voices. Headache, desire to lie down, and occasional vomiting occur very frequently in such children at school. This condition is wrongly called "migraine." Deformities of the chest succeed to this constant mouth-breathing, just as in laryngeal stenosis. Diligent examination should be made of the naso-pharynx. The growth must be removed. In very young children anæsthesia must be obtained. No one method of operating is suitable for all cases. The post-nasal forceps are best for large masses, and the surface may be curetted afterwards.

Meyers' ring-knife is suitable for some cases. The principal object of the operation being to establish free respiration, it is not necessary to remove every trace of growth. Any portions remaining after the operation will atrophy. The growths do not recur after removal. The author operates with the child in the upright position. The author rightly insists on the improvement in physique caused in children by removing adenoid growths.

R. Norris Wolfenden.

LARYNX.

D'HEILLY.—Intubation of the Larynx in Croup. *Gaz. des Hop.*, *May* 3, 1888.

THE author has performed the operation at the Hôpital Trousseau, in thirteen cases of croup, using O'Dwyer's instruments. In all the cases the conditions were such as would have called for tracheotomy, and the author has taken by preference children under three years of age. American statistics show that intubation has five times as much success in children under two as tracheotomy. After four and a half years of age tracheotomy has the advantage. D'Heilly's youngest patient was nineteen months, and oldest four years of age. Of the thirteen cases, two were in such extreme condition that death could not be attributed to the introduction of the tube. Out of the eleven others were two cases (children of two years of age and two and a half years, respectively). The tube was retained between six and seven days. Intubation is accomplished without bleeding or wound, and is easy to accomplish. These are its advantages over tracheotomy. In case of failure by intubation, tracheotomy can still be performed. The canula is well supported. As to the complaint of wounding the larynx by the passage of the tube, it would require considerable brutality or absolute maladroitness to accomplish it. As soon as the tube is in place, an immediate change occurs in the condition of the infant. There is neither traumatic shock nor rise of temperature, and cold air does not penetrate into the lungs, a most important thing in the case of young infants. But there is a reverse shadow to this favourable picture. The tube is often occluded by false membrane, and it must then be taken out and replaced. This can always be done immediately at the hospital; but in other places it is another question.

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The Americans say, indeed, that when the tube is occluded, it is expelled by coughing, and false membranes with it; but d'Heilly has not seen this occur. Another drawback, and one much more grave, is the interference with deglutition, and consequent difficulty of alimentation. This dysphagia is more pronounced for liquids; and as the child will not take solids, but craves for fluids, one cannot give the former. This dysphagia also leads to passage of alimentary products into the air passages with resulting broncho-pneumonia, which American physicians are wrong to deny, and others are equally wrong to exaggerate. D'Heilly has often found it at the autopsy; but it must be noted that it occurs quite as frequently after tracheotomy, in which deglutition is not the cause. It is probably explained in both cases by presence of diphtheria. The dysphagia can be readily overcome by feeding systematically through the nose. The tube need not be carried into the œsophagus, if the external thread is employed. Intubation appears to be indicated in—

1. All young infants, in whom tracheotomy offers such poor chance, and who bear losses of blood very ill.
2. In slight croups, in which tracheotomy is a grave operation.
3. Inversely in those toxic diphtheritic cases in which the patient is deprived of all resistance, and is incapable of supporting tracheotomy.
4. In croups secondary to measles, and which never succeed by tracheotomy, intubation offers a better chance.
5. In all cases where tracheotomy is impossible or dangerous.

R. Norris Wolfenden.

RADESTOCK (Dresden).—**Total Extirpation of the Larynx and the Suprasternal Portion of the Trachea on account of Carcinoma.** *Langenbeck's Archiv*, Bd. 36, Hft. 1.

A PATIENT, aged twenty-seven, was tracheotomized for dyspnœa. The canula could not be removed. The laryngoscope gave no positive indications, except a swelling of the regio hypo-glottica. The diagnosis was confirmed two years later by laryngotomy, and when this was performed a tumour was found perforating the cartilages, and filling the whole larynx, and the greater part of the trachea. After inferior tracheotomy, the larynx and the suprasternal part of the trachea were removed. There was no severe complication. Three days later an artificial larynx was introduced, with which the patient could speak well. The microscope showed that there was a carcinoma. No recurrence a year after. **Michael.**

ZEMAN (Wien).—**Case of Angio-Sarcoma of the Trachea.** *Wiener Med. Presse*, 1888, *No.* 21.

SCHRÖTTER'S well-known case, first operated on in 1867, then in 1873, and often quoted in laryngological literature, has now died twenty years after the first operation. The autopsy showed a walnut-shaped tumour situated at the fifth cartilage of the trachea. The microscopical examination showed that it was an angio-sarcoma. **Michael.**

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NOLL (Hanau).—**Case of Dismemberment of the Trachea from the Larynx, with nearly Intact External Soft Parts.** *Cure by Operation. Dtsch. Zeitsch. für Chir.*, Bd. 27, Hft. 5.

