Bœcker's (see this Journal, Jan., 1887), which he describes "as a very useful antidote to those who are inclined to be too active in attacking by surgical operations the noses of those who suffer from asthma and other neuroses."

COHEN, S. S. (Philadelphia).—**A Case of Hysterical Sneezing apparently Cured by Intra-Nasal Applications of the Continuous Battery Current.** *New York Med. Journal, January* 29, 1887.

In a neuro-mimetic, hysterical girl, subject as she said to paroxysms of violent sneezing, and who came to be treated for "hay fever" by the electric cautery, Cohen found the nasal passages apparently free from disease, but on the left side of the septum high up, pressure with the probe gave rise to exquisite pain, and a sensation as if she were going to have an attack. After trying a palliative course of treatment with cocaine, internal medication of various kinds was instituted without success. The paroxysms were finally kept under control for two months by the application of belladonna and cacao-butter in various strengths to the sensitive spot on the septum. Six weeks after cessation of treatment she had a recurrence, and daily applications of the constant current were decided upon, the positive electrode being placed on the sensitive area, the negative upon an indifferent point on the cheek. After two weeks, the patient professed herself well. Cohen is uncertain as to whether the cure was due to the current, or to the mental impression which the electricity created.

J. N. Mackenzie.

TONSILS, PHARYNX, &c.

MORGAN, E. C.—**The Question of Hæmorrhage following Uvulotomy.** *A Reprint from the New York Med. Journal*, 1886.

The author has produced an elaborate historical essay, of quite a unique character. The opinions of various authors as to uvulotomy are here collected and expressed, from 400 B.C. to 1886 A.D. The author addressed inquiries to all prominent laryngologists throughout the world as to cases of uvular hæmorrhage met with by them in their practice. The replies to questions asked enabled Dr. Morgan to formulate the following conclusions:—

1. A fatal or uncontrollable hæmorrhage has, in one instance, followed a uvulotomy.

2. A persistent, obstinate, or alarming hæmorrhage is only encountered in the rarest instances.

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3. A moderate bleeding, ceasing spontaneously or by the use of mild styptics, occasionally happens.

4. The loss of a few drops of blood at the time of operating, followed by slight oozing, is of common occurrence.

5. The most reliable surgical methods for controlling uvular hæmorrhage are the ligature, compression by the clamp or forceps, or the use of the galvano or actual cautery.

6. The most reliable styptics are, in the order named, solid silver nitrate, or iron persulphate, directly applied to the bleeding stump, and solutions of gallo-tannic acid, or alum. To these may be added the local use of ice, ice-water, and vinegar.

7. The most reliable systemic means are opium, lead acetate, sulphuric acid, and ergot.

The author has devised an ingenious clip, to seize the bleeding uvula and arrest hæmorrhage.

Accidents during Tonsillotomy. *Brit. Med. Journal, March* 12, 1887.

Dr. Schuler (of Rorschach) in excising the tonsils with Mathieu's tonsillotome met with a rather serious accident. The middle (cutting) ring of the instrument suddenly gave way, and a piece about one centimètre long fell out, but was promptly picked out of the patient's mouth. In a similar accident, which recently occurred in the practice of a colleague of Dr. Schuler, the patient swallowed the part of the knife which had become detached. A third case of the kind was recently published in the *Union Médicale*, No. 48, 1886, by Dr. Edmond Barré. The circular knife was broken into two pieces, one of which was extracted from the pharynx, while the other, two and a half centimètres long, was swallowed by the patient, and expelled from the anus three days later.

RENDLEMAN, J. J. (Makuda, Illinois).—**Dysphagia Clericorum.** *Southern Practitioner.*

Nothing new. J. N. Mackenzie.

GRADLE, H. (St. Louis).—**Diseases of the Vault of the Pharynx.** *Chicago Med. Jour. and Examiner, January,* 1887.

Nothing new. J. N. Mackenzie.

HASLUND (Copenhagen).—**Two more Cases of Syphilis arising from Infection through the Pharynx.** *Hospitalstidende, March* 9, 1887.

