THREE deep incised wounds crossed the junction of the occiput into the nape of the neck, a similar one in front partially divided the sterno-mastoids, the depressors of the hyoid bone and the thyroid cartilage, the latter passing between the ventricular bands and vocal cords. On the left side of the chest two wounds penetrated the pleural cavity.

Norris Wolfenden.

Little.—*Suicide Apparently by an Attempt to Cut Off the Head from Behind.* "Lancet," October 19, 1889.

THE case was that of a woman, aged thirty-six, who had, in 1879, been discharged, apparently cured, about a week before from Garland Asylum, where she had been an inmate about three months, with the symptoms of puerperal insanity. "About 8 a.m. on July 2, 1879, the daughter of the patient came to the author, saying that her mother had attempted to commit suicide, and on arriving at the house he met a ghastly spectacle. She had a knife in her hand, and on the back of her neck was a huge wound, which had apparently taken half her head off. It had gone through skin, muscles, ligaments, the very bone itself, and had opened into the spinal canal, but had not touched the cord. The head itself, having lost all its connections at the back, was bobbing about in a manner that would have been ludicrous had it not been so ghastly. The instrument was a blunt and rusty table knife, with which she had been peeling potatoes. Such treatment as was possible was applied, but she died on the sixth day from septicæmia. No post-mortem was obtained."

The chief interest of the case lies in the fact of the wound having undoubtedly been committed by herself, and in the very determined manner in which she had set to work apparently to decapitate herself.

R. Norris Wolfenden.

ASSOCIATION MEETINGS.

American Rhinological Association.

Seventh Annual Meeting, Chicago, October, 1889.

DR. L. B. GILLETTE, of Omaha, read a paper entitled, *Report of a Case of Brain Abscess emptying into the Naso-Pharynx.* The patient, aged twenty, farmer by occupation, strong and healthy, while working on an embankment in September last with a wheel scraper, in driving along with it loaded, it in some way become unlatched and the handle in flying up, struck him forcibly under the chin, knocking him down a sixteen-foot embankment, where he lay unconscious for thirty minutes. A week afterward he noticed that something was wrong with his eyes. About October 15th he went to work in a brick-yard, worked three days, and then complained of being nervous, and of having a slight headache. On the evening of the third day he got soaking wet in a rain, went home cold, had a chill, followed by fever. A physician was called and pronounced it malarial fever. Dr. Gillette being subsequently called to see the case found the patient suffering with intens

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headache, the pain extending down between the shoulder blades, and particularly into the right arm. Both pupils were widely dilated. Temperature was 101° F.; pulse, 105. He knew he had an inflammatory condition to deal with. A day or two after his advent into the case there developed marked compression of the brain. Temperature went down to 96°; pulse as low as 42; respirations to 9 or 10. Complete paralysis of right side and partially of left; complete loss of sensibility as well as of consciousness. He also lost the sense of sight, and remained in this condition four days without any perceptible change whatever. The patient took his food and medicine regularly. He was surprised one morning on finding that the patient had much improved. The mother told him that during the night the patient had a violent attack of coughing and showed him the character of the sputum. It was about an ounce of green, stinking pus, mixed with mucus. From this time the patient began to improve. There was an immediate return of consciousness, a quickening of the heart's action and respirations. Examinations of the throat showed that the pus came from above. No pus came out of the Eustachian orifices, and when the patient leaned forward it would come out of the anterior nares. The discharge lasted two weeks. Where it came from, or how it got through, he could not tell. His opinion favoured the ethmoidal and sphenoidal sinuses. As a result of this terrible ordeal the patient, when seen three months since, was totally blind, sense of hearing lost in right ear, has not got the use of his right arm, and his mind is not what it was. Could such results take place without some destruction of the brain-tissue proper? Could the patient have the same results from an intra-meningeal accumulation?

In the treatment Dr. Gillette used opium, quinine, mercury, cold applications to head, and cupping at the back of the neck, and the triple bromides as they were indicated. As soon as marked compression of the brain had developed he began to use eighty grains of iodide of potash each day, and kept it up for thirty days. Did this treatment have anything to do with the results?

Dr. THOMAS F. RUMBOLD, of St. Louis, read a paper entitled *Five Reasons for Failure in Treating Chronic Rhinitis.* The first is defective instrumentation. Not one of the physicians whose offices he had visited had a tongue-depressor that would not cause the patient to retch as soon as it was introduced into the mouth. The blades of all the instruments he saw were too wide to go between the teeth, and too long, being about six inches in length. These instruments were seldom used in examinations, the exceedingly defective method of drawing the tongue out with a napkin being employed instead.

