life were almost *nil;* the third year was better than the second, and after the third year and a half age did not play an important *rôle.* Lovett had said that tracheotomy saved one in fourteen under two years, while intubation in Dr. O'Dwyer's cases had saved one in six.

Secondary tracheotomy was not likely to prove of much avail when intubation failed because of membrane extending to the trachea. The author thought that from all the facts presented the conclusion seemed inevitable that intubation accomplished practically all that tracheotomy accomplished without any of the unpleasant features of the latter operation,

Dr. Lewis Pilcher, of Brooklyn, continued discussion with a paper. He thought that in any case of exudative laryngitis it was absolutely impossible to exclude the existence of diphtheritic infection. This was of importance in considering operative measures. The laryngeal affection was but the effect of a general disease. The general effects of that disease were to be guarded against, and local emergencies were to be prepared for.

Granting that both intubation and tracheotomy would remove the laryngeal stenosis, which was best adapted to assist the system in its struggle against the general infection? The answer to this question involved three points—blood aeration, local cleansing and antisepsis, and general nutrition.

Intubation as well as tracheotomy met the first point, and intubation admitted air which was warmed in the natural passages, but it did not admit so well of meeting further obstruction down the trachea, and it was also liable to detach membrane in the larynx and push it before the tube. To meet these results it might be said that theoretically tracheotomy could be resorted to secondarily, but practically it was then too late.

Tracheotomy permitted of the air being warmed and medicated, and of removal of obstructing exudate coming up into the trachea. It also permitted of carrying on nutrition perfectly, whereas, judging even by the statements of Dr. O'Dwyer himself, he inferred that the presence of the tube in the larynx caused considerable difficulty with feeding the child.

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It would seem, then, that the three points were met better by tracheotomy than by intubation. Whether these advantages of tracheotomy were real or imaginary could as yet hardly be determined by statistics. The difference in the character of the cases, and the fact that intubation was much more likely to be permitted than tracheotomy, formed the greatest obstacles in the way of a correct judgment.

He would accept Dr. O'Dwyer's personal experience with intubation without question, and among the first set of cases which he had reported twenty-four per cent. had recovered; later ones had given even a better result. Of 21,000 cases of tracheotomy collected by Lovett, twenty-eight per cent. had recovered. Dr. Pilcher's own results from tracheotomy for membranous laryngitis had been twenty-two recoveries out of sixty-six cases, or thirty-three and a third per cent. On the other hand, one of his neighbours had intubated a number of cases and had fifty per cent. recover.

While he did not wish to gloss over the disadvantages attached to tracheotomy, yet he thought intubation answered the indications for surgical interference when the diphtheritic exudation had formed within the larynx and trachea much less perfectly than did tracheotomy, and that therefore, as a rule, it should not be considered a substitute for tracheotomy in such cases.

To what Extent has Intubation supplanted Tracheotomy?

To this question Dr. PILCHER answered, evidently to a very considerable extent during the past few years in this country. Tracheotomy would always be accepted as a last resort unless it were in institutions, and he did not doubt but what for this reason intubation would save many lives which would without it be lost, parents rejecting what he regarded as the safer procedure until too late, if they permitted it at all. His neighbour had within four years intubated 140 cases, 40 of which, or twenty-nine and a half per cent., recovered, whereas Dr. Pilcher had had opportunity to tracheotomize only 66 cases in seventeen years, with recovery of one-third. Yet the cases of diphtheria in Brooklyn had remained about the same. This showed that intubation was both supplanting tracheotomy and also making a new field for itself. He thought there should be pavilions or houses scattered in different parts of the city, where diphtheritic cases could be readily transferred and put under skilled medical attendance, and as soon as the emergency arose a surgeon connected with the hospital of which these were a branch should be called to do tracheotomy. This would show better actual and comparative results for the bloody operation.

Dr. GEORGE W. GAY, of Boston, read a paper in continuation of the discussion. The statistics which he brought from the Boston City Hospital were later than those of Dr. Lovett, although they did not differ much; they showed about four per cent. in favour of the older operation.

