DIPHTHERIA.	FOLLICULAR TONSILLITIS.
Highly contagious.	Contagion doubtful.
Paralysis common, even after milder cases.	No paralytic sequelæ.
Prevails epidemically.	Cases may have a common origin, *e.g.*, sewer gas.
Exudation.	*Exudation.*
Fiery blush over whole throat.	Blush usually on tonsils only.
Isolated spots, coalesce, grey early, greenish later.	Isolated yellow spots or continuous membrane.
On tonsils, uvula, and pharynx.	On tonsils only.
Mucous membrane bleeds readily on removal of diphtheritic membrane.	Mucous membrane does not bleed on removal of the grey spots.
Infiltrates tissue and cannot be wiped off.	Superficial, often can be wiped off, not adherent.
Reforms if forcibly removed.	Does not reform after removal.
May not appear for forty-eight hours.	Appears early.
Spreads.	Does not spread.
Frequently unilateral for two days.	Always bilateral.
Clears off slowly, lasting from five to twenty days.	Clears off quickly.

"Liquor ferri subsulphatis," of full strength, swabbed on the throat frequently, is highly praised. *B. J. Baron.*

NOSE, NASO-PHARYNX, &c.

Wilkin, G. C.—*An improved Ecraseur Nasal Snare.* "Brit. Med. Journ.," Mar. 11, 1893.

THIS is a combination instrument; it can be used as an ordinary snare, or the écraseur mechanism can be made to act when required. The finger-rests placed on the under surface do not interfere with vision, and give steadiness to the instrument. It is made by Messrs. Mayer and Meltzer, Great Portland Street. *Wm. Robertson.*

Johnstone, R. Mackenzie (Edinburgh). — *Transillumination of the Antrum.* "Brit. Med. Journ.," Feb. 18, 1893.

A DEMONSTRATION to show the efficacy of the test as a diagnostic measure. The light shone through the right antrum, while the left was in umbra. Pus was suspected in the left antrum. *Wm. Robertson.*

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Anton (Prag).—*Results of Internal Massage of the Nasal Mucous Membrane in Chronic Diseases of the Nose.* "Prager Med. Woch.," 1892, No. 49.

THE author obtained satisfactory results in simple chronic nasal catarrhs, but the treatment was not so satisfactory in cases of ozæna and hypertrophic catarrh. *Michael.*

McClure.—*The Etiology of Atrophic Rhinitis.* "The American Practitioner and News," Sept. 24, 1892.

THE following are the conclusions at which the author arrives :—

1. Atrophic rhinitis is the ultimate and logical result of neglected hypertrophy of the nasal mucous membrane, and never occurs as a primary disease.

2. Its chief cause is from lack of nutrition, caused by cutting off its blood supply.

3. The atrophic process is by desquamative inflammation.

4. The chief point to regard is the apparently paradoxical statement that at the beginning of atrophy the nasal mucus is due to anæmia, superinduced by hyperæmia of the membrane.

The sequence of the various pathological processes is as follows :—

1. Dilatation of arteries and veins with diapedesis of leucocytes, with hypernutrition. This is of short duration ; the tonicity of the dilated blood-vessels is weakened and then lost, and the blood within this hypertrophied tissue becomes stagnant. Tortuosity of blood-vessels still further hinders healthy circulation, and after a varying time atrophy begins to replace hypertrophy.

2. Desquamation of superficial epithelial cells takes place, beginning on the mucous membrane covering the turbinated bones first, as the direct result of interference with blood supply.

3. When the desquamation reaches the mucosa, crusts form and fœtor is noticeable ; when the mucous glands are involved, the crusting is very marked from withdrawal of fluid supply.

4. Lastly, the periosteum covering the inferior turbinated bones is attacked and atrophy of these structures ensues. *B. J. Baron.*

Bresgen (Frankfort-a-M.)—*Headache in Diseases of the Nose and Pharynx.* "Münchener Med. Woch.," 1893, No. 5.

HEADACHE is often observed and caused by disease of the nose and pharynx. It is caused by swelling of the mucous membrane of the nose, as in acute coryza. Narrowness of the nose predisposes to this complication. In cases of suppuration, headache arises if the pus has no free discharge. The headache in cases of hypertrophied and inflamed tonsils is also caused by the swelling of the nasal mucous membrane—always complicating this disease. Psychical irritations also often cause swelling of the nasal mucous membranes and consecutive headache. In all cases of headache, therefore, the naso-pharynx should be examined, and its disorders treated. *Michael.*

Fearnley, W. (London).—*A Rhinolith discovered by Accident.* "Brit. Med. Journ.," Feb. 25, 1893.