2. The spray-producers used were made for watery solutions only. These physicians did not possess an instrument that could throw warm vaseline. Liquid cosmoline was found in every office. While this remedy is far superior to tannin, iodine, nitrate of silver, or any of a dozen other agents commonly found in offices, yet it is much inferior to warm vaseline.

3. The compressed air used was taken from a container of a capacity of from three to four or five gallons. Air enough was forced into this reservoir to show a pressure of from thirty to seventy pounds. The reservoir was filled by an air-pump whose barrel was made of brass; the piston was packed with leather, which is partially decomposed animal tissue, and it was lubricated with rancid oil of some kind. Ten pounds is the greatest pressure that the mucous membrane can stand without producing irritation, while by far the greater majority of patients require from six to eight pounds pressure only.

The fourth reason for failure was an anatomical one. He meant by this an error in locating the disease. Innumerable clinical observations and post-mortem examinations prove conclusively that rhinal inflammation invariably commences

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on the superior and middle turbinated processes and extends in all directions in the nasal passages and into the passages connected with them, except on the floor of the nasal passages or so-called inferior meatuses. These two portions are seldom affected with inflammation.

Keeping in mind that every irritation produces inflammation, what are the indications for treatment of chronic rhinitis?

(*a*) The diseased secretion, which is always acrid, therefore irritating, should be removed. If morbid growths are present, as these also are irritating, they should be removed, thus removing the local sources of inflammation.

(*b*) The new secretion, that is, that which is to be formed upon the surfaces that have been cleansed, should be prevented from becoming acrid, thus preventing another cause of inflammation.

(*c*) Hygienic and sanative measures should be insisted upon. This is to prevent a continuance of the irritation to the sensory nerves that are located upon the surface of the body and mucous membrane, by colds and other irritating agents, thus removing the originating causes of the inflammation.

Dr. A. DE VILBISS, of Toledo, in opening the discussion, differed from Dr. Rumbold in that he did not believe properly tanned leather readily decomposes. Rancid oil for lubricating the air-pump is hardly ever used. Personally he used vaseline and naphthol as an application to the mucous membrane. With regard to vaseline it was used as a protector to the mucous membrane on account of its density.

Dr. O. F. MCGAHAN, of Chattanooga, heartily concurred in what Dr. Rumbold had said regarding vaseline. Where we want the surface protected nothing will better take the place of vaseline. He sometimes uses iodine in weak solutions, and has not as yet had any bad effects from it.

Dr. A. G. HOBBS, of Atlanta, used the oil of vaseline. First, for cleansing purposes, and, second, for its celerity. He can warm it much quicker than the solid vaseline. The danger and greatest objection to the douche in cleansing the nasal passages is its liability to set up middle-ear catarrh, which is sometimes produced by the post-nasal and anterior nasal douche.

Dr. JOHN NORTH, of Toledo, did not favour the use of tongue-depressors. Patients should be trained to manage their tongues without them. When he did use one it was a small wire tongue-depressor. He uses the oil of vaseline for cleansing the nasal passages, with a little alkaline spray, or even with eucalyptus, or some other antiseptic dissolved in it. High pressure the rhinologist did not want.

Dr. C. L. DREESE, of Goshen, Indiana, read a paper on *Reflex Symptoms of Rhinal Diseases with Reports of Cases.* The first case was one of heart, stomach, and lung troubles, caused by sympathy from rhinal disease. The removal of the latter affection was followed by recovery of the former. The second case was one where incontinence was a reflex symptom of chronic nasal catarrh, and was cured by treating the catarrhal trouble alone. The third was one in which epilepsy was a complication of rhinal disease.

Dr. C. H. MOORE, of Indianapolis, contributed a paper on *Ocular Reflex Symptoms in Nasal Diseases.* He had relieved a case of neurotic affection of the Eustachian tube of the left ear by spraying the nasal passages with vaseline. Hack mentions a number of cases of hemicrania and asthma cured by the galvano-caustic destruction of the hyperplasia of corpora cavernosa of the nasal cavity. Voltolini demonstrated that asthma may be relieved by the removal of nasal

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polypi. A certain group of eye symptoms, such as lachrymation, photophobia, conjunctival hyperæmia, are observed in a number of patients that come to the rhinologist, and yet the examination of their eyes reveals no anomaly. The vision is normal, no eye strain, conjunctivæ healthy, the puncto lacrymalia favourably placed, and the tear-ducts open. For such cases a simple eye-wash has been ordered, cold or warm applications recommended, general hygienic treatment advised, without any relief to patients. Relief of the rhinal affection in these patients was generally followed by a cure.