In the majority of cases the result of intubation depended upon three conditions: laryngeal obstruction, bronchial croup, and septicæmia. The type of the disease, more than anything else, determined the result after the operation. In very many instances the operation was satisfactory

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although the result itself was fatal. The patient succumbed to sepsis or other trouble, but not to dyspnœa. In 110 cases at the Boston City Hospital, in 75 intubation resulted in immediate and complete relief of the dyspnœa, partial relief in 22. Surely any method which gave immediate relief in nine cases out of ten was worthy consideration. As to whether tracheotomy would give relief where intubation failed, it might where the tube pushed membrane before it, enhancing the dyspnœa, but this accident was not common. But where the dyspnœa was due to extension of the morbid process or sepsis there was little hope. In 58 cases of secondary tracheotomy at the Boston City Hospital, only seven recovered.

The author attributed many of the failures with intubation to employment by unskilled hands. He also said that the diminished number of tracheotomies at the Boston City Hospital, and the much larger number of intubations, showed that the latter had considerably supplanted the former. In the majority of cases in children under seven years intubation was preferable to tracheotomy.

Dr. F. E. WAXHAM, of Chicago, could not be present, and sent his recent statistics of intubation. He believed intubation would yield results which could not be obtained by tracheotomy. His cases were not selected, but included all requiring it which came under his observation. The number of cases for the several years of age were given, with percentage of recoveries. In all he had intubated 421 cases, with 146 recoveries, or 34·67 per cent. In the first 100 cases there had been 27 recoveries; in the second, 34 recoveries; in the third 40 recoveries; and in the last 21 cases there had been seven recoveries.

Dr. A. JACOBI referred to a discussion on this subject before the Academy four or five years ago, at which it was all intubation, while to-night it had been part intubation and part tracheotomy. At the former meeting he endorsed intubation, notwithstanding the fact that he had been a pioneer in the performance of tracheotomy in this country, having resorted to it in a great many cases. Indeed, his statistics with tracheotomy must now run up to 600 or 700. The reason why he then and now endorsed intubation in preference to tracheotomy was the fact that it was very easy among the public at large to get permission to intubate, while it was very difficult to get permission to tracheotomize. Because of this difficulty the latter operation was often put off until it was known to be almost certainly too late. Yet now and then a case operated upon at so late a stage did recover, and it justified interference even in apparently hopeless cases. Another weighty reason for turning to intubation was the fact that, no matter what amount of care was exercised, infection and erysipelas or diphtheritic deposit might take place at the tracheotomy wound. Moreover, tracheotomy sometimes necessitated leaving the tube in a long time. While endorsing intubation, he confessed to not having performed it himself, for the reason that Drs. O'Dwyer, Huber, or others skilled in the operation had been within so convenient reach.

Dr. FRANCIS HUBER sent a note in which he said that both tracheotomy and intubation would relieve the dyspnœa, but after considerable

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experience with both measures he expressed preference for intubation as a primary procedure in laryngeal diphtheria. The mortality of either operation varied in different epidemics, the variations depending upon other conditions than the operation. Both procedures might present intrinsic difficulties in individual cases, and might be attended by unforeseen complications. Unfortunate results from inexperience and the use of improper instruments could not be placed as objections to intubation. The difficulties of *technique* in young children were not limited to intubation, but were often equally great in tracheotomy. Whatever might be the difference of opinion regarding the comparative results in older children, under two years and a half intubation gave a higher percentage of lives saved. He incidentally mentioned the great value of bichloride of mercury in diphtheria, as recommended by Dr. Jacobi.

Dr. BERG had performed intubation in a considerable number of cases, and in all it gave immediate relief to the dyspnœa, but the picture was apt to change within twenty-four hours. The following objections to the procedure had led him to practically abandon it: 1, interference with feeding and nutrition, which was of such great importance; 2, interference with the administration of a solution of bichloride of mercury, as recommended by Dr. Jacobi, which also was of extreme importance, for, greatly to his surprise, he had found since adopting this treatment that its curative powers had been so great as to lessen the number of cases requiring intubation or tracheotomy fifty per cent. The bichloride, unfortunately, would act on the tube.

Dr. W. P. NORTHUP related some observations in Vienna and London during the past summer, illustrating the right and the wrong way of choosing tubes and introducing them into the larynx. He believed that, as a rule, difficulty from feeding the child wearing the laryngeal tube came from its unskilful introduction and injury to the parts.

