TONSILS, PHARYNX, &c.

FRÖHLICH (Riès a). — **Follicular Tonsillitis and Idiopathic Peritonitis.** *Deutsch. Medicinal Ztg.*, No. 73, 1887.

THE following cases are of great interest, because they prove that follicular tonsillitis, which is usually regarded as a harmless disease, can become an object of great importance.

A military musician, L——, acquired a follicular tonsillitis; he had no fever, but the pulse was small and frequent, and the general health bad. The next day temperature 39·1, pulse 108, meteorism, and complaints of abdominal pains. There was also an enlargement of the spleen, rendering the condition like typhoid. But the next day it was obviously seen that the man suffered from a peritonitis. In spite of energetic treatment with ice, calomel, and camphor and benzoin injections, the condition aggravated, the weakness increased, and the patient died the next day. The post-mortem examination showed a simple peritonitis without perforation, œdema pulmonum and swelling of the tonsils, without, however, the presence of membranes. The affection was considered to be simple peritonitis. During the post-mortem examination, the author cut himself in a finger, and in spite of energetic disinfection he was attacked the next day with violent lymphangeitis and lymphadenitis of his arm, high fever, and very bad general condition. He also experienced pain in the pharynx, and examination showed a follicular tonsillitis. The next day the wife of the author also suffered from a follicular tonsillitis, and the same day an assistant who had sewn up the cadaver, and also wounded his finger, acquired a follicular tonsillitis. It was now evident there was a connection between the infection of the fingers and the tonsillitis, and that the tonsillitis was also so infectious that the wife had acquired it. It was nearly certain that the tonsillitis of the author and the assistant was caused by the peritoneal pus from the cadaver, and that both affections were caused by the same micro-organism. The author, his wife, and the assistant were successfully cured. The author refers to some cases in literature of similar affections, but the connection is not so certainly established in any of these as in this case. Bacillary examinations were not made because the musician had been already buried when the chain of events became interesting. MICHAEL.

RABITSCH (Cairo).—**Case of Primary Syphilis of One Tonsil.** *Berlin. Klin. Wochenschr.*, No. 17, 1887.

ULCERS of the right tonsil followed by a bubo submaxillaris and syphilitic skin disease, cured by iodine and mercury. MICHAEL.

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SANDS, H. B. (N.Y.).—**Obstinate Hæmorrhage after Tonsillotomy. Recovery after Ligation of the Common Carotid Artery and Transfusion of Salt Solution.** *N. Y. Surgical Society, May* 11, 1887; *Med. News, Phila., May* 28, 1887.

THE hæmorrhage which followed the operation was insignificant, but some hours later the tonsil began to bleed, and continued all night long, in spite of efforts made to restrain it. Although the patient belonged to a family of bleeders, Sands believes the hæmorrhage due to the division of a large tonsillar artery. For details of the case the above reference should be consulted. J. N. MACKENZIE.

TEMOIN, M.—Retro-Pharyngeal Abscess. Two Cases of Incision, followed by Phenomena of Asphyxia. *Revue des Maladies de l'Enfance, April*, 1887.

IN these two cases the opening of the abscess was followed—in the first, immediately, and in the second, after a short time—by an accident which might have been fatal, and may have been the cause of the broncho-pneumonia from which the patients suffered; but the special point of interest was the dyspnœa, amounting to real asphyxia. Temoin quotes instances of other authors where the asphyxia was complete from the moment the abscess was opened, and death resulted. So, to avoid the asphyxia and swallowing of pus, he recommends Duprè's method of first inserting a trochar, and then enlarging the incision with a bistoury. Operating in this manner, one need not fear ill effects from a large incision; and, on the other hand, the enlargement of the primary incision renders the patient less liable to a premature closing of the wound. The author omits to speak of the mechanism by which asphyxia is produced. JOAL.

ERBEN.—Paralysis of Pharynx and Larynx in Unilateral Bulbar-Paralysis. *Wiener Med. Blätter*, Nos. 1 and 2, 1887.

(1.) A patient, thirty-eight years old, had hemiparesis of the left side and atrophy of the tongue, paralysis of the musculi arytænoidei, and anæsthesia of the pharynx.

(2.) A patient, thirty-six years old, had double ptosis, paralysis of the left oral fold, paralysis of the left side of the palate, anæsthesia of the pharynx, and dyspnœa. MICHAEL.

VERNEUIL.—Myeloplastic Tumour of the Palatine Arch and Maxillary Sinus. *Gaz. des Hop., April* 7, 1887.