A WOOLLEN handkerchief was twisted by a portion of machinery so as to cause strong compression of the neck. Dyspnœa, cough, expectoration of blood followed. Tracheotomy was performed. The trachea was drawn down and fixed with needles, but not joined to the larynx again, in consequence of this being fractured. After cure of the wound, it could be seen that the larynx was closed by cicatricial tissue. Laryngo-fissure was done, and a canula applied. Some months later the canula was removed, and the fistula closed by a plastic operation. After treatment consisted of using Schroetter's bougies. A cure resulted.

Michael.

SOMMERBRODT (Breslau).—**The State of the Larynx in Ventriloquists.** *Berlin Klin. Wochenschr.*, 1888, *No.* 14.

THE author has examined a ventriloquist during his performance, and has made the following observations. The velum was strongly retracted, the naso-pharynx was closed. During normal phonation the expiratory air-current passes through the whole glottis during the ventriloquial performance, and there is closure of both posterior parts of the vocal bands. The air-current passes through a little triangular opening lying in the anterior part of the glottis. By this closure the posterior part of the glottis cannot participate in the vibrations. This condition is so characteristic that the ventriloquy can only be diagnosed from the view of the larynx. Ventriloquising has therefore the same mechanism as the falsetto voice (see Morell Mackenzie's "Hygiene of the Vocal Organs"), and can therefore be called falsetto of the speaking voice. By this economy of air the ventriloquist is able to speak with much less respiration than the normal speaker.

Michael.

BANDLER (Prague).—**On Acute Œdema of the Larynx.** *Prager Med. Wochenschr.*, 1888, *No.* 19.

1. Œdema of the glottis, a first symptom of disease of the kidneys. Cure.

2. Acute œdema of the right arytænoid cartilage, and of the ligam. aryepigl. dextrum, with unknown etiology.

3. Acute œdema of the larynx in variola, lasting three days.

Michael.

DEHIO (Dorpat).—**Primary Tuberculous Neoplasm of the Larynx.** *Petersburg Med. Wochenschr.*, 1888, *No.* 16.

THE patient, forty-one years old, had had difficulty in swallowing for some weeks. On the left ventricular band was a tumour, which was nearly the size of the whole band. It was greyish-coloured, and presented an irregular surface. The other mucous membrane of the larynx was reddish and swollen. The lungs were normal. As it was not possible to extirpate the tumour completely *per vias naturales*, laryngo-fissure and incision of the left ventricular band were performed. The microscopic

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examination showed that the tumour was a conglomeration of miliary tubercles. Some days after the operation the patient became feverish, and the wound ulcerated. The patient died some weeks later. Autopsy could not be performed. This case shows that by a sanguinary operation, a tuberculous tumour can infect the whole organism, and that it would be better to destroy it by cauterization. **Michael.**

AVERBECK (Laubach am Rhine).—**Massage of the Larynx.** *Dtsch. Med. Zeitung*, 1888, *Nos.* 34, 35.

THE author described in detail the different methods of massage, and their application in diseases of the larynx. He recommended massage for nervous disturbances of the larynx, passive hyperæmia of the brain, inflammatory conditions of the organs of the neck and carcinoma laryngis (!)

Michael.

ONODI (Buda Pesth).—**Contribution to the Knowledge of the Innervation and Paralyses of the Larynx.** *Monatschr. für Ohrenheilk.*, 1888, *No.* 5. (With a Plate.)

SEE report of the sixtieth meeting of Natural Sciences in Wiesbaden.

Michael.

SCHÜLLER (Berlin).—**Treatment of Cicatricial Laryngo-Stenoses.** *Berlin Klin. Wochenschr.*, 1888, *No* 14.

REMARK upon Liniché's essay. (In No. 6 of this Journal.)

GAREL, I.—Specific Perichondritis simulating an Acute Œdema of the Larynx and Coincident with a Laryngeal Polypus. *Ann. des Mal. de l'Oreille, June*, 1888.

A WOMAN of 42 took cold and felt pain in the larynx, in phonation or deglutition. Five months after this had increased, and six months after there was absolute aphonia. Seven months after there was intense dyspnœa. There was œdema of the left arytenoid and left ventricular band entirely hiding the left vocal cord. Scarifications were made.

A month later a small tumour was removed from the anterior commissure, which proved to be a fibro-myxoma. Under anti-syphilitic treatment the patient got rapidly better. **R. Norris Wolfenden.**

NECK, &c.

HENNES. — Congenital Excrescences of the Neck. *Archiv für Kinderheilk.*, 1888, p. 451.

DESCRIPTION of a case. A boy nine years old had an excrescence on both sides of his neck of 2·5—3·5 centimètres in size. They were extirpated.

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