One speaker said he had seen a number of patients wearing the laryngeal tube at the Willard Parker Hospital, and taking food without any difficulty, and that the house physician there employed irrigation with bichloride freely without causing any injury to the tube.

Another speaker thought the weakness following some hours after the introduction of the tube was due to inability to fully respire, and finally complete stenosis and death. A second objection to the tube was the liability to cough it up during the absence of the physician. He had lost one patient from that cause.

Dr. JOHNSON, of Jersey City, was not sure that where the tube was coughed up the cause was always membrane; nor did he think dyspnœa the usual cause of a change of the picture for the worse about twenty-four hours after introducing the tube.

https://doi.org/10.1017/S1755146300163012 Published online by Cambridge University Press

REPORT of the FIRST MEETING of the CONGRESS of the ITALIAN SOCIETY OF LARYNGOLOGY, OTOLOGY, AND RHINOLOGY,

Held at the University of Rome, October 26-28, 1892.[1]

From Notes by the Secretary, Prof. A. FASANO.

THE inaugural meeting on the morning of October 26th was held at the Presidency, under the auspices of the Committee composed of Profs. Grazzi, Massei, Fasano, Masini, and Dr. Egidi. Amongst the invited guests were Commander Ferrando, representing His Excellency the Minister Martini; Commander Calenda, Prefect of Rome; Prof. Toscani, representing the Rector of the University; Prof. Rosseo, Assessor of Hygiene; Profs. Baccelli, Durante, Maragliano, many physicians, and other guests, including several ladies. During the inaugural sitting the following dispatch was received from His Excellency the Minister for Public Instruction. "I regret that it is not possible for me to assist at "the inaugural meeting of the Society, which I thank for its amiable "invitation, and I am confident that, with the prosperity and beneficent "character of the new institution, there is a fresh benefit to science and "a new splendour added to Italian studies. MARTINI."

To this dispatch the President replied on behalf of the Congress. "S. E. le Ministre Martini,

"The Italian Society of Laryngology, Otology, and Rhinology, while "thanking your Excellency for your amiable attention, will do all that is "possible to render itself worthy of its mission under the patronage of "your great assistance. GRAZZI."

The associates present were Dr. Louis Ajello (Naples), Dr. Fauste Brunetti (Venice), Dr. Conrad Corradi (Verona), Dr. Antoine Damieno (Naples), Dr. Ignace Dionisio (Turin), Dr. Francois Egidi (Rome), Prof. Adolphe Fasano (Naples), A. Francois Felici (Rome), Dr. Joseph Ficano (Palermo), Dr. Vincent Garzia (Naples), Prof. Joseph Gradenigo (Turin), Prof. Victor Grazzi (Florence), Dr. Joseph Isaia (Naples), Prof. Charles Labus (Milan), Dr. Sauveur Marano (Salerne), Prof. Jules Masini (Genoa), Prof. Ferdinand Massei (Naples), Prof. Masucci and Dr. Vincent Morra (Naples), Dr. Victor Nicolai (Milan), Dr. Joseph Nuvoli (Rome), Dr. Compte Francois Roncalli (Bergamo), Dr. Charles Secchi (Bologna), Dr. Joseph Strazza (Genoa), Dr. Alexander Trifiletti (Naples).

Dr. Carmelo Abate (Catania), whose absence was apologized for by Dr. Fasano, and Dr. Bobone (San Remo) were admitted associates.

Prof. V. GRAZZI, of Florence, opened the session by thanking his colleagues for the honour they did him in selecting him as president. He referred to absent colleagues in affectionate terms, and speaking of physicians who followed their practice far from scientific centres, he hoped that a short time would see all who left the University schools

[1] This report is merely a summary of the proceedings of the session. The Secretary edits the volume containing the full report of the Congress, in which will be found the various theses and discussions in full, along with all the public and private acts of the Association.

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thoroughly equipped with theoretical and practical knowledge, to recognize and treat at least the most frequent affections of the important organs of speech, hearing and smell.

