with pus near the surface and subcutaneous diseased glands, stitches and drainage tubes are dispensed with. All sinuses and suppurating cavities are to be cleansed by means of scraper and lint, and drainage maintained until deep parts are healed. The visible abscess is often a subcutaneous reservoir of pus, the source of which (a degenerate gland) is not subcutaneous, but sub-fascial or sub-muscular. Mere incision of an abscess in the neck, without further search for eradication of diseased gland structure, the cause of the abscess, is to be condemned. As soon as it has been determined that the enlargement of a gland is no longer temporary but permanent, these means for its removal ought to be undertaken at once, in preference to waiting for softening. In Teale's experience, in the majority of instances of scrofulous neck there was no indication of constitutional weakness or taint. The origin of the ailment was often clear and defined—bad drains in many instances, scarlet fever, mumps, etc.—health in the individual being restored after the elimination of the septic matter.

Mr. Teale concludes by remarking that it is possible to get to the root of the trouble by one or two operations, and that in most instances disease of the cervical glands is a local disease, and curable by local measures. Mr. Knight Treves holds that time for nature to arrest the progress of the disease should be given, after which the operation should be done, when tearing or lacerating the gland is to be avoided. No drainage tubes are used, the wound closed, and pressure externally applied. Ugly scars are due to diseased tissue left at the operation. Mr. Godlee would operate when it was clear that disease had not gone beyond the limits which the knife could reach. Howard Marsh condemned the removal of glands in their early stage of disease. He thought a free incision desirable. Inflammatory products ought to be removed. A careful dissection was better than scraping. Cummins noted a case of acute phthisis, following removal of glands. He recommended early incision. Milburn inclined to think that the disease was not purely local, nor always the result of local irritation. Barlow referred to the uselessness of drug treatment in this condition. The result arising from peripheral irritation, he thought it advisable to improve the peripheral mucous membrane by removing hypertrophied tonsils, ablating disease in the naso-pharynx, and instituting hygiene of mouth, gums, &c. By removing these the glands often subsided (a point long ago insisted on by the reporter).

Dr. Barlow objected to the use of the scraper, as by it tubercular absorption might take place. *Wm. Robertson.*

EARS.

Daae, Hans (Christiania).—*A Contribution to the Anthropology of the Ear in Criminals.* "Arch. of Otol.," Oct., 1893.

MEASUREMENTS were made on the ears of convicts in the prison at Christiania. Daae found the length, breadth, and base of the ear

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increasing with age. Darwin's tubercle comes nearer the base line in advancing years—due, not improbably, to a shrinking of the helix margin. Other results are given, which the writer considers, on the whole, in accord with those obtained in normal persons, and he arrives at the conclusion that there is no type which may be considered the "criminal ear."

Dundas Grant.

Bezold, F. (Munich).—*A Case of Removal of the Stapes.* "Arch. of Otol.," Oct., 1893.

SURPRISED at the remarkable results of stapedectomy reported by others, and notably by Jack, Prof. Bezold determined to try the effect of the operation on a case under his care, in which dulness of hearing and constant tinnitus had resulted from adhesions following chronic suppurative otitis. The operation was performed without any particular difficulty under cocaine. There was persistent giddiness for three days, and then tinnitus. Whisper previously heard at two centimètres was not heard at all. The lower tone limit rose from sixty-four to one hundred and ten vibrations per second. Ten weeks later, conversation previously heard at twenty centimètres was only heard at three. He has heard from Blake that in his two cases there was no permanent improvement, and from Ludewig that deafness resulted in six cases of unintentional extraction of the stapes. [Prof. Bezold's experience is most welcome in view of the rosy accounts we have had before.—ED.]

Dundas Grant.

Blake, Clarence J. (New York).—*Removal of the Stapes.* "Arch. of Otol.,' Oct., 1893.

