He also exhibited the older and newer instruments necessary for the operation.

RANKE wished that a collective investigation should be entertained, and reported on the results obtained in Germany and Switzerland. His results have been elsewhere published. He resumed that intubation will not displace tracheotomy, but that it is a welcome addition to our methods of treating diphtheria.

BOUCHUT (Paris), who first described the method in 1858, showed the instruments of that time, and described their advantages.

NORTHRUP (New York), reported one hundred and three *post-mortem* examinations of intubated children.

MOUNT BLEYER (New York) reported five hundred and fifteen cases, with thirty-three per cent. cures.

MASSEI reported six cases. STOERK, CASSELBERRY, MELTZER, ROOT, and RAUCHFUSS also participated in the discussion.

This interesting meeting ended in a somewhat melodramatic manner. The honorary president of the meeting extolled in his concluding words the merits of Bouchut and O'Dwyer ; to the former belonged the honour of being the inventor of intubation, and to the latter the honour of introducing it into practice, and perfecting and propagating the method. Strongly applauded by the assembly, he joined the hand of the aged Bouchut to that of the younger O'Dwyer.

ASSOCIATION MEETING.

American Laryngological Association.

Baltimore, Thursday, Friday, and Saturday, May 29, 30, *and* 31, 1890.

President—DR. JOHN N. MACKENZIE.

THE PRESIDENT read a paper upon *The Relationship between Bulbo-Nuclear Disease and Obscure Neurotic Conditions of the Upper Air Passages.* The author spoke of the intimate connection between many affections of the upper air tracts and the cerebro-spinal and sympathetic systems, remarking that the subject was indifferently dealt with or passed over in silence by text-books on laryngology. He thought that "functional aphonia" and "spasm of the tensors of the vocal cords" were connected with central trouble. He believes that his former contention of the intimate connection of certain obscure respiratory troubles and disorders of the sympathetic system is correct. He related the history and notes of a case of a woman, aged forty, who, after much trouble and mental excitement, was seized suddenly with a drawing downwards and outwards of the left side of the face. There was no difficulty in articulation, and the attack passed off in three days. After an interval of apparent health,

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she one morning awoke with loss of power of the right hand, and abolition of sensation in the fingers, numbness and tingling in the extremities, and twitching of one of the tendons in the palm. The tingling sensation extended into the throat. These symptoms lasted about a week, and as they disappeared the patient noticed difficulty in articulation, and mumbled her words. There was no aphasia. The symptoms grew worse, and the mouth became drawn a little to the left side. After a week in bed she improved, speech became clear, but pain in the throat and legs, with swelling of the latter, occurred. All these symptoms disappeared, and several weeks after she was seized with foaming of the mouth and puffing of the cheeks, but without convulsion, and with nothing but tingling of the right hand. She walked upstairs, but could only mumble words. When the attack passed off there was weakness of the tongue, with difficulty of protrusion and of articulation. There was swelling of the legs, with tingling and formication. The tongue trouble grew worse, and dysphagia for liquids followed; pains in the head and back of the neck, which came on afterwards, passed away. Along with partial paralysis of the tongue, and inability to whistle or kiss, though she could blow out a light at a foot distance, but not further, there was now complete paralysis of the soft palate and uvula, with diminution of reflex excitability of the larynx, which was of normal appearance, difficulty in expiratory efforts, thick and tenacious saliva, mumbling speech, muscular weakness of right hand and both legs. The movements of the vocal cords were normal. No aphasia, and no confusion of words or syllables. Temperature, normal; pulse regular, 120; respiration, 30. Patient breaks into spells of noisy weeping, followed by laughter, but the intelligence is unimpaired.

DISCUSSION.

Dr. BOSWORTH thought that the evidence was in favour of a neuritis, particularly of the trifacial, and not of any bulbo-nuclear condition.

Dr. DELAVAN referred to the two cases published by Garel lately of laryngeal paralysis produced by a cortical lesion. While many cases are due to bulbar lesion, it is possible that the same symptoms may depend upon central lesions.

Dr. BOSWORTH failed to recall any well-authenticated case of laryngeal paralysis produced by cortical lesion, where such lesion was found *post-mortem*. Garel has had reasons submitted to him for making a change in his diagnosis since that case was published. Hughlings Jackson, from clinical observations, concluded the source of paralysis of laryngeal muscles to be in the medulla.

Dr. DELAVAN remarked that physiological experiments have clearly shown the existence of a cortical centre for the larynx. There are cases in which, where laryngeal paralysis has occurred, careful *post-mortem* search has proved no lesion to exist in the bulb, but in the brain.

Dr. BOSWORTH admitted the existence of psychical centres in the cortex for the larynx, but not motor centres. He remarked, in answer to a question, that Jackson's views were based upon cases, not experiments.

The PRESIDENT, in concluding, stated that he was at a loss to know

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how trifacial neuritis could produce the symptoms in this case, as Dr. Bosworth contended. Unless the trifacial was distributed to the throat and back of the neck, the œsophagus, tongue and other organs, the dorsal region and lower extremities, as well as the face, loss of its function could not produce the phenomena present in this patient. The symptoms corresponded closely with those presented by others as symptomatic of bulbar disease.