He then made reference in rapid survey to the history of the Italian Society of Laryngology, Otology, and Rhinology, which had its inception at Sienna, in consequence of his suggestions last year, when the General Medical Congress met in that town. He exhorted his colleagues to render it worthy by its works and its common accord of amiable Sienna, which was the cradle of the Society, and of illustrious Rome, which was chosen as the permanent seat of the Association ; and having referred to the great international reunion which will take place in this metropolis next year, he concluded with the hope that the constant efforts of the Society of Laryngology, by its intelligence, efforts, and work, would succeed in rendering these special studies always more worthy of public esteem, for the well-being of those who suffered and for the honour of Italy. To this address of the President, which was warmly applauded, Prof. Massei added some words in acknowledgment of Prof. Baccelli, who ought to be considered a benefactor to the Society, since it was he who, when Minister of Public Instruction, founded the first chair of Laryngology in Italy, remarks which were received with general applause.

Dr. ALEXANDER TRIFILETTI, assistant to the Clinic of Laryngology of Naples, then read a long communication interesting to general physicians upon *The Importance of Laryngology, Otology, and Rhinology in Medical Practice ; Considerations and Propositions.*

This thesis, developed with great intelligence and with serious appreciations, was listened to with great interest, especially its latter part, where the author made allusion to the few means yet existing of studying these specialties, and expressed the desire that this teaching should be provided in all the universities of the kingdom, and that they should be made obligatory.

The session terminated at 11.30 in the morning.

AFTERNOON SESSION.—TWO O'CLOCK.

Private Meeting.—President, Prof. GRAZZI.

VOTING was taken for the Council of the Society, and the following officers were elected :—President, Grazzi ; Vice-President, Massei ; Councillors, Labus and Gradenigo. Secretary of the Society, Fasano ; Secretary to the Council, Corradi ; Treasurer, Egidi.

On taking the presidential chair, Prof. Grazzi thanked his *confrères* for the testimony of their esteem and sympathy.

Public Meeting—President, Prof. GRAZZI.

The Phases, Nature, and Therapeutics of Papillomata of the Larynx. By Prof. MASSEI, Naples.

Amongst the phases special and common to papillomata of the larynx, that which attracts most notice is *retrogression*, if not constant at

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least frequent at the end of a certain time. While this is a feature of which particular notice must be taken in the explanation of the marvellous disappearance of certain tumours in some conditions, which, however, do not always prevent the death of the patient from laryngo-stenosis if assistance be not given, it permits us to review the anatomico-pathological history of these productions. And in giving a rapid survey of their structure, we cannot deny that their structure is represented by a small number of fibres of connective tissue, chiefly in which young cellular elements or true myxomatous tissue prevail. There are some papillomata which ought to be considered as being rather granulomata, and on such grounds we can conceive the idea of their disappearance after tracheotomy. These considerations must influence treatment greatly, violent methods (laryngo-fissure, laryngotomy) being illusive and too aggressive. So if endo-laryngeal treatment does not suffice or is impracticable, tracheotomy alone should be enough. For direct treatment scraping, when combined with treatment with ichthyol (1 to 100) in cases of infiltrative tumours, ought to be preferred, and this treatment is recommended for its prompt and certain effect.

Prof. GRAZZI asked the reader if he had observed the nature of the tumour to change after extirpation, scraping, or other operative measures?

Dr. NUVOLI confirmed what Massei had said *àpropos* of the spontaneous evolution without any operation, relating a case he had seen.

He put several questions to the speaker, as also did Dr. Egidi.

Answering Grazzi, Prof. MASSEI said that at the commencement of his professional career he believed that papillomata could change in nature, but he now believed the opposite.

Prof. GRAZZI related *Two Cases of Papilloma of the Uvula.* After the interesting remarks of Prof. Massei upon papillomata of the larynx he thought that his communication had only a small value, but he desired to make it because it seemed to him that papillomata of the uvula were rather rare and also because the symptoms were disproportionate to his idea, in comparison with the smallness of the condition. These disorders ought to be considered in great part as nervous troubles of reflex action. He then described the two cases in detail, with the symptoms and the treatment adopted.

LABUS remarked that he had in his practice observed several cases of papilloma of the uvula, and he had some now under treatment.

FELICI thought with Grazzi that they were rare, as he had only seen one case, and in that the growth was not entirely in correspondence with the uvula.

