from a kind of hiccough, which came on at irregular intervals. Every attempt to swallow appeared to cause great distress, and he stated that solids were more easily got down than liquids. There was also occasional laryngeal spasm, inspiration being at times whooping and laboured. During the times he struggled to swallow food he tossed himself about in bed, and was in great distress, but the pulse was found to be good, and the face in no way livid. He complained of thirst, but not of hunger. The various organs were found on examination to be healthy. He was given one-sixth of a grain of morphia hypodermically, and the faradic current was applied to his neck. The muscles reacted well, but no improvement in the power of swallowing resulted. Nutrient enemata containing thirty grains of bromide of potassium were given every four hours. After having been in this state for six days, a stomach tube was passed into the stomach, and entered without the least difficulty. Death took place quite suddenly early one morning. *Post-mortem* examination showed the arachnoid slightly thickened in places over the cerebral hemispheres. The convolutions near the longitudinal fissure were in parts slightly atrophic, the sulci being unusually wide. The floor of the fourth ventricle seemed finely granular, and some of the nerve cells of the medulla were found full of brown pigment. The pharynx, larynx, and œsophagus were found normal. The mucous membrane of the trachea and bronchi was bright red in colour, and coated with some slimy mucus. The author states that the hiccough and occasional laryngeal spasm went on quite irrespective of the presence of food in the œsophagus, and the clinical features of the case looked extremely like what might be considered a violent chorea of the muscular apparatus of the pharynx, larynx, and diaphragm. *W. Milligan.*

**Karewsky** (Berlin).—*Acute Idiopathic Retro-pharyngeal Abscess in Children.* "Berliner Klinik," Heft 57.

A REVIEW of the subject is concluded by the author with the remark that retro-pharyngeal abscess may be caused by very different diseases, and that therefore an idiopathic origin can only be thought of if, by an exact examination, all other causes can be excluded. *Michael.*

## LARYNX, &c.

**Weil** (Stuttgart). — *Laryngoscopy and Inferior Tracheoscopy.* "Monats. für Ohrenheilk.," 1892, No. 12.

THE author has applied, for the examination of the larynx and trachea, little glass mirrors introduced into the tracheal opening of a child tracheotomized for papillomata. He could see well tumours situated in the lower part of the larynx and the trachea, and recommends the method. *Michael.*

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**Kurz, Edgar** (Florence).—*Lipothymia Laryngea.* "Deutsche Med. Woch.," 1893, No. 20.

AN Italian patient, fifty-eight years old, suffering from laryngeal catarrh, during an attack of coughing suddenly lost consciousness, and respiration seemed to cease. After some moments the attack passed off, and the patient became better. The author refers to some similar cases in literature, and believes that such so-called laryngeal crises occur more often in individuals of the Roman race than of the German race. *Michael.*

**Kobner** (Berlin).—*Tuberculosis of the Skin of the Under-Jaw and Laryngeal Tuberculosis.* "Berliner Klin. Woch.," 1893, No. 19.

THE title explains the case. *Michael.*

**Masini, Prof. G.**—*New experimental Researches on the Motor-Cortical Centres of the Larynx.* "Boll. delle Malattie dell'Orecchio, della Gola e del Naso," July, 1893.

THESE new experiments were performed, not with electric stimulation and removal of portions of the cerebral cortex, but with local application of cocaine (solid grains of this substance) and injections of a cocaine solution coloured with aniline. This was to answer Semon and Horsley's experiments, which were in contradiction with the first experiments of the author. According to Masini, there was a crossed influence, and in unilateral impairment only there occurred a glottic paresis. The present conclusions are identical with those formulated by the author in the year 1886, and he affirms that Semon and Horsley have not separated the effects which he allies to electric stimulation and the removal of cortical substance. Even allowing largely for this, it was not possible to obtain a complete paralysis, or a complete and permanent loss of the vocal function. Hence the necessity of admitting that other portions undertook a compensatory function for the destroyed portions, and the existence of sub-cortical centres.

The conclusions are as follows :—

1. Upon the cortex of the brain of the dog there are two bilateral centres, which regulate the movements of the opposite side of the larynx.

2. These centres are connected with other motor centres, and particularly with those presiding over the glottic function.