THE surgeon is called upon sometimes to practise detestable, but necessary operations, since in some cases they are crowned with success. The patient in question has had for four years a myeloplastic tumour of the upper jawbone. These tumours,

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are generally a phenomenon of youth, are indolent, progress slowly, and rarely ulcerate. Very rarely is there any glandular enlargement. The place of origin generally selected is the upper or lower jawbone. In this case it occupied the maxillary sinus, and compressing the nerves had caused trophic lesions of the eye. There was thus a carotid and a maxillary focus, and Verneuil interfered only with repugnance. He proposed to first remove the glandular mass in the neck, ligaturing the external carotid. The operation on the face would comprise two incisions, from the angle (internal) of the eye to the median line of the upper lip, and another semilunar horizontal incision along the edge of the orbit to the malar bone, thus laying bare the whole maxilla and permitting the opening of the sinus and an estimation of the full extent of the tumour. JOAL.

PERRY (Glasgow).—**Impaction of a Bone in the Œsophagus.** *Glasgow Med. Jour., April*, 1887.

EXHIBITION of specimen before the Pathological and Clinical Society of Glasgow, November 8, 1886. The bone, which measured about $1\frac{1}{2}$ inches in length, and $\frac{1}{2}$ inch in breadth, had been impacted in the œsophagus about the level of the upper end of the sternum. The patient had consulted several surgeons in London, who, after passing probangs, had declared there was no bone in the throat. A few days before death, the above piece of bone was coughed up. On post-mortem examination the œsophagus was found to be the seat of a large ulcerated aperture, and in the apex of the left lung there was an abscess. It was presumed that the bone had pierced the lung, and had thus set up disease.

Dr. Newman, referring to the fact that such a large piece of bone had escaped detection, pointed out the advantages to be derived from the use of a resonator-probang in such cases.

HUNTER MACKENZIE.

SYMONDS, CHARTERS J. (London).—**The Treatment of Malignant Stricture of the Œsophagus by Tubage or Permanent Catheterism.** *Brit. Med. Journ., April 23*, 1887.

THE author's cases recorded in this paper comprised: 1. Epithelioma of œsophagus, treated by permanent tubage or catheterism; death from extension to pleura and lung. 2. Epithelioma of upper end of the œsophagus, treated by tubage; permanent dilatation effected; death from exhaustion and prevertebral suppuration. 3. Stricture of œsophagus at the lower end; relief by tubage. The author discusses the question of short and long tubes, the effects of the tube, and the applicability of the method. In reviewing the treatment of this form of stricture the author suggests the following plan:—

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1. So long as solids can be swallowed, let the patency be maintained by the passage of bougies, for neither by tubage nor through the opening formed by gastrostomy can solid food be introduced. Well-stewed tripe, rabbit, and pigs' and calves' feet are swallowed readily.

2. When solids can no longer be taken, a short tube should be introduced. This, when considerable dilatation has been effected, may be removed altogether from time to time, and the patient allowed to take solids. This form can be worn till the case terminates, unless pulmonary symptoms supervene, especially cough on swallowing.

3. When the passage of fluids can no longer be borne, then they must be withdrawn altogether from the gullet. This can be accomplished in two ways: (*a*) by the use of Krishaber's long tube; (*b*) by gastrostomy.

The duration of life after this stage has been reached will in no case be long, and it becomes a question of giving the patient the greatest amount of comfort. The experience of others as well as the author shows that long tubes may be worn till the termination of a case; and that ulceration will be avoided by using rubber tubes, and passing them by the nose. To this method the author gives adhesion, rather than to gastrostomy. Those who have seen many cases know the difficulty that often arises from escape of the gastric juice, and that not a few have been fed into the peritoneum, while the operation, if done when the patient is in a depressed condition, is very likely to be unsuccessful, either from want of union or exhaustion. Other means are sufficient in the earlier stages.

The most recent advocate for gastrostomy, Dr. Gross, seems to believe that only those cases of malignant disease in which there is no ulceration are suitable for permanent catheterism. To this the author may reply that his most successful case had certainly ulceration when first seen; and this condition existed in all the others at a time when catheterism was giving complete relief.

Again, while thinking that greater caution must be exercised in dealing with disease at the lower end of the tube, it by no means follows that it is impossible, as Dr. Gross suggests, to enter the stomach. One of the author's cases shows this. He had great difficulty in traversing the stricture in two cases; but believes, with suitable instruments, and a period of complete rest, with the use of sedatives and rectal enemata, most of the strictures will be overcome; and once a tube has been passed and retained, there will be no further difficulty.

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