A TABULAR statement of twenty-two cases of stapes operation for deafness or tinnitus, due to chronic non-suppurative adhesive catarrh, with comments, seems to justify amply the writer's conclusion that in such cases stapedectomy does not afford a promising outlook. The patients were, in almost every case, no better—in several, worse—than before. In the cases resulting from suppurative disease operation is less hopeless. In all the non-suppurative cases he advises a preliminary incision of the membrane under local—not general—anæsthesia, and of sufficient extent to serve for the completion of the operation, if tests for hearing and further exploration afford encouragement to perform such operations as synechotomy, tenotomy, incudectomy, incudo-stapedectomy, or stapedectomy. [In all his cases bone conduction seems to have been impaired before operation. We should consider this an almost absolute contra-indication. The publication of these discouraging details does great credit to Dr. Blake's scientific and professional frankness.—ED.]

Dundas Grant.

Sheppard, J. E.—*Removal of the Ossicles.* "Arch. of Ophthal. and Otol.," Oct., 1893.

SEVENTEEN cases, with the object of curing suppuration, and two in adhesive inflammation, after suppuration, to improve hearing. In the first three suppuration was in the attic, two were permanently cured, and the third was healing ; the malleus and incus were removed in two, and

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the malleus only in the third, as no incus could be found. In the next three Stacke's operation was done, the larger ossicles being removed as part of the operation; two were healed, one healing. The next was tubercular, and the two larger ossicles and membrane were removed; cured. Next two were the mallei from one patient—result, not cured. The next, all three ossicles removed, marked improvement; (11) malleus, no incus found, not cured; (12) all three ossicles, marked improvement; (13) malleus only, others not found, temporary facial paralysis eight days, after operation, cured; (14) malleus removed, both incuses exfoliated, tubercular patient, not cured; (15) ossicles removed, cured; (16) malleus removed, incus absent, dizziness and vomiting followed, cured; (17) malleus and incus removed, cured; (18) malleus and incus removed, cured; (19) malleus and stapes, incus absent, cured.

The second series consist of twelve cases of chronic non-suppurative catarrh. The first two were removals of malleus only, one derived no benefit, the other slight, but also got slight vertigo; in four more the malleus, incus, and head and crura of stapes were removed—two negative results, one great benefit, and one slight benefit; one of these developed transient facial paralysis twelve hours after the operation. In three cases incus and crura of stapes—one better, one negative, one worse; bad vertigo in one, slight in another, and autophonia in the other. Incus and stapes two sides of one patient, great benefit. Cocaine was frequently the anæsthetic used. The removal of the footplate of the stapes seems not absolutely necessary in all cases. Eight out of the thirty-one had unpleasant symptoms, viz., four severe and prolonged vertigo, two vomiting, two facial paralysis, two meningeal irritation. *R. Lake.*

Holmes, C. R. (Cincinnati).—*The Stacke Operation for Caries, involving the Middle Ear, as modified and practised by Prof. Hermann Schwartze; with an Historical Sketch, Method of Operating, and Report of Twelve Consecutive Cases.* "Arch. of Otol.," Oct., 1893.

In Schwartze's "classical" operation the opening was made in the outer surface of the mastoid only. Stacke, after separating the auricle and membrano-cartilaginous meatus, worked from the posterior wall of the osseous meatus into the antrum and attic. Schwartze's modification consists in first opening the antrum from the outer surface of the mastoid process, and then cutting away the wedge of bone between the external meatus and antrum.

In the introduction are given Schwartze's indications for opening the antrum. These are well known, but his indications for removal of ossicles are less familiar, and are as follows:—(*a*) To induce cessation of suppuration without regard to hearing-power, (1) in caries of hammer and anvil; (2) in chronic purulent discharge in the tympanic cavity without signs of caries of the hammer and anvil; (3) in cholesteatoma of the tympanic cavity. (*b*) For the improvement of hearing and the cure of subjective noises, (1) when there is fixation of the hammer, but ability to hear the voice, and improvement on trial incision of the membrane; (2) in incurable obstruction of the Eustachian tube and improvement on incision; (3) in sclerosis of the tympanic cavity, with temporary improvement on cathe-