3. When one of these centres is impaired or destroyed (whatever may be the manner) there does not follow paralysis, but a glottic paresis, on account of the presence of crossed and direct fibres.

4. Bilateral impairments produce a more evident and persistent paresis, without reaching the degree of a true paralysis. *Massei.*

**Griffin.**—*Hysterical Aphonia with a perfect Singing Voice.* "New York Med. Journ.," May 20, 1893.

THIS was the case of a young girl, and the aphonia was of eleven months' standing. Her high, middle and low registers were perfect, and she could sing a song that she knew as well as ever, the volume of her voice being unimpaired, and the words, when *sung*, clearly uttered. The ingenious treatment of making her sing words and sentences after her medical man, and then gradually speak them as he dropped into a

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speaking voice, was completely successful. This form of vocal abnormality has been seen in men as well as in women. *B. J. Baron.*

**Kassowitz** (Wien). — *Laryngismus Stridulus and Tetany in Children.* "Wiener Med. Woch.," 1893, Nos. 13 to 20.

THE majority of authors believe, as Elsasser first pointed out, that a relation exists between rachitis and laryngismus stridulus. During latter years some authors have denied this relation. In his very extensive treatise the author proves that laryngismus is always combined with rachitis and is caused by this disease, and that the treatment must be anti-rachitic; he recommends his own anti-rachitic treatment, consisting in the application of phosphorated cod liver oil. *Michael.*

**Massei, Prof. F.**—*Tracheotomy preceded by Intubation.* "Bollettino delle Malattie dell'Orecchio, della Gola e del Naso," July, 1893.

A LETTER directed to Prof. Grazzi, in which the author represents the question discussed by Ricci, with the conclusion that, while intubation is undoubtedly very serviceable in tracheotomy (when possible to be performed and according as Catti and Massei some years ago advised), we cannot overlook the real advantages of intubation in croup, and when it fully succeeds we do not find any reason to perform tracheotomy immediately after The case is very different when intubation does not improve breathing and tracheotomy is required, although in such cases the chances of success are lessened. A surgeon who recommends intubation in croup, in order to perform tracheotomy with great benefit, denies in an absolute manner the services which the first may render in a proportion of about twenty-five to thirty per cent. of cases of croup. *Massei.*

**Hagenbach-Burckhardt** (Basel). — *Retention of Secretions in Tracheotomized and Intubated Patients.* "Correspbl. für Schweizer Aerzte," 1893, No. 11.

IN cases of tracheotomy for diphtheria the author has sometimes had difficulty in removing the canula on account of retention of secretion in the bronchi. He relates a case in which the secretion was so great that the canula could only be removed in fourteen days, each effort to remove being followed by dyspnœa arising from retention. By the introduction of O'Dwyer's tube, retention of secretion is always observed, and pneumonia often arises from it. During the presence of the tracheal canula, improvement follows from free discharge of the mucus. Intubation, therefore, cannot be regarded as a substitute for tracheotomy, and can only be applied in chronic cases. In healthy and strong children the application of emetics removes the mucus, and by this means the pneumonic complication is often prevented. *Michael.*

**Monks, G. H.**—*Unilateral Laryngectomy. A Case of Excision of the Right Half of the Larynx for Carcinoma—Recovery—No Recurrence at the end of a year.* "Annals of Surgery," July, 1893.

THE patient was a man aged thirty-nine, who had suffered from marked and persistent hoarseness for about a year. When first seen the right vocal cord was thickened and reddened, and its movement during

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expiration and phonation was extremely limited. There was no marked pain in his throat or difficulty of swallowing. No cachexia was present, and there was no family history of cancer. The case appeared to be a favourable one for operation, as the growth was confined to one side of the larynx, and no enlargement in the cervical glands could be made out. The operation was performed as follows: two straight incisions were made, the one vertical, in the median line of the neck from the hyoid bone to about an inch and a half below the cricoid cartilage, the other horizontal, on the right side of the neck, about the level of the lower border of the thyroid cartilage. The thyroid and cricoid cartilages upon the right side were laid bare, the soft parts having been carefully dissected away. The trachea was opened at the lowest part of the wound, just below the cricoid cartilage, and a silver tracheotomy tube inserted. The whole larynx was then split in front, in the median line, and the two halves held apart while gauze was firmly packed into the lowest part of the cavity upon the tracheotomy tube. The right half of the trachea was now divided just below the cricoid cartilage. The knife was then placed within the larynx, and the posterior part of the cricoid cartilage split vertically in the median line from the front. The thyroid cartilage was then carefully separated from its attachments to the soft parts behind, and after this the thyro-hyoid membrane was divided. Lastly, the superior cornu of the thyroid cartilage was pulled down and cut out. The bleeding was not excessive, and the patient stood the operation well. Microscopic examination showed the normal tissue of the cord to be almost entirely replaced by a new growth made up of irregular masses and nests of large epithelial cells. Here and there broken-down muscular fibres were seen, surrounded by the growth.

