the meatal skin. The spontaneous nystagmus still faintly persists. The vomiting continues, but is less frequent. Patient still suffers from vertigo. The facial paralysis is unchanged. Leucocytes 8,000 per c.mm.

June 17th.—The vomiting ceased three days ago, and has not returned. He still complains of vertigo. Nystagmus to right can still be plainly elicited. Facial paralysis unchanged.

June 23rd.—There is still some slight vertigo. Spontaneous nystagmus cannot be elicited, and has now ceased after a duration of twelve days.

The patient is now up and about, and the facial paralysis is his only complaint.

July 9th.—The facial paralysis is slowly recovering. There is a moist eczematous patch, the result of the herpes in the concavity of the concha. There is desquamation and débris over the surface of the tympanic membrane, but no visible defect of the membrane. There is still some slight deafness of the middle-ear type only.

In conclusion, may the writer be permitted to emphasise separately the outstanding facts of the case? First and foremost comes the alarming resemblance in the first few days of the disease to an acute intracranial complication. At this stage the patient was prostrated, and had the appearance of being very seriously ill.

The herpes itself is the decisive factor in the diagnosis. In this case it made its appearance early, and lasted for eight days. The vomiting for the first three days was intense, frequent, and uncontrollable. It lasted altogether six days. It is a question whether or no this vomiting is really attributable to some ganglionic involvement of the vagus. The spontaneous nystagmus made its appearance on the third day. Its total duration was twelve days. The duration of the herpes was eight days. It followed an auriculo-temporal distribution. Throughout the attack the temperature was subnormal and the pulse slow. The leucocyte count was not raised. The spinal fluid was healthy.

VON BEZOLD'S MASTOIDITIS.

By H. Lawson Whale,
Capt. R.A.M.C.(T.).

A soldier was admitted in July, 1916, to No. 13 Stationary Hospital with long-standing right-sided otorrhœa, a tense red swelling from the top of his mastoid down to the middle of the sterno-mastoid muscle, slight paresis of the right orbicularis oris, and moderate pyrexia. At operation no chisels or gouges were used; the outer antral walls, and the bony posterior meatal wall down to and including the facial ridge, were replaced by septic osseous *débris*, which was easily cleared by lightly curetting. The mastoid apex was removed to evacuate pus from the digastric groove and the sterno-mastoid sheath. What had been the antrum and aditus was now a space occupied by a smooth coherent greyish-yellow mass, whose appearance suggested either cholesteatoma or tuberculosis. But it lacked any pearly limiting membrane, and chemically contained no cholesterin; and the microscope showed no evidence of tubercle. The cavity was cleaned and treated as an ordinary Stacké operation; the facial paresis slowly disappeared, and recovery was uneventful, and Capt. C. E. West, to whose care I sent the patient as soon as possible, wrote to tell me that all was well.

https://doi.org/10.1017/S1755146300016747 Published online by Cambridge University Press

The upper part of the cavity had exactly and minutely resembled that of a radical mastoid performed by experienced hands, showing Nature's approval of that proceeding. Findings similar to mine at this operation occur sometimes, but sufficiently rarely, I think, to be worth while reporting.

SOCIETIES' PROCEEDINGS.

PROCEEDINGS OF THE AMERICAN LARYNGOLOGICAL ASSOCIATION.

Niagara Falls, Canada, June 1, 2, 3, 1915.

(*Continued from p.* 489.)

Observations Upon the Intra-nasal Exenteration of the Ethmoidal Labyrinth in Pansinuitis. — Harris P. Mosher. — The speaker detailed the fundamental points in the anatomy of the ethmoidal labyrinth, describing the anterior cells, the naso-frontal duct, the unciform cell, the posterior ethmoidal cells, and the superior nasal spine.

After mentioning Hajek's and Ballenger's operation, he then described his own method, as follows: The anterior end of the middle turbinate is first removed. The initial plunge of the curette into the ethmoidal labyrinth is best made by disregarding the agger nasi cell if it is present and going higher on the superior overhang—that is, the extreme upper part of the middle turbinate and a little further backward. If the curette does not really break into the labyrinth, it should be carried a little higher and a little further back. Finding this point may bother the beginner. Once in the labyrinth the curette is turned and swept forward until it strikes the posterior surface of the ascending process of the superior maxilla. Then it is turned so that it faces posteriorly, and by backward and downward sweeps the unciform process, the ethmoidal bulla and its cells are opened. The cavity so made in the anterior part of the ethmoidal labyrinth is cleared of fragments by using a small round tonsil punch. The operator is now ready to probe for the naso-frontal duct and to enlarge it by sounds, rasps and burr.

In a great majority of instances the ascending process of the superior maxilla is a guide to the naso-frontal duct, so that a probe slipped upward along its posterior border finds the sinus. In the small percentage of cases where this fails the duct can be found by carrying the probe backward to the limit of the roof of the operated cavity and then bringing it forward with the point turned outward. Only as a last resort should the point be turned inward.

The second part of the operation: The head of the patient is held so that the cribriform plate is level, and it is kept so. The curette is now plunged through the attachment of the middle turbinate and carried backward to the outside of the middle and superior turbinates to the front wall of the sphenoidal sinus. This is firm and stops the instrument with a dull and sometimes with a sickening thud. The face of the

https://doi.org/10.1017/S1755146300016747 Published online by Cambridge University Press