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terization and on trial incision. The last two indications are recommended with considerable reservation. The familiar steps of the operation are fully described. Holmes advises that all measurements should be made from the *spina supra meatum*. They are then pretty constantly as follows :—To the facial nerve, fifteen millimètres ; to the horizontal semicircular canal, sixteen millimètres ; to the posterior, eighteen millimètres ; to the footplate of the stapes, twenty-two millimètres ; to the end of the short process of the incus, sixteen millimètres. A safe guide to the extreme distance we may penetrate is *the distance from the spina to the posterior superior margin of the membrana tympani*, which in health fluctuates but little from fifteen millimètres. All diseased tissue should be removed, even if the dura or lateral sinus be exposed in the process. The possible thinness and even dehiscence of the bony walls of the tympanum in relation to the internal carotid artery, vestibule and cranial cavity must be kept in mind. The wound is sometimes kept open, sometimes closed, and the plugging and dressing entirely carried on through the meatus. Twelve cases, illustrative of simple and complicated conditions, are appended. *Dundas Grant.*

Vulpius, W. (New York).—*A Peculiar Case of so-called Bezold's Mastoiditis.* "Arch. of Otol.," Oct., 1893.

An acute case of middle-ear disease in a woman aged twenty-eight, in which repeated paracentesis failed to cure, and the mastoid was opened by operation. A probe in the mastoid reached down to a hole on the inner surface of the tip, through which a quantity of pus could be squeezed up from an abscess cavity in the side of the neck. This was scraped out and drained through a counter opening made at its lowest point. Excellent recovery soon followed. He thinks that extension to the mastoid is caused in some cases by abnormal thickening and resistance of the membrane to the escape of pus, and that it may then be prevented by free paracentesis, practised preferably by means of the galvano-cautery. He recommends a narrow and short platinum wire loop, doubled on itself to form a shallow hook, attached to slender varnished copper or silver shanks. Cocaine affords a sufficient anæsthesia for this paracentesis.
Dundas Grant.

Vickery (Newcastle-on-Tyne). — *Septic Thrombosis of the Lateral Sinus; Recovery.* "Brit. Med. Journ.," Nov. 25, 1893.

The record given by the author forms an interesting study. The case was that of a boy, aged eight, who had suffered from ear discharges at intervals. When seen there was high fever, tenderness and swelling behind the right jaw and in front of the tragus, pain in the neck and stiffness. There was no mastoid swelling or redness. With these data in view, it was supposed that the sinus was involved, and from the fact of the swelling under the tip of the mastoid that the jugular was involved. The jugular was exposed (no thrombosis) and tied, when, the upper part of the vein collapsing, it was presumed that thrombosis existed above. The sinus was now exposed. On opening it there was the usual free rush of blood, which was controlled in the usual way. The mastoid antrum

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was not opened, nor was the condition of the middle ear referred to [Comment on this case is embarrassing. It is high time that the general surgeon should become acquainted with the symptoms diagnostic of Bezold's variety of mastoiditis, especially with that one symptom, viz., swelling of the tissues beneath the tip of the mastoid process, and extending down the neck.—REP.] *Wm. Robertson.*

Vulpius, W. (New York).—*An Unusual Case of Bilateral Fracture of the Temporal Bone.* "Arch. of Otol.," Oct., 1893.

AFTER a severe fall on the head, resulting in hæmorrhage and temporary unconsciousness, there was found three months later, on complaint of tinnitus and giddiness, extreme deafness of the right ear both for air and bone conduction, facial paralysis, and loss of taste in the anterior part of the right side of the tongue. The membrana tympani was relatively normal. On the left side, however, there was a clot in the meatus and evidence of injury to the membrane, but comparatively good hearing, and no evidence of nerve-deafness. The rupture of membrane seemed to have acted as a safety-valve as regards the labyrinth on the left side.

Dundas Grant.

Dercum, F. K. (Philadelphia).—*Optic Neuritis, Blindness, Deafness, and Knee Jerk in Cerebellar Disease.* American Rhinological Association. "Boston Med. and Surg. Journ.," Oct. 26, 1893.