The patient made an excellent recovery—breathes easily, talks intelligibly, and sleeps and eats well. *W. Milligan.*

**Piniaczek** (Krakau).—*On Laryngo-Fissure, and the Author's own Experiences of this operation.* "Deutsche Zeitschrift für Chirurgie," Band 36, Heft 3 and 4.

A PAPER of great interest, because up to now there does not exist any statistical compilation of such rich material observed by so well-known a laryngologist as the author, and assisted by a celebrated surgeon such as Dr. Obalinsky. The statistics relate to forty-two cases, which are shortly reported as follows:—

1. A patient, thirty years old, with chorditis inferior hypertrophica. Treatment with Schroetter's bougies. Some days later tracheotomy necessary on account of attack of suffocation. Laryngotomy, followed with removal of the hypertrophic mucous membrane. Cure resulted; respiration without canula lasting three months. Later, death occurred from pulmonary phthisis.

2. Membranous adhesions of the larynx from attempts at suicide. Tracheotomy. Galvano-cautery without effect. Laryngotomy and excision of the cicatricial tissue. Sometimes the patient could respire with his canula closed; but the stenosis recurred, and the patient had eventually to wear a permanent canula.



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3. A patient, eighteen years old, with numerous papillomata of the larynx. Cricotomy; extirpation of the neoplasms. Recurrence later.

4. Papillomata of the larynx. Laryngotomy; extirpation of the neoplasms. The growths did not recur, but the larynx became stenosed from cicatrices, so that a permanent canula was necessary.

5. Idiopathic perichondritis thyroidea. Tracheotomy, laryngotomy, and removal of the necrosed cartilages. Cure.

6. Rare case of a mucous polypus seated in the inter-arytenoid region, and of the size of a pea. As the patient had great dyspnœa on account of the arytenoid cartilages being hindered in movement by the neoplasm, this was removed by laryngotomy. Cure.

7. Papillomata of the arcus palato-glossi and the right vocal cord, combined with Stoerk's blennorrhœa. Great dyspnœa. Tracheotomy, laryngotomy, and enucleation of the larynx. The operation had no good effect. The patient remained hoarse, and had to wear a tracheal canula.

8. A patient, eighteen years old, with ozæna and Stoerk's blennorrhœa. Tracheotomy; laryngotomy; enucleation. Cure. Some recurrences were cured by treatment with Schroetter's hard rubber bougies.

9. A patient, tracheotomized some years ago, always had to wear the canula on account of specific laryngeal stenosis. Laryngotomy; extirpation of the cicatricial tissue. After some operations, cure of the stenosis resulted. The hoarseness remained.

10. Laryngeal tuberculosis. Laryngotomy; excision. Improvement. One and a half years later, death from pulmonary phthisis.

11. Chorditis inferior hypertrophica. Laryngotomy; extirpation of the hypertrophied mucous membrane. Cure.

12. Chorditis inferior hypertrophica. Laryngotomy; extirpation of the hypertrophied mucous membrane. Cure.

13. Case similar to case 8.

14. Case similar to cases 11 and 12.

15. Case similar to cases 11 and 12.

16. A girl, sixteen years old, tracheotomized for croup nine years before. Decanulement was not possible, because the whole larynx was obliterated over the canula. Laryngotomy; excision of the membrane; tamponing with iodoform gauze. After some corrective operations the operator was able to remove the canula definitively.

17. A patient tracheotomized ten years previously. The canula could not be removed. The laryngoscope showed old perichondritis and chorditis inferior hypertrophica. Laryngotomy; Excision of the hypertrophied mucous membrane. Cure.