Dr. AJELLO read a paper on *The Laryngeal and Tracheal Phenomena of Gout,* which was discussed by Corradi, Nuvoli, Trifiletti, Massei, Masini, and Fasano.

Dr. DAMIENO read a paper on *Pachydermia Laryngis* (a histological note), which was discussed by Masini, Dionisio, and Massei.

Dr. EGIDI read a paper on *Epithelioma of the Larynx*, upon which Dr. Nuvoli made some observations.

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Prof. FASANO recorded some *Clinical Studies on the Symbiosis of Laryngeal Syphilis and Tuberculosis.* Masini and Nuvoli made several observations, and Massei, Felici, and Prof. Maiocchi took part in the discussion.

Meeting of October 27th, at 9 a.m.—President, MASSEI.

Dr. GARZIA read a paper upon *Oral and Pharyngeal Pemphigus.*

Dr. MARANO presented a paper upon *Epithelioma of the Left Tonsil.*

Dr. STRAZZA (Genoa) presented a paper on *The Diagnosis and Treatment of the Diseases of Accessory Cavities of the Nose.*

Affections of the sinuses were divided into those of neoplastic nature, and those of secretory nature. McBride, of Edinburgh, has also established two groups—affections of the sinus which dilate the cavities, and those which do not. To the first group belong mucous tumours and suppurative conditions, in which by the closure of the natural opening pus burrows a way to the exterior; to the second group empyema properly so-called. Without ignoring other forms, the author dwelt more fully upon the suppurative form as most interesting in rhinology. He established rules for differential diagnosis between carcinoma and sub-acute empyema of the antrum, tumours in general, and mucocele.

As to the *antrum of Highmore*, mucocele is characterized by dilatation of the sinus. Exophthalmos frequently also exists. The external walls of the antrum sometimes become papyraceous, thus permitting fluctuation. Illumination is useful to exclude solid tumours by reason of the side affected assuming a more marked redness than the healthy side. Treatment consists in giving an exit to the liquid, and correcting that which impedes respiration. Suppurative conditions present acute and chronic forms, the former being distinguished by an accentuation of the subjective phenomena. Chronic forms have as characteristic signs--(1) a flow of pus, inconstant and fœtid; (2) the presence of creamy pus in the middle meatus along with a polypoid mass. B. Fraenkel's sign, when present, is of great importance. Illumination gives uncertain results. Exploratory puncture with the needle is the only means of arriving at a certain diagnosis.

Dr. STRAZZA gave a *résumé* of the treatment. In acute forms all methods lead to cure, if there are no adverse dyscrasic conditions. In chronic forms the method of Hartmann ought to be adopted. When this is not possible, and when suppuration is continuous, trephining the cavity through the alveolus or the canine fossa should be performed, and followed by tamponing with iodoform gauze. This treatment should be repeated every five days. The author prefers opening through the canine fossa, since by this means direct inspection of the cavity is possible.

With regard to the *frontal sinus*, mucocele has the general characters of slow dilatation of the cavity. Illumination and exploratory puncture confirm the diagnosis. The treatment consists in making a large opening and removing the bony masses. Nasal opening is not necessary. In

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the suppurative conditions which open spontaneously towards the internal side of the orbital wall, the diagnosis is made from the fistulous track.

Treatment should consist in a free opening into the cavity in the transverse line, and removal of the purulent and polypoid masses and the osseous portions which are often found. A nasal opening is indispensable. In forms which show a free flow, *i.e.*, in true empyema of the frontal sinus, diagnosis is sometimes difficult when subjective phenomena are wanting, and rhinoscopy only reveals the presence of pus in the middle meatus. The absence of intermittence in the flow, and of Fraenkel's sign, would indicate an affection of the frontal sinus.

Illumination and exploratory puncture of the maxillary sinus are useful in excluding an affection of the antrum. If exploration succeeds, the diagnosis can be confirmed by irrigation. Treatment ought to consist of exploration of the fronto-nasal canal and disinfectant washes. The topography of the canal in most subjects renders this manœuvre impossible, and in those cases where it is impossible from the first, or after many irrigations, the anterior wall ought to be perforated.