IN this case the patient suffered from a thick, offensive discharge from

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the right nostril for some months, and a mucous polypus could be seen at the outlet. Under chloroform the operator felt with his finger a hard body, and from a fragment dislodged it was discovered to be a rhinolith with a central aperture probably situated around the opening of the posterior nares. *Wm. Robertson.*

Jeffery.—*A Plea for a more conservative Treatment of Nasal Affections.* "Brooklyn Med. Journ.," Nov., 1892.

AFTER naming a host of remedies, medical and surgical, that have had or are having their day in the treatment of nasal affections, and many of which the author thinks have been used too frequently, he proceeds to state his views as to the treatment of nose troubles.

He expresses a belief that a large number of symptoms of disorder in the upper air tract are due to constitutional disorder, and especially is the kidney to be carefully examined in this connection.

The local treatment should be of a stimulating character—*i.e.*, healthy arterial supply should be increased, nerve activity stirred up, and an equilibrium in the secretive powers of the racemose glands and the epithelial cells established. Neither the cautery, nor galvanism, nor Gottstein's tampons, nor sprays of stimulating solutions, satisfies the writer.

Systematic home-treatment is what is wanted. Cleanliness is an essential, and the hand atomizer or soda and vaseline in the case of children, where there are aural troubles, will accomplish this. Next, the nasal muscles should be systematically drilled by passive motion until able to sustain themselves. He praises the apparatus of Dr. William A. Dayton, which keeps open the vestibule of the nose, and permits atmospheric pressure to exert its influence on the intrinsic structures.

Phthisis he considers is the cause of catarrh, and not the result of it. Weak solutions of cocaine ought not to be used for long periods, from the temporarily paralysing effect of the drug being deleterious.

Dr. RICE agreed with a good deal that was said by Dr. Jeffery, and especially condemned spraying the nostrils with other than very mild solutions; copper and zinc solutions being quite unsuitable. He does not, however, think that there is more nasal surgical work done to-day than five or six years ago.

Dr. FRENCH believed that there is a great deal too much nasal surgery done. His criterion as to whether a patient has nasal passages that are patent enough is to tie up the chin every night for a week or ten days, and if this can be done and cause no disturbances, then there is no need for surgical interference. He relies largely on cleanliness, application of weak, oily solutions, careful attention to personal hygiene, digestion, etc., and keeping the mouth as far as possible closed.

Dr. DOUGLAS believes that forty-nine fiftieths of all pharyngeal and laryngeal troubles are traceable to obstructions in the nose. For the treatment of these troubles surgical methods are imperatively necessary, but nothing except what is really obstructive ought to be removed.

B. J. Baron.

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Herynɡ (Warsaw). — *Tuberculosis of the Mucous Membrane of the Nose.* "Medycyna," 1892, Nos. 33, 38, 42, and 44.

BASED upon ten cases observed by himself, the author reviews the etiology, symptomatology, and therapy of this rare disease (of which were hitherto known ninety cases). As to the etiology the author draws attention to the transportation of the tubercular contagium upon the mucous membrane of the nose, by means of fingers and pocket handkerchiefs. By differential diagnosis he points to the importance of a microscopic and especially bacteriological examination of secretion of the ulcers. In one-half of the author's cases tubercular bacilli were found. In general, three affections especially should be taken notice of: syphilis, lupus, and chronic eczema in scrofulous children. The course of the disease is long. Prognosis is doubtful. In cases of secondary tubercular ulcerations a sharp spoon and lactic acid applications proved most successful.

John Sendziak.

Chabory, F. (Mont Dore).—*The Influence of Nasal Affections upon the Respiratory Apparatus.* Paris, 1892.

IN this brochure Dr. Chabory discusses asthma, hay asthma, cough, sneezing, stridulous laryngitis, glottic spasm, laryngitis and bronchitis, tracheal ozæna, blennorrhœa, tuberculosis of the upper air passages, rhinoscleroma, pneumokonioses, malformation of the thorax, and emphysema in their relation to nasal affections, and is led to the following conclusions :—

Nasal affections react upon the respiratory apparatus by reflex action; very often we are only in the presence of manifestations of a diathesis, which evolves simultaneously and without any relation of cause and effect.

In other cases it is the extension of a pathological process of which the nasal mucosa is the point of departure, as *e.g.*, in certain laryngitis and bronchitis, tracheal ozæna, laryngeal and pulmonary tuberculosis, and scleroma.