Dr. S. O. VANDER POEL read a paper entitled *A Case of Myxoma of the Epiglottis.* Cases of laryngeal myxoma are rare. In this case the patient was a German, fifty-four years of age, and he presented a yellowish-red translucent tumour, the size of a horse-chestnut, springing from the lingual side of the epiglottis, attached by a broad band to the glosso-epiglottic fossa of the left side. Its surface was glistening, lobulated, and traversed by numerous small vessels. It was soft in consistence, and gave a sensation of fluctuation. The left free edge of the epiglottis was lost in the growth. It was extirpated with the galvano-cautery snare, easily and without hæmorrhage. It was examined by Dr. Ira van Giesen, and reported to be a pure hyaline myxoma. Two months afterwards the patient died with signs of pernicious anæmia, a careful autopsy failing to reveal the presence of cancer in any organ, as had been feared. Pernicious anæmia and pseudo-leucocythemia are frequently associated with new growths located in different regions of the body, and the author quotes Mosler's remarks on pseudo-leucocythemia in Ziemmsen's Encyclopædia as to the enlargement of the follicles of the tongue and tonsils, and existence of soft, shiny, translucent nodules on the epiglottis. In this patient a slight recurrence of the growth was noticed several weeks after its first removal.

DISCUSSION.

The PRESIDENT thought that growths in the locality described by Dr. Vander Poel were rare, but perhaps were not of such rare occurrence lower down in the larynx.

Dr. SWAIN had removed a growth such as this from the glosso-epiglottidean fossæ. It resembled a nasal polypus in every respect, except that it was more consistent.

Dr. VANDER POEL replied. These growths were essentially embryonic tissue tumours, myxomatous tissue being only present in the adult in a typical form, *e.g.*, the vitreous, and in small amount in bone medulla. These growths are frequently of mixed form, *e.g.*, fibro-myxoma and lipo-myxoma, and frequently become sarcomatous.

Dr. S. SOLIS-COHEN read a paper entitled *Look beyond the Nose.* He remarked upon the increasing danger of narrow and unenlightened specialism, and the magnifying of the importance of local lesions, coincident with certain general disorders of the system or with local disease in some other region. This tendency is most pernicious in rhinology. It is not true that enlargements and malformations of nasal tissues are, to anything like the extent one might infer from many literary contributions, the sole cause of persistent and distressing headaches.

He reported three cases bearing upon this point. One of them is

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amusing as well as instructive. It was the case of a woman, aged twenty-seven, who had had excruciating headaches and occasional periods of insomnia for years. She first consulted a woman doctor, who ascribed the headaches to the uterus, and gave her three months' special treatment in a sanitarium. Her next adviser scouted the uterine theory, and found the origin of her troubles in errors of refraction of the eyes, which he corrected. A third believed it to be entirely nervous, and gave her a course of electricity. The fourth, fifth, and sixth were homœopaths, the seventh a gynæcologist, and the eighth was the author. At this time the patient believed the nose to be the *fons et origo mali*. Treatment was directed to the relief of deflection of the nasal septum, and failed to cure the headaches and insomnia. Treatment of a feeble digestion, lithæmia and intestinal atony, produced some benefit. Dissatisfied, the patient consulted another oculist, who found the previous correction all wrong, and consequently had aggravated her condition, while his correction was bound at once to restore her to robust health. It did not do so, and on her return two months later to the author she was put upon general treatment again, and was improving greatly.

Without denying that conditions of headache and other nervous disturbances, including asthma, depend upon nasal lesions, a far greater number of cases occur without any nasal abnormality; therefore, while examining the nose as a matter of routine, or when special indications are present, and treating *secundem artem* whatever nasal lesion is present, let us not forget to look beyond the nose.

DISCUSSION.

Dr. ROE remarked that "any man who attempts to ascribe a headache in every instance to a single specific cause should be regarded as scarcely less abnormal than the headache itself." He had seen many cases in which complete relief from a persistent headache followed the removal of a nasal obstruction. The nasal obstruction may be the primary cause of a headache, or it may be only an incidental concomitant.

Dr. JARVIS had often noticed the fact that nervous symptoms may appear in one person and not in another, and there is a difference between the educated, or wealthy, and the labouring classes, in that the latter are far less susceptible to external irritations than the former on account of the inertia of their nervous system. He had found a slight amount of nasal obstruction in a brain worker produce a great deal of distress, headache, etc., while a much greater amount in a labouring man may give rise to no discomfort at all. The nerve symptoms are due to the increased susceptibility of the central nervous system to peripheral impressions.

Dr. A. MACCOY read a paper on *A Case of Myxoma of the Naso-Pharynx in a Child six years old.* The author's experience can recall but one case of nasal polypus in a child, and this was in an infant under one year of age. It was in the right nostril, and was removed by the Jarvis snare. Since the occurrence of this case, in 1883, the author has not seen another. Myxomatous growth in the naso-pharynx is still rarer in children. The case now reported was that of a girl, aged six, who in 1888 contracted a cold which developed into chronic rhinitis. In 1889

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complete occlusion of the nostrils followed, with muco-purulent discharge. A large pinkish mass completely filled the naso-pharyngeal region, the finger being with some difficulty got round the growth. Its attachment was the free surface and lower part of the vomer. It was removed with the galvano-cautery snare, and there has been no recurrence. It weighed six drachms, and was pyriform in shape. It was examined microscopically, and pronounced to be a sub-mucous myxoma.