The cases he reported had the following symptoms in common:

1. Burning and smarting sensation of the eyelids, especially in the morning.
2. Difficulty in distinguishing an object in ordinary daylight.
3. Increased vascularity of the conjunctiva and lachrymation on exposure to the air.
4. The sound condition of the eyes and their appendages.
5. Failure of ocular and general treatment.
6. The efficiency of nasal treatment.

Dr. N. R. GORDON, of Springfield, Illinois, said his rule of proceeding with such cases is to examine the eyes for irritation or the condition of refraction, and if the latter is normal, and no other source of inflammation can be found in the eye, he examines the mucous membrane of the nasal passages, and very often the cause is to be found there.

Dr. E. R. LEWIS, of Indianapolis, said there was no doubt but that a number of such cases are being constantly referred to the rhinologist. It should be determined that there is no error of refraction requiring treatment before the rhinologist accepts the case. About one-third of his cases were sent to him by Drs. Thompson and Stillson, oculists, but not until the eye trouble had been corrected, after which he commenced to treat them for rhinal troubles. This he believed to be the logical course to pursue in such cases.

Dr. E. FLETCHER INGALS, of Chicago, related the case of a lady, which illustrates the possibilities of eye trouble being caused by nasal disease. She came to him with hypertrophic rhinitis. He proceeded to cauterize the turbinated bodies, and before she left the office she asked him if he could not do something for her eyes, that she was unable to use them more than five minutes at a time for the last three years. He referred her to an oculist that she might get relief. She did not return to his office for two weeks; on her return she said she had not been to an oculist, but that the next day after the nose had been cauterized she was able to read at night, and it did not affect her eyes.

Dr. N. R. GORDON read a paper on *Therapeutic Measures in Rhinology*. He said that after the surgical removal of hypertrophied tissue, a curative local treatment, continued at short intervals for one or two years, or even longer, is necessary. This should consist of the oil of vaseline, with a small amount of eucalyptol or something of that character. Astringents do but little, if any, good. Where the oil of vaseline fails, salt and water in proper proportions, with a small amount of Listerine, or Dobell's solution, are suitable remedies. To prevent mouth-breathing during sleep, he recommends his patients to wear a little instrument made of celluloid that fits nicely between the teeth and lips.

In atrophic catarrh, after the removal of all secretion on the surfaces, where the mucous membrane is very thin or even ulcerated, he finds the application of a solution of resorcin, one drachm to the ounce, to be exceedingly beneficial. In the most unyielding and obstinate form of nasal catarrh he uses a glycerine suppository composed of ninety-five per cent. glycerine and five per cent. stearin.

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The solidified glycerine is placed so as to come in contact with the atrophied or ulcerated portion of membrane. The glycerine soon asserts its well-known affinity for water, and the result is an abundant flow of thin mucus.

Dr. C. H. VON KLEIN, of Dayton, O., read a paper entitled *Atrophy, Hypertrophy, and Deviations of the Septum*, in which he said he had examined the nasal cavities in over six hundred patients, and found not exceeding two per cent. to have an absolutely straight division of the nares. In almost every case he observed deformities of some sort, either atrophy, hypertrophy, or deviation of the septum.

The causes which are most common to deviation of the septum occur to people when they are in their babyhood. When children commence to creep and walk around, passing from chair to chair, they fall, and nine times out of ten it is on their nose. Personal observation leads him to believe that atrophy of the septum is confined to the cartilaginous portion. Hypertrophy, on the other hand, is confined to the osseous portion of the septum, and these conditions are generally caused by such injuries as may occur to any other part of the bony system. A stroke or fall on the osseous portion of the septum may produce hypertrophy.

Dr. C. F. MCGAHAN, of Chattanooga, read a paper on *The Treatment of Chronic Nasal Catarrh*, in which the author said the remedies for its treatment comprise almost the whole materia medica. Formerly it was treated principally with strong astringents—for example, strong solutions of nitrate of silver by the post-nasal syringe, sprays of tincture chloride, tannic acid, etc. Where we have polypi the first thing to do is to remove them, which can be done by the snare or the galvanic cautery. Where the polypi are located in the anterior chamber he prefers the cautery; but when they are in the posterior chamber of the nose, the snare. Acids he did not like in the treatment of hypertrophies, as it is impossible to control the exact amount of tissue they will destroy, and then the pain is always more intense than after the use of the cautery. The hypertrophy being reduced we have simply a case of chronic catarrh with moderate hypertrophy to combat.