As to the *ethmoidal cells.* Mucocele of this region exhibits itself by an osseous tumour in the nasal fossæ, and exophthalmos always exists. Neoplasm is excluded by the slowness of the development. Illumination allows us to exclude solid growths, and exploration with the needle confirms the diagnosis. Suppurative forms are generally relieved by dilatation of the cavity.

When this does not follow, diagnosis becomes difficult, and it is necessary to exclude affections of the frontal and maxillary sinus.

To say that in empyema of the anterior ethmoidal cells pus is found in the middle nasal meatus, and in empyema of the middle and posterior ethmoidal cells the pus is found in the olfactory rima, is a statement of no practical value. Treatment consists in opening the cavities and curetting the parts.

As to the *sphenoidal sac*, anatomico-pathological researches show that this cavity is the frequent seat of suppurative processes, especially in general infective forms, but in the living subject diagnosis is difficult. The speaker had not had occasion to observe it, and therefore avoided speaking of it.

Prof. MASSEI demonstrated the difficulty of diagnosis and treatment, especially of the frontal sinus, by reason of its peculiar anatomy. He dwelt upon exophthalmos as a pathognomic symptom, which oftener falls under the observation of the oculist than the rhinologist.

Dr. POLI insisted upon the importance of ophthalmological examination.

Drs. FELICI and GRADENIGO joined in the discussion, and STRAZZA replied.

Dr. DIONISIO made a communication upon *Deviations of the Nasal Septum and their Treatment*, and presented instruments. Drs. Gradenigo, Massini, Ficano, Felici, Masucci, Nuvoli, and Nicolai joined in the discussion.

Dr. DIONISIO read a communication upon *Nasal Tuberculosis.* Drs. Massei, Masini, and Strazza discussed it.

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Prof. FASANO spoke *On Mercurial Treatment in some so-called Nasal Scrophulides.*

NUVOLI gave the history of a case in which the diagnosis was doubted, but after Fasano's exposition he felt no further doubt in including the case in this category. Prof. De Amicis confirmed Fasano, and related some similar cases.

Prof. MASSEI made a communication *On the Treatment of Large Naso-Pharyngeal Tumours.*

Prof. MORRA reported *Clinical Studies on Ozæna.*

Dr. NICOLAI presented a circular saw for operations upon the nose, and exhibited his electric laryngoscope.

Dr. ISAIA read a communication entitled *Therapeutic Contribution upon the Otorrhœas of Scrofulous Subjects, and on Crusting Chronic Rhinitis*, which was discussed by Prof. Fasano.

Morning Meeting, 28th October.—President, MASSEI.

Papers were read by—

POLI, on *Chronic Nasal Glanders.*

NICOLAI, *Empyema of the Antrum of Highmore.*

Strazza, Damieno, Trifiletti, Massei, Poli, and Nicolai took part in the discussion.

EGIDI, *Two Cases of Chronic Croup.*

Poli, Massei, Trifiletti, Nicolai, Ficano, Masini, and Egidi discussed the paper.

Upon the proposition of Prof. Masini a commission of three members (Egidi, Concetti, and Masucci) was appointed.

STRAZZA, *Bacteriological Considerations in Ozæna.*

FIACCARINI, *Diphtheritic and Scarlatinal Sore Throat.*

MAIOCCHI, *Actinomycosis of the Tongue and Larynx.*

FICANO, *Case of Hysterical Mutism.*

MASINI, who had a communication on the same subject, supported a long physiologico-pathological discussion, arriving at conclusions directly opposed to Ficano.

Massei and Damieno joined in the discussion.

Prof. MASSEI presented some *New Intubation Tubes for Adults*, and an *Apparatus for School Demonstration* (praxinoscope).

Afternoon Meeting.—President, GRAZZI.

Prof. MASSEI read a paper entitled "*Cicatricial Hypoglottic Stenosis.*"

EGIDI related notes of *Eighty-two Intubations, and as many Tracheotomies; a Contribution to Statistics;* upon which a prolonged discussion followed.

At a private meeting the President read a letter addressed to Prof.

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de Rossi, asking him to join a Commission to prepare modifications to be introduced into the Statute, and read Prof. de Rossi's letter accepting the same.