The suppression of nasal respiration may pathogenically influence inflammation of the respiratory mucosa, and spasmodic respiratory phenomena.

Malformation of the thorax and pulmonary emphysema may follow from nasal affections.

Some original cases illustrate the author's thesis, which is a good *résumé* of the subject though containing nothing new.

R. Norris Wolfenden.

Owen, Edmund.—*Post-Nasal Growths or Adenoids.* "The Practitioner," March, 1893.

ADENOID tissue, which exists normally in the mucous membrane of the naso-pharynx, consists of a fine network of connective tissue fibrils, with fixed cells, wrapped around and partly concealing them, so that the tissue looks like a network of branching and anastomosing cells. The meshes of this network are occupied by pale blood and lymph corpuscles. As regards the causation of disease of this adenoid tissue nothing very definite can so far be stated; the balance of evidence, at present, is

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against the tubercular nature of the lesion. The diagnosis of this condition is probably best made by means of the index finger passed into the naso-pharyngeal space. In a few cases posterior rhinoscopy may be of service. The symptoms complained of are a vacant or stupid expression, "dead voice," snoring, sleeping with the mouth open, deafness, headache, and constant tendency to catch cold. As regards treatment, nothing short of erasion will suffice. Cod-liver oil, iron, tonics, etc., may do a certain amount of good, but will never effect a cure. In preparing for the operation the child's head should be enveloped in a towel, arranged *à la Turque;* the arms and chest should be enshrouded in a bath towel, the floor should be covered with a dust sheet, or a few newspapers, and a toilet pail should be placed at the end of the table so as to receive the blood. The child should be placed upon his back, with the shoulders raised over a firm pillow, and with the head thrown well back, and hanging over the end of the table. Blood is in this way prevented from passing into the trachea, and runs out at the anterior nares. The patient should be under the influence of an anæsthetic. The author operates before the stage of complete narcosis is reached, for the reason that the "glimmer of consciousness which is thus left is sufficient to ensure against blood entering the trachea." [*This appears somewhat unnecessary. If the head be sufficiently dependent it is a mechanical impossibility for blood to travel uphill into the trachea. The struggles of a patient imperfectly narcotized are most embarrassing to the operator, and the risk of injuring important surrounding parts is surely increased.*—ABSTRACTOR.]

The author uses his index finger in many cases to scrape away the growths. Ring-knives, scrapers, forceps, delicate Volkmann's spoons, etc., may be used also. In the after-treatment iced lemonade is usually grateful to the patient. The patient should be kept indoors for a few days, especially if the weather be damp or cold. *W. Milligan.*

Owen, Edmund (London).—*Post-Nasal Growths in Children.* "Brit. Med. Journ.," Feb. 18, 1893.

THIS familiar topic formed the subject of a paper read at a meeting of the Harveian Society of London. In the discussion that followed, Messrs. Butlin, Lennox Browne, Mark Hovell, Scanes Spicer, Felix Semon, and Dr. Silk took part. Mr. Owen referred to the analogy both as regards structure and lesion existing between the pharyngeal tonsil and the other lymphoid elements of the naso-pharynx and the faucial tonsils. Any association of tubercle and adenoids was questioned [the constant association of adenoids and cervical adenitis was not noticed —ABSTRACTOR], though in feeble children enlarged pharynx tonsil is often present. The adenoid facies was considered by the author a sufficient proof of the disease, while in children the use of the finger in the post-nasum generally confirmed its presence, rendering the use of the post-nasal mirror unnecessary. Mr. Owen urged the prompt removal of the growth as a preventitive of recurrent attacks of deafness or even of permanent deafness. He operates invariably under chloroform, not pushing the anæsthetic too far, and having the child placed on its back with its head raised and

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hanging over the end of the table. He finds that for children the finger usually suffices, only at times finding it necessary to use forceps or a sharp spoon. The after-treatment followed was keeping the child quiet and avoiding nasal douches.

The author referred to a fatal case in the practice of a friend, and urged a record of all such.

Mr. BUTLIN operates under chloroform, as it allows of the patient being kept longer under, especially when Junker's inhaler is used. The patient he prefers lying on his side, with the head forward, and advises the palate to be kept in view during operation. Reference is made to one fatality in 750 operations—that of a delicate girl, aged fourteen, where a few growths were removed and two small faucial tonsils. Mr. Butlin looks upon recurrence as rare, only having met with one such after six or seven years' observation in his practice.