18. A patient tracheotomized for fracture of the larynx. The laryngoscope showed stenosis by dislocation of the cartilages and the mucous membrane. Extirpation of the mucous membrane; reposition of the cartilages. No effect.

19. Cancer of the larynx. Laryngotomy; excision of the neoplasm. Four months later, recurrence. Extirpation of the larynx. One year later, no recurrence.

20. A patient, forty years old, had some years previously perichondritis

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thyroidea externa, followed by stenosis. Tracheotomy. The laryngoscope showed collateral swelling of the whole mucous membrane, and eversion of the ventricles. Schroetter's bougies were applied without effect. Laryngotomy; excision of the swollen mucous membrane. No effect. A second operation, the extirpation of the mucous membrane of the ventricles, the patient did not allow.

21. Case resembling cases 11 and 12. Cure. Chorditis inferior hypertrophica.

22. A girl, four years old, with papillomata of the larynx. Laryngotomy; enucleation. Death some days later from diphtheria.

23. Case resembling cases 11 and 12. Chorditis inferior hypertrophica. Cure.

24. A patient, forty years old, was in 1890 operated upon for papilloma of the larynx *per vias naturales*. Some months later, recurrence. Laryngotomy: enucleation. Cure. The microscopical examination now showed that in the deeper parts of the papilloma there was an exquisite epithelial carcinoma. One year later, recurrence. Extirpation of the larynx. Cure.

25. A patient, fifty years old, had in the year 1884 perichondritis typhosa and stenosis. In 1886 the laryngoscope showed immobility of the right arytenoid cartilage. Tracheotomy. Dilatation by Schroetter's tin bougies, without effect. Laryngotomy; extirpation of the hypertrophied tissue; galvano-caustic treatment of the hypertrophied posterior laryngeal wall. Cure.

26. A patient, thirty years old, was tracheotomized for laryngeal perichondritis. Hypertrophy of the subglottic mucous membrane was found in spite of the immobility of the vocal cords. Laryngo-fissure and extirpation of the hypertrophied mucous membrane. Cure.

27. Laryngeal phthisis and stenosis. Tracheotomy; laryngotomy. Death.

28. Case similar to 11 and 12. Chorditis inferior hypertrophica. Cure.

29. Case similar to 11 and 12. Chorditis inferior hypertrophica. Cure.

30. Recurrence of rhinoscleroma in the patient described in case 8. Severe stenosis. Tracheotomy; laryngotomy; enucleation and galvano-caustic treatment of the hypertrophied mucous membrane. Cure, but aphonia persisting. Some months later a second recurrence. Operation *per vias naturales*. Death from traumatic cerebral hæmorrhage from falling of a cab. The *post-mortem* examination showed the larynx to be in a good condition, only filled with cicatrices.

31. A patient, twenty years old, was tracheotomized for typhoid perichondritis. Both arytenoid cartilages were immobile, the subglottic mucous membrane was swollen. Laryngotomy; extirpation of the hypertrophied mucous membrane. Ten days later the canula could be removed; but some days later an attack of suffocation necessitated a second tracheotomy. The patient left the hospital relieved.

32. Similar case to 31. Operation followed by treatment with Schroetter's tin bougies. Cure.

33. Case similar to 11 and 12. Chorditis inferior hypertrophica existed in spite of two laryngotomies.

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34. Chorditis inferior hypertrophica. Recurrence. *See* case 13. Second laryngotomy: extirpation of the hypertrophied mucous membrane. Cure. Some months later, commencing recurrence.

35. Case similar to 11 and 12. Chorditis inferior hypertrophica. Cure, but aphonia persisting.

36. A patient, forty years old, tracheotomized for perichondritis. Laryngotomy; extirpation of the hypertrophied parts. Cure.

37. Hypertrophy of the mucous membrane of the larynx and the air tube by tertiary syphilis, treated during one year in Schroetter's clinic. The patient had to wear a long canula. Enucleation of the trachea, so that an ordinary canula can be worn. Laryngotomy; excision of the larynx. Cure. During the treatment iodide of potassium was also used.

