NOSE AND NASO-PHARYNX.

BABER, CRESSWELL.—On the Anterior Rhinoscopic View. *Revue de Laryngologie, &c., June,* 1887.

A COMMUNICATION made to the Congress of Laryngology of the author's method of obtaining diagrammatic designs of the nasal fossæ.

JOAL.

OBOLINSKI (Krakau).—**Plastic Operations for Deformed Noses.** *Deutsch. Zeits. f. Chir.*, Bd. XXIV., Heft 1, 2.

THE original is illustrated, and the details cannot be understood without this. The author's success was good. MICHAEL.

WEIR.—Injuries of the Nose and a Peculiar Bony Tumour of the Nose. *Med. News, March* 5, 1887.

1. A BOY fell a distance of four feet, flattening his nose by crushing in the cartilaginous septum. The nose was increased in breadth, sunken in, and the nasal processes of the superior maxillary bone were unduly prominent. Septum thickened but not deviated. Three days after the accident, Dr. Weir cut through from without the superior maxillary processes and forced them inward and toward each other, and held them *in sitû* by a needle passed transversely across the nose, the ends of which were prevented from pressing against the skin by pads of iodoform gauze. At the tip of the nose, from within the nares, the thick skin was separated upward for a considerable distance by subcutaneous dissection from the cartilage, and pulled forward, and held by a silver wire clamped at each end with a shot over a little cork plate, so that the broad flattened under surface of the skin could be brought together. The upper pin was removed on the fourth day as sloughing was apprehended; this immediately ceased. The lower wire was kept in for twenty-four hours longer; no ulceration had taken place under the pads. Results excellent. 2. Plastic operation to replace the end of the nose, which was bitten off in a fight. 3. The long growth consisted of a greatly developed inferior turbinated bone, which was removed with forceps. The patient was a woman of twenty-two, who from her tenth year had suffered from obstruction of the right nostril, with which hemicrania had recently been associated. As nothing could be passed alongside the bony mass, it was decided, after the bone was exposed by the usual incision from the middle of the lip around the nose, to open the antrum. This cavity was free from disease. J. N. MACKENZIE.

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STRONG, G. C.—Nasal Catarrh and its Treatment. *Trans. Med. Soc. of Wisconsin*, 1886.

A *résumé* of the principal points connected with the subject, without original matter. J. N. MACKENZIE.

MACDONNELL, R. C. (Montreal).—**Interstitial Nephritis, with Hypertrophy of the Heart, and Hæmorrhage into the Brain and Nasal Mucous Membrane.** *Med. News, January* 15, 1887.

CLINICAL lecture containing original observation.

J. N. MACKENZIE.

JOAL (Mont Dore).—**On Nasal Vertigo.** *Memoir read at the French Congress of Laryngology, &c.*, 1887.

THE author states the following conclusions :—

1. There exists a nasal vertigo, a true *vertigo a naso læso.*

2. It belongs to the group of reflex vertigos, such as gastric, laryngeal, uterine vertigo.

3. Irritation of the trigeminal filaments innervating the mucosa of the turbinated bodies and the septum is the starting-point of the condition.

4. This irritation is transmitted to the vaso-motor nerves, through the spheno-palatine ganglion, whence arises circumscribed anæmia of the brain and vertigo.

5. The affections which give origin to vertigo are: (1) Nasal fluxions (odours, irritant vapours, snuff, flowering grasses); (2) Acute coryzas; (3) Chronic catarrh, especially the hypertrophic form; (4) Mucous polypi; (5) Post-nasal catarrh.

6. Vertigo is especially provoked by nasal affections of little importance.

7. The nasal reflexes are principally developed in arthritic individuals.

8. Vertigo can occur alone, or be accompanied by other nervous phenomena—troubles of vision, muscæ volitantes, hemicrania, nausea, vomitings, great excitability, hypochondria, intellectual disability, nightmares, spasmodic cough, dyspnœic crises, exaggerated secretions, syncope, feeble pulse, pallor of the face.

9. In order to establish the diagnosis the nasal fossæ should be examined in every individual suffering from vertigo.

10. The recognition of nasal vertigo will sensibly diminish the number of cases of gouty, rheumatic, anæmic, congestive vertigos, as well as cerebro-cardiac neuropathy.

11 Vertigo ceases with the cure of the nasal affection to which it owes its origin.

The condition has no connection whatever with Menière's disease,

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and is independent of any affection of the ear. The author cites nine cases, on which, together with cases recorded by Massei, Guye, Gennaro, Hering, Hack, and others, his essay is founded. It is carefully written, and will well repay perusal.

SEISS, R. W.—Thymol in the Treatment of Atrophic Nasal Catarrh. *Med. News, April* 2, 1887.

USES four solutions.

(1) Thymol, gr. ss.; alcoholis, ℥ss.; glyc., ℥jss.; aq. dest., q.s., ad ℥j.

(2) Thymol, gr. jss.; alcohol, ℥jss.; glyc., ℥ss.; aq., ad ℥j.

(3) Thymol, gr. v.; alcohol, glycerine, āā. ℥ss.

(4) Twice the thymol strength of No. 3. Nos. 1 and 2 to be used in spray, 3 and 4 by means of cotton carrier.

The author describes the various forms of atrophy, dwelling particularly on the cirrhotic form or *rhinitis cirrhotica*, concerning the etiology of which he is substantially in accord with the views of the reviewer, published in a former number of the *Medical News.* (October 4, 1884.) J. N. MACKENZIE.

SCHIFFERS (Liege).—**Treatment of Catarrh of the Maxillary Sinus.** *Rev. de Laryngologie, &c., June*, 1887.

A METHOD should be employed which will permit of medicaments being applied directly to the seat of the disease. This must be sought through the middle meatus, and it is possible to obtain the desired end without any need of practising perforation of the sinus by the alveolus. This is a surgical proceeding only to be resorted to in case the other fails, which indeed is exceptional.

A cannulated sound is introduced into the middle meatus to a depth of six centimètres beyond the ala of the nose, the latter being forcibly elevated; care is to be exercised in introducing the sound under slight pressure, and directing its inferior extremity towards the lateral wall. If the orifice is directed forwards, the sound penetrates readily; a fine stem is glided down the cannula, ending in a small button-like bistoury extremity, slightly concave (recalling an instrument often used to practise resection of the tonsils); one or two incisions are then made in order to open out the orifice.

Schiffers thinks that the nasal origin of this complaint is much more frequent than the dental. JOAL.

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