At the outset we should spray the nasal cavity thoroughly with Dobell's solution, or the combination with Listerine, which is recommended by Leffert. Seiler's tablets are convenient and effective. He has the spray tubes of Sass, Rumbold, Davidson, and Richardson in his office, but prefers the De Vilbiss, for with one of the De Vilbiss make for aqueous fluids, and another of the same make for oils, the rhinologist can apply nebuke to any part of the nasal cavity. Having cleansed the nasal cavity thoroughly we are now ready to apply our medicament. When there is moderate hypertrophy he generally used about three times a week a spray of vaseline with a combination of the iodides, or with iodine and carbolic acid. The liquid albolene, as manufactured by McKesson and Robbins, is by far the nicest vehicle he had as yet used, although it does not remain upon the tissues as long as vaseline, and when used for its protective effect the vaseline was preferable. He now uses the iodine and iodides dissolved in albolene, first as a spray, for their alterative effect, and then spray in just pure vaseline to protect the tissue from air, or any particles that may be suspended in the air. After cleansing the nasal cavity thoroughly, he usually sprays the parts with vaseline, combined with a few drops of eucalyptol or oil of gaultheria, sometimes a drop of carbolic acid to the ounce of vaseline. On account of the hydragogue effect of glycerine upon the tissues it occurred to him some time ago that in hypertrophic conditions of the nasal cavity it may be useful in drawing the water from the tissues, and thereby reducing them in size. He had often seen it advised in combination with other drugs in the different sprays, but his way of using it was similar to that of the gynæcologists when they apply it on tampons for different hypertrophic conditions of the uterus. The cavity having been thoroughly

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cleansed, he applies to the hypertrophic membrane a tampon, soaked in a solution of glycerine one part, water four parts, which he allows to remain in from one to four hours. As the membrane becomes accustomed to the glycerine he rapidly increases the proportion of it in the solution, until he uses equal parts of it and water. He advises plugging the anterior nares with absorbent cotton, which prevents the tampon from being expelled. He has been experimenting with this treatment for the past six months, and thinks it is of great benefit in reducing many cases of hypertrophies.

Dr. A. DE VILBISS, of Toledo, contributed an interesting paper, entitled *Surgical Treatment in Diseases of the Nose*, in which he said until recently few diseases have caused more dissatisfaction in their treatment than chronic nasal catarrh. He did not wish to be understood that in every case of nasal catarrh there is a demand for surgical interference, but in every case that demands operation a catarrhal condition of the nasal passages was usually found to exist. He had given relief from frontal headaches, mental depression, etc., by the removal of hypertrophic tissue from the middle turbinate. He believed the time was not far distant when the sphenoidal sinus, frontal sinus, post and anterior ethmoidal cells—after death—would be looked into and examined to find a special cause for certain symptoms that existed during life, and the answer found. Schwable, Axel-Key, and Retzius have demonstrated the fact that not only can the lymphatics of the nasal mucous membrane be injected from the subdural and subarachnoidal spaces, but if force be used the fluid will pass through the lymphatic canals to the surface of the nasal mucous membrane. Permanent nasal stenosis should be relieved by an operation, as it is due to either traumatism, hypertrophic tissue over turbinate bones, thickening of tissue or deflections of nasal septum, gelatinous polypi, adenoma of vault of pharynx, fibromata or sarcomatous tumours, and the only source of relief is their removal or correction of misplaced parts. Preparatory to operating he always cleanses the nasal cavities of acrid matter, and protects the cut surfaces after operation by keeping them covered with iodized or carbolized albolene or vaseline. Hæmorrhage, if necessity demands it, he controls by cotton plugs. If the source of hæmorrhage is well back in the nasal cavities he uses small cotton plugs, tied with a string in the form of a kite-tail, which are easy to introduce and easy to remove.

Dr. R. S. KNODE, of Omaha, contributed a paper on *The Importance of Constitutional Treatment in Rhino-Pharyngeal Inflammation*, in which he said the rhinologist ofttimes becomes discouraged, with all the means at his command, when he finds that patients do not improve as he would like them to do; but, if the history is carefully looked into, there would be found some diathetical condition at the bottom of the nasal trouble, which, if the rhinologist could relieve, would cause a subsidence of the local inflammation. This catarrhal condition frequently extends into the stomach and intestines, and from the duodenum to the ductus choledochus, in which we have the combined symptoms of gastro-intestinal catarrh, associated with jaundice, and when the nutritive system becomes implicated there is a wide range of sympathetic disturbances which invariably follow.