AFTER discussing blindness, Dr. Dercum referred to deafness in certain cases of cerebellar tumour. The studies of Spitzka, Manakow, and others, have made it extremely probable that the posterior quadrigeminal bodies stand in the same relation to the auditory fibres as do the anterior to the optic fibres. It would simply be necessary, therefore, to have pressure on these bodies to account for a deafness in such a case.

R. Lake.

Urbantschitsch (Vienna). — *On Reciprocal Interaction of the Two Ears.* "Archiv für Ohrenheilk.," July, 1893, Band 35, Heft 1 and 2.

ABNORMAL conditions of one ear have an injurious effect on the other one, which may be of a similar or dissimilar character. These may be classified and subdivided as follows:—

A. Similar—(i.) vaso-motor; (ii.) trophic; (iii.) sensory; (iv.) functional: (*a*) Sensorial: (*b*) accommodative.

The similar effects may differ in being (1) analogous, (2) alternating, (3) contrary.

B. Dissimilar—in particular the influence on the hearing of one ear, of disturbance of the sensory nerves of the other.

A. SIMILAR—(i.) *Vaso-motor* changes are illustrated by section or stimulation of the sympathetic on one side affecting secondarily the opposite ear, and (ii.) *trophic* changes similarly when the fifth nerve is experimented on. Clinically, localized inflammation in one meatus has been observed to be followed by a similarly situated affection in the other, as also inflammation "alternately" in one and the other ear. Before attributing them to reflex nervous causes the possibility of

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physical transference of irritating material, its transmission by lymphatic channels, etc., and simple community of cause, must be eliminated. (iii.) *Sensory* disturbances—otalgia, circumscribed inflammation—in one ear may determine in the other one painful, hyperæsthetic or hypæsthetic phenomena at the corresponding point. A case is narrated in which the secondary pain in the sound ear was removed by local treatment—removal of malleus—of the affected one. (iv.) *Functional* changes are illustrated by a case of spontaneous "transference" in a non-hysterical subject, and also by Gellé's experiments with magnets in hysterical patients with unilateral deafness. Acuteness of hearing in one ear may diminish, while that in the other increases, and *vice versa*, these periods of inverse changes lasting for hours or days. Similar variations have been observed in subjective tinnitus aurium, the phenomenon passing suddenly from one ear to the other without apparent cause. By experimental comparison of monaural and binaural hearing it was shown that less intensity of sound was necessary for perception in the latter, and this is explained by the doubling of the acoustic stimulus rather than by transmission of waves from one ear to the other. Perception by means of the better ear is, therefore, increased by the assistance of the worse one, even for sounds which are inaudible to the latter. Stoppage of one ear diminishes the acuity of the other, and the removal of an obstruction increases it, as shown by the effect of syringing away a ceruminal plug. Auditory stimulation of one ear rouses the opposite one and exercises it in the same way as cultivation of the sense of locality or of muscular power on one side of the body produces improvement on the other. Similarly judicious operative interference on one ear benefits the other one, even though the hearing of the ear operated on is not improved (*e.g.*, removal of ossicles). As these effects follow in cases in which the stapes is isolated and unaffected by any nervous muscular mechanism, Urbantschitsch considers that they are dependent on stimulation of the centre rather than on any accommodative synergy. In very many cases, however, he ascribes the effects to accommodative rather than sensory causes, and quotes Gellé and Pollak. Both modes of action often combine to produce the improvement.

B. DISSIMILAR.—Interchanges between the two organs of hearing, in particular the influence of sensory irritation of one ear on the functions of the other, are exemplified by diminution of tinnitus in a very deaf ear on catheterization of the opposite Eustachian tube, or blistering or rubbing of the opposite auricle. Unfortunately, the reverse effect has also ensued. It is questionable whether such inter-action should be called dissimilar, as it may be due to accommodation.

The practical outcome is the necessity of treating vigorously by operative or other measures an ear which is not in itself susceptible of restoration of useful hearing-power with a view to improving the condition of the opposite one, as in cases of sclerotic progressive deafness.

Dundas Grant.

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