Two resolutions presented to the Government were read, one signed by Profs. Massei, Grazzi, and Fasano :—

"The Assembly, after the thesis of Dr. Trifiletti on the importance "of Laryngology, Otology and Rhinology in practical medicine, unani- "mously approves of his conclusions, and prays S. E. the Minister of "Public Instruction that, following the initiation of many European "Universities, the teaching of Laryngology, Otology and Rhinology "ought to be made obligatory in every Italian University."

On the Diagnostic Importance of the Perception of Sounds by Perosseal and Aerial Conduction in Diseases of the Ear. By Dr. CORRADI, Verona.

The work is divided into three parts ; the first gives a description of the signification and object of certain methods of examination, and of the best way of practising them. In regard to speech the author holds that it is not a reliable test for hearing, although so generally recommended, and that simple tones ought to be preferred, especially before coming to any definite determination, as for example, whether a patient ought to be submitted to treatment or not.

He described the various tests, and expressed some ideas on the way of practising Rinne's experiment, and suggests a theory which goes to explain the increased sensibility for low tones through the bones, as in the experiments of Rinne and Schwabach. He next considered objections which had been made to the experiments of Weber and Rinne on sensibility for high and low tones, especially those by Steinbrügge, Kieselbach, Schwabach, and Jacobson, and endeavoured to confute them.

In the second part he described the physiological foundation of his experiments, and in the third parts his methods and his manner of tabulating the results. He replied to some objections raised by Gradenigo and Masini, referring them to his forthcoming work for the necessary luminous explanations. A discussion followed, in which Gradenigo, Masini, Trifiletti, Grazzi, Egidi, and Corradi took part. A committee consisting of Professors Corradi, Gradenigo, and Masini, was appointed for the purpose of investigating the controverted points and reporting their results.

Functional Energy of the Acoustic Nerve. On Bone Conduction in Otitis Media in general. By Prof. GRADENIGO. (The results obtained from an examination of the ears at the Royal Institute, Victor Emmanuel, for blind children, at Florence).

The author undertook these observations in order to test the general belief that the loss of one sense is compensated for by the perfection of another. It is thought that the deaf have a very strong sight, and that the blind have very good hearing power. Of the thirty-seven pupils examined, twenty-one were boys and sixteen girls ; among the first there was only one with very acute hearing, ten with pretty good hearing, and ten with aural disease past or active, rendering them comparatively deaf.

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Among the girls there was not one with very acute hearing, nine heard pretty well, and seven had deficient hearing from past or present auricular disease. Gradenigo, Nuvoli, Poli, and Isaia asked several questions concerning the ages of the children, the causes of their blindness, the diseases (either general or of the nose and throat) which might have contributed to make diseases of the ear so frequent in this Institution.

On the Functions of the Otologist and Laryngologist in Institutions for the Deaf and Dumb. By Prof. GRADENIGO.

He explained the system on which he examined the organs of smell and the pharynx and larynx in deaf and dumb pupils of both sexes, and set forth the chief difficulties met with, especially in examining the larynx. He thought that every deaf and dumb institution should have an oto-laryngologist. A formal recommendation to the Minister of Public Instruction was proposed by Masini to the effect that in all institutions for the deaf and dumb the work of the instructor should end where that of the specialist began.

Diseases of the Labyrinth and their Diagnosis. By Prof. MASINI.

Prof. MONPORGO, of Trieste, was elected a corresponding associate.

Profs. POLITZER, DELSTANSCHE, of Brussels, and B. FRAENKEL, of Berlin, were unanimously elected associates. Other business was transacted.

NOTE.

THE next General Meeting of the BRITISH LARYNGOLOGICAL AND RHINOLOGICAL ASSOCIATION will be held at the Medical Society's Rooms, 16, Chandos Street, W., on December 9th, when a discussion will take place on Mr. Mayo Collier's paper, "The Surgery of the Frontal Sinus."

ERRATUM.

ON page 491 (lines 2 and 29) of the October number of the JOURNAL the "word lanoline" in Dr. Seth Bishop's communication should have been "lavoline," which is a purified liquid vaseline.

Witherby & Co., Printers, 326, High Holborn, London, W.C.

https://doi.org/10.1017/S1755146300163012 Published online by Cambridge University Press