The author, who has formerly described four cases of chancres of the pharynx, believes that they are more common than generally

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thought. In the first patient, a girl aged eleven years, there was a chancre with distinct induration of the size of a halfpenny-piece, extending from the left side of the uvula down to the pillars of the fauces and the left tonsil. In the other patient, a single woman aged twenty-seven years, the ulceration was healed, leaving an unusually hard induration of the right side of the whole space between the pillars, extending backwards to the side wall of the pharynx. In both cases there was a hard swelling of the corresponding glands about the angle of the jaw, and in both patients secondary syphilitic phenomena were present. In neither case could the mode of infection be traced or even suspected. HOLGER MYGIND.

VIARD.—Contribution to the Study of Tertiary Syphilis of the Throat. *Thèse, Paris*, 1887.

TERTIARY syphilis has a special predilection for the back of the throat, and is manifested in that situation by tuberculo-ulcerative syphilides, or gummata. These lesions occur generally about the fourth or fifth year of the diathesis, at the period when the malady becomes constitutional. Hereditary syphilis is frequently localized in the back of the throat, and may, under these circumstances, lead to difficulty in diagnosing from scrofulo-tuberculosis. In cases of doubt, the author recalls Ricord's dictum: "Scrofula possible, syphilis probable." The exciting causes are, the gravity of the diathesis, alcoholism, privation, and absence or insufficiency of treatment. JOAL.

CHABROL.—"Ludwig's Angina." *Thèse, Paris*, 1887.

THE author considers this complaint to be an affection of the sub-hyoid region, distinct from sub-maxillary adeno-phlegmonous conditions. The disease is characterized by induration of the sub-maxillary region, and of the floor of the mouth, accompanied with falling back of the tongue, and troubles of respiration and deglutition, proceeding rapidly to gangrene, and accompanied with typhoid symptoms. It is probably due to a micro-organism, the nature of which is yet undetermined, and the disease appears to be, in some cases, contagious. JOAL.

ROSS (Montreal).—**Cancer of Œsophagus.** *Canadian Practitioner, February*, 1887.

STRICTURE with increasing difficulty in deglutition during life. Sudden death. At the autopsy, epithelioma of œsophagus forming

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ulcerated surface 5 inches long; calibre of gut not much narrowed. Death from bursting of a cerebral abscess.

OGSTON, Prof. Alex.—On the Diagnosis of Stricture of the Œsophagus. *Manchester Med. Chron., January*, 1887.

STRICTURE at the lower end is usually cancerous, and occurs after middle life, and is the easiest to diagnose. Peri-œsophageal irritations, suppuration and abscess are common in such patients, and the passage of a probang may perforate the wall, and at all events usually aggravates the condition and determines the formation of abscess. A small probang may also easily pass the stricture without detecting it. Stricture at the upper end is usually found in the young, or under middle life, and is the most difficult of diagnosis. Prof. Ogston refers to Hamburger's statement that on ausculting the œsophagus the ear will recognize a sound produced at the seat of stricture by the passage of swallowed food, solid or liquid, for at this point the "egg-shaped form" of the ingesta is broken up and the change can be recognized. Ogston says that at this point is heard a detention of the normal sound—which is a rushing or gurgling of the food in the gullet—and followed, if the food be fluid, by a squirting sound. But this is not always heard, for in the cases especially where the stricture is narrow and opposite the larynx, the churning produced by the pharynx, in efforts to force on the food, drowns all other sounds. The rapidity of the passage of the food along the gullet is a very valuable sign. A healthy person requires four seconds for passage of food from the mouth to the stomach. The rising of the pomum Adami tells that it has passed the pharynx into the œsophagus, and placing the ear three inches below the angle of the left scapula, a distinct amphoric gurgle or rushing sound tells that food has entered the stomach. With watch in one hand, finger on the pomum Adami, and directing the patient to hold fluid in the mouth till told to swallow, the time of entrance into the stomach can easily be calculated. In case of stricture, the food takes fourteen or sixteen seconds instead of four to traverse the œsophagus. Though the sign may mislead, or be inapplicable occasionally, Ogston finds it very useful and reliable in most cases.

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