DISCUSSION.

The PRESIDENT stated that he had in Keating's Encyclopædia recorded two cases of myxoma occurring in a brother and sister, aged respectively four and six. In one the mother had noticed something protruding from the nose at one year of age, in the other the growth was probably congenital.

Dr. SWAIN said this tumour had the appearance of a fibro-myxoma. He had seen such a case in a child eight years of age.

Mr. CHARLES H. KNIGHT read a paper on *A Case of Fibro-Sarcoma of the Right Nasal Fossa, with unusual Clinical History.* The patient was a baker, forty-two years of age, and came under observation in 1886. Twelve years before he received a blow on the nose; for the last two years he had nasal obstruction and catarrhal discharge, loss of the sense of smell, frequent sneezing, and constant frontal headache. Two months ago he expelled from the right naris masses of bloody tissue, and a large, fleshy mass from the posterior naris. Œdematous swelling of the lids closed the right eye, and there was swelling and sensitiveness of the right infra-orbital region. A soft, vascular, sensitive mass completely occluded the right naris, and could be seen projecting into the naso-pharynx. There were no glandular enlargements, and no cachexia. Profuse hæmorrhage and extreme pain followed an attempt to surround the growth with a wire loop. A large piece was removed from the anterior portion, but was reproduced within three days. It was found microscopically to be fibro-sarcoma.

On November 15th, Dr. Weir performed Chassaignac's operation, a quantity of growth being removed by the curette and wire loop, but as it invaded the ethmoid and sphenoidal cells it could not be followed. The patient made a good recovery, but six weeks after reappeared with the nostril blocked with recurrence, and amblyopia and impaired vision in the right eye, and with divergent strabismus. In a week the sight of that eye was completely lost. An ophthalmoscopic examination by Drs. Roosa and Emerson, etc., showed no change in the fundus. A week later the left eye began to lose power, but nothing abnormal was seen with the ophthalmoscope. In two weeks the patient was completely blind. There was no impairment of hearing, and no muscular paralysis. The tumour then projected from the anterior nares, and filled the naso-pharynx, so as to interfere with speech and deglutition. Several attacks of wild delirium followed. There was no rise of temperature. Two weeks later the right eye and side of the face disappeared beneath a fungoid mass of friable, vascular tissue, from which bloody serum constantly oozed. There was intolerable fœtor. The tumour had extended backwards, so that speech was unintelligible, and dysphagia

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was extreme. The patient became much emaciated, was at times violent with various hallucinations, but for the greater part of the time lay in a condition of stupor.

A week after this, and three months from the date of the operation, Dr. Knight was called to the patient. During an attack of delirium he had torn a portion of the tumour from the face, and had dragged out a mass of the tumour from the naso-pharynx with his finger. The rush of blood was so profuse as almost to suffocate him. The bleeding ceased, the patient lay, covered with blood, in a comatose condition, and died in about five hours. Autopsy was not allowed.

Probably the growth began in the sphenoid or ethmoid cells. No operative interference could have been very promising, but resection of the jaw would have given better access to the affected region, and permitted a more radical removal. Partial and palliative operations should be discouraged, except for relief of swallowing or breathing, or arrest of hæmorrhage. The author agrees with Plicque (see this Journal, May, 1890) that ablation with snare or forceps should never be undertaken, but always an external incision, removing enough of the bony structures to permit the tracing of the neoplasm to its origin.

The author discusses the question whether the traumatism received ten years before bore any causative relation to subsequent developments, and concludes that it alone is not capable of creating malignancy.

(To be continued.)

REVIEWS.

1.—**Diseases of the Nose.** By JAS. B. BALL, M.D., pp. 243. H. K. Lewis, London.

2.—**Diseases of the Nose.** By SPENCER WATSON, F.R.C.S., pp. 218. H. K. Lewis.

THAT Rhinology, of which so little was known outside the circle of a very few specialists in this country even a few years ago, is making rapid strides is evident from the number of works that have lately been presented to the public in England.

Of the two works under review, that of Dr. Ball is intended "to give, within a moderate compass, such a description of the diagnosis and treatment of diseases of the nose and naso-pharynx as might be useful to the senior student and practitioner." A book of this kind, of course, makes no pretension to thoroughness, but we can say that, so far as it goes, the work in question is a reliable one for commencing rhinologists, and well up to modern methods. It deals with the subject more from a medical than a surgical standpoint, and for the special surgery of many rhinological conditions the student will be compelled to seek information from other sources.

Being, however, modest in its aims, and evidently intended as an introduction to the subject for those who may desire to become acquainted with the main features of the modern science of rhinology, it would perhaps be out of place to expect the author to deal with the pure surgery

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