The principal sympathetic phenomena transmitted from this condition are sick headache, depression, melancholy, sleeplessness, hypochondria, the heart's action is often disturbed, there is sympathizing dyspnœa, and to these may be added languor, lassitude, and irritable temper.

The general principles in the treatment of such cases would be a properly restricted diet, consisting of milk, stale bread, soft boiled eggs, and well-cooked rice. If milk is not well tolerated it should be peptonized; foods containing

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little starch and largely diluted with water are the best tolerated. Among the internal agents may be mentioned the alkaline carbonates, combined with purgative salines, especially where the nasal trouble is associated with disease of the stomach, which is a frequent complication in malarial districts; and in these regions no treatment is effective until we diminish the engorgements of the liver and spleen, and nothing accomplishes this so well as the use of alkaline and saline laxatives, and these may be assisted by small doses of mercurials. Carlsbad and other mineral waters have been extolled, but phosphate of soda and Rochelle salts, if perseveringly used, may take their place. General hygienic treatment in all cases must be insisted on.

Dr. E. L. SIVER, of Fort Wayne, Ind., read a paper entitled *Reflex Inflammation of the Nose and Throat.* The author reported a case of laryngitis, with aphonia, which lasted two weeks, and which, he thinks, arose from a deflected septum and posterior hypertrophy of the inferior turbinated bone.

Dr. A. G. HOBBS, of Atlanta, read a paper on *Catarrhal Neuralgia*, by which he meant to include not only the headaches and browaches that are caused by the pressure from nasal hypertrophies or foreign bodies, but all reflex pains that have for their origin pressure in the nasal cavities, whether they be located in the forehead, the temples, across the bridge of the nose, or over the cheek bones. That such reflex pains do occur, and have for their cause pressure in the nasal cavities, was known long ago. If they were only occasional, or of short duration, they might not demand so much attention, but in many cases the pains are more persistent than the neuralgias from any other cause, and they many times produce a more profound impression upon the general system, indicated by a sense of lassitude, a haggard expression, a malassimilation, and a decided loss of weight. He had no statistics bearing upon the comparative frequency of catarrhal and ocular neuralgias other than his own note-book of the last three years. In it he found fifty-four cases under the combined headings *Catarrhal Neuralgia,' Ocular Headache, and Catarrhal and Ocular Neuralgia combined*; thirty-six cases occur under the first caption, fourteen cases under the second, and four cases under the third.

After recognizing the etiology of a case exhibiting these reflex pains, on account of the severity of the pain, temporary relief should be given the patient by the application of cocaine sprays, or, in the case of complete stenosis, the cotton probe saturated with cocaine first, then the sprays. The effect should then be to reduce the pressure permanently by the means that is most rapid.

If the pressure be due to a polypus, extract it; if to a deflected septum, remove the deflection; and if it be (as is most likely the case) due to an hypertrophy, reduce it with the galvano-cautery, the snare, glacial acetic acid, or chromic acid. He most frequently resorts to the latter. After the removal of the pressure, pain ceases to a great extent, if not entirely; then the more soothing treatment of vaseline sprays, in combination with cocaine, pinus canadensis, oil of terebene, or oil of eucalyptus, daily or tri-weekly, will complete the resolution.

He knew of no class of cases that apply to the rhinologist for relief in which treatment gives more prompt and satisfactory results. Indeed, when there is no mistake made in the etiology, the result is absolutely sure, if means are resorted to that are effectual in removing the pressure upon the terminal sensitive nerves that are distributed to the nasal mucous membrane.

Dr. ELY MCCLELLAN, of Chicago, read a paper on *The Physiological and Therapeutic Action of Certain Drugs in the Treatment of Affections of the Upper Air Passages.*

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THE ELECTION OF OFFICERS

resulted in the choice of the following :

President—Dr. A. G. Hobbs, Atlanta, Ga. ; *First Vice-President*—Dr. A. B. Thrasher, Cincinnati, O. ; *Second Vice-President*—Dr. E. R. Lewis, Indianapolis, Ind. ; *Secretary and Treasurer*—D. R. S. Knode, Omaha, Neb. ; *Librarian*—Dr. John North, Toledo, O. ; *Member of Council*—Dr. C. H. Von Klein, Dayton, O.

Next place of meeting, Louisville, Ky., 1890, in conjunction with the Mississippi Valley Medical Association.

At the solicitation of Dr. SETH S. BISHOP, of Chicago, a committee was appointed by the President to co-operate with the United States Hay Fever Association, with reference to the investigation and treatment of hay fever, to report annually. *The Medical Record*, Nov. 23, 1889.

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