38. A patient, forty-six years old, with cancer of the larynx, commencing in pachydermia verrucosa. Laryngotomy; excision. Cure. Some months later recurrence, and death from suffocation.

39. A patient, thirty years old, with perichondritis, was treated for some time with tin bougies. Immobility of the left arytenoid cartilage, and swelling of the subglottic mucous membrane, still existed. Laryngotomy; enucleation of the hypertrophied mucous membrane. The effect was not very satisfactory, and the author has no information as to the result of the operation.

40. Chorditis inferior hypertrophica, similar to cases 11 and 12. Laryngotomy. Cure.

41. Syphilitic cicatrices in a patient tracheotomized some years ago for dyspnœa. Laryngotomy: extirpation of the cicatrices, so that the canula could be removed. Systematic after-treatment with bougies. The cure is not yet quite finished.

42. Perichondritis typhosa, resembling case 39. Laryngotomy; excision of the hypertrophied mucous membrane. After-treatment not yet finished.

The author then gives a description of the operation. He believes that it is not dangerous. Of forty-two operations, only two fatal cases occurred, but both without relation to the general condition (diphtheria and tuberculosis). Laryngotomy (if tracheotomy is already performed) is less dangerous than simple tracheotomy, also because of the simplicity of the narcosis, which is often dangerous in cases of tracheotomy. The cricoid cartilage is best cut by a herniotome. The aspiration of blood is prevented by tamponing of the trachea, or by Rose's position. If there is a reaction from the mucous membrane, consisting in coughing, it must be brushed with cocaine. Sometimes it is not easy to put the patient in the right position to determine the anatomical details; this is easier by remarking the ventricles of Morgagni, by the use of a reflector, and by provisory tamponing. When the operation is finished, a tampon is introduced in the larynx, to control hæmorrhage, and also for dilatation. The canula must be removed if possible after a few days. Laryngotomy, without tracheotomy, is never performed by the author. It is better to perform tracheotomy some days before than both operations at once; crico-tracheotomy is to be preferred. The operation should only be

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performed if endo-laryngeal operation is impossible, or without success, as in broad and deeply-seated benign neoplasms of the larynx; malignant neoplasms, as long as it is possible to remove them without extirpation of the larynx; stenosis, which cannot be cured by systematic endo-laryngeal dilatation; chorditis inferior hypertrophica, where the extirpation of the hypertrophied mucous membrane is indicated; perichondritis and fractures of the larynx for reposition of the fragments; impacted foreign bodies. Tuberculosis is only in rare cases an indication for the operation.

The reader may excuse the length of this report, as it must be said that for a long time no laryngological paper of such great interest has been published, and especially that up to the present no other surgeon has had so great an experience of the question of laryngotomy.

*Michael.*

**Zeller.**—*Tracheal Fistula.* Stuttgärter Aerztlicher Verein, Meeting, Nov. 3, 1892.

A GIRL, aged sixteen, cured of this condition, was shown. The patient was tracheotomized for papillomata of the larynx. The neoplasms have been removed by endo-laryngeal treatment. The canula could be removed; but the tracheal fistula did not close spontaneously, and had to be closed by a plastic operation. *Michael.*

**Kruse** (Norderney).—*Treatment of Asthma Bronchiale seu Nervosum.* "Wiener Med. Woch.," 1893, Nos. 22 and 23.

REPORT on the different methods of treatment, and a recommendation of sea air. *Michael.*

# REVIEWS.

**Macdonald.**—*Diseases of the Nose and its Accessory Cavities.* By GREVILLE MACDONALD, M.D. London: Alexander B. Watt, 2, Paternoster Square.

THE popularity of this work has been shown by the call for a second edition in little over twelve months after the publication of the first. The author has made several valuable additions on the important subjects of croupous rhinitis and cysts of the middle turbinated bone, while the much disputed and interesting question of the association of asthma with nasal disease has been revised and in some parts modified. The surgical procedures have also been reviewed; the volume is made still more interesting by the writer's experience in the treatment of deviated septum and post-nasal adenoids, and thirteen new cases have been added to the table of cases of empyema of the antrum. It will thus be seen that the second edition is much more extensive than the first, and it may at once be said that the work as it now stands must prove a valuable help to the senior student and general practitioner.

In criticizing such a work as this, one must always take into account

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