Mr. LENNOX BROWNE considers that in 90 per cent. of enlarged faucial tonsils adenoids co-exist; hence it is his custom to search for and remove these contemporaneously with tonsillotomy, and refers to lesions left behind by atrophied pharynx tonsil, *e.g.* (Eustachian synechiæ ad.), deafness, etc., clearly preventible had these growths been operated on during childhood. Mr. Browne considers the facial aspect of the disease sufficient proof, and therefore rarely employs digital examination. He refers to other conditions associated with adenoids, *e.g.*, laryngismus, barking cough of puberty, pertussis (?—ABSTRACTOR), granular pharyngitis, quasi-hypertrophic neuritis, catarrhal inflammation of the larynx and lower respiratory passages, and even laryngeal growths. It was remarked that mouth-breathers were more prone than others to be attacked by the exanthemata, while on the other hand these might occasion the growths in suitable soil. Recurrence was rare.

Mr. T. MARK HOVELL showed a finger-guard made out of thick rubber tubing to protect the digit while examining for any lesion in the post-nasum. He always employs an anæsthetic, as otherwise parts of the growth may be left behind and keep up middle-ear catarrh. He prefers the patient on his back, with the head extended moderately, extreme extension interfering with the return of blood from the head, and thus increasing hæmorrhage. Mr. Hovell prefers the forceps first to clear out the bulk of the growth, and the finger to remove smaller nodules. Recurrence was the exception.

Dr. SPICER said recurrence only took place after imperfect removal, and that failure to get perfect nasal respiration subsequently depended upon some concomitant intra-nasal condition neglected or overlooked.

Dr. SEMON considered that, while digital exploration was indispensable for small children, in older patients the post-nasal mirror replaced this. Reasons were given for operating before the spontaneous atrophy of the growths took place at puberty. Principal among these were:—(1) The influence of the obstruction upon general health, mental development, and upon the formation of the face—results which remained for ever, even if the glands themselves atrophied; (2) the ever-present danger of ear complications; (3) the greater liability to and seriousness

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of infectious diseases of childhood, especially diphtheria and scarlet fever, as long as the growths were present.

The position preferred for operating was with the head hanging over the table slightly, slight chloroform narcosis, usually Gottstein's curette and only rarely forceps. Recurrence was most frequent after finger-nail procedures.

Dr. SILK used nitrous oxide and ether in a large number of cases, but believed these increased the hæmorrhage. He now gives the A C E mixture up to abolishing the corneal but not the laryngeal reflex, *i.e.*, Snow's third but not the fourth stage.

Mr. OWEN, in reply, concurred with Mr. Lennox Browne as to the co-existence of enlarged faucial and pharynx tonsils. He gives the preference to chloroform not too lavishly administered, and agreed with Dr. Semon that it was inadvisable to let adenoids take their course.

[The above represents in miniature the views of several eminent English authorities on the diagnosis and treatment of a condition widely prevalent in all European countries. At least, on the Continent, perhaps, exception will be taken to the almost universal use of a general anæsthetic amongst English surgeons. In hospital practice where, perhaps, as many as five or six cases may be met with in a day, the question of using an anæsthetic in each becomes a serious one from various aspects. At several large cliniques on the Continent a general anæsthetic is dispensed with altogether, cocaine being considered sufficient for the requirements of the operation. Under the circumstances referred to and with the proviso mentioned, the rapid and effective use of Gottstein's curette (Hicguet's form) and a digital survey to remove stray nodules from the nares and the region of the tubes occupies a brief interval, and is unaccompanied by any anxiety as regards hæmorrhage. These remarks apply more especially to young children, where the growths are neither so distributed nor difficult of removal. The previous use of cocaine prevents hæmorrhage to a certain extent—an important point at this age. In older children and in young adults, where the growths have become more consistent and spread over a larger area, chloroform is indicated.

Very little reference is made in the discussion to the presence of these growths at more advanced ages, although, of course, this is widely recognized.

The co-existence of hypertrophied lingual tonsil with both faucial and pharynx tonsillar hypertrophy, sometimes met with, is worthy of notice, inasmuch as this condition is often developed as early as the ages of ten or twelve years, and, attended by a distressing explosive cough, may mislead the operator who supposed that this was dependent upon the adenoids.

A too close dependence upon the adenoid facies as all the necessary proof of the presence of the growths is not to be relied upon. Large developments of these are often met with, where there are neither the facies nor deafness of a pronounced degree. A somewhat close association has been noticed between adenoids and cervical adenitis, not the least serious condition for which adenoids must be held largely, if not entirely, responsible.—ABSTRACTOR.] *Wm. Robertson.*

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