following the line of articulation of the ossa nasi with the os frontis, and then down the right side in the line of articulation with the maxillaris ; breaking through the articulation of the os frontis with chisel and mallet, he turned the nose over upon the cheek, and had a good, unobstructed opening through which to work, and with a curette removed the tumour piecemeal, replaced the nose, and fastened with sutures. Two days afterwards the patient's nose looked "as natural almost as ever." J. N. MACKENZIE.

BENOIT.—Hay Asthma. *Paris Médical, March* 14, 1887.

AN observation of a patient attacked with dyspnœic phenomena, and having inflammatory affection of the nose. Nothing new.

JOAL.

LARYNX.

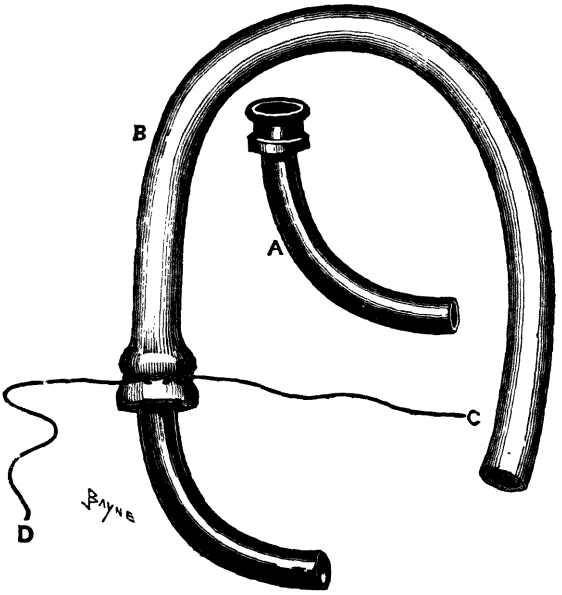
ANNANDALE, Prof. (Edinburgh). — **Note on Preliminary Tracheotomy as an Aid to Certain Operations.** *Edin. Med. Jour., March*, 1887.

THE writer lays down two important principles of preliminary tracheotomy in certain operations involving the mouth, throat, or jaws :—(1) The prevention of blood passing into and obstructing the air-passages ; (2) the security of free and proper respiration, together with the safe and convenient administration of an anæsthetic. He further adds that much blood should not pass down into the stomach, as it may cause vomiting, and so interfere with the operation. He does not believe in the efficiency of Trendelenburg's tampon-canula, or in any of its modifications, and accordingly has devised a special apparatus, which he thus describes :—

"My apparatus, figured in the woodcut, consists of a vulcanite tracheotomy tube (A) which has a broad ring attached to, but moving round its neck, and of a piece of ordinary india-rubber tube about eighteen inches long, and having a diameter of half-an-inch. One end of the india-rubber tube (B) is passed over the ring at the neck of the tracheotomy tube, and secured to it by a piece of strong silk, the ends (D and C) of which are left long. The trachea or larynx having been opened, the tracheal tube is introduced as far as its neck, and then each end of the silk is, by means of a needle, brought through the corresponding edge of the wound of the skin, and when these are tied together they not only retain the tube in the trachea, but also close the external wound, and prevent any blood passing into the trachea in this way. The movable ring round the neck fo

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the tracheal tube has the advantage that it allows of some corresponding movement of the tubing connected to it, so that the latter is much less liable to be twisted or bent, and its canal to become obstructed. To administer an anæsthetic, the fore-end of the tubing is introduced into a glass or tumbler, in the bottom of which a little cotton wadding is placed, and upon this cotton wadding, chloroform or ether is dropped from time to time, as may be required to keep up the anæsthesia." After the performance of the tracheotomy the throat should be thoroughly stuffed by means of a piece of sponge or some cotton wadding, *covered by oil silk or some other thin waterproof material,* in order to diminish the chance



of any blood oozing through the pad. The tube may be removed immediately after the performance of the major operation, but only if the bleeding have ceased, and there be no risk of swelling or œdema in the neighbourhood of the glottis.

The writer believes that, under the above circumstances, preliminary tracheotomy ought perhaps to be practised more frequently than is the case. He further adds that in three recent cases involving the removal of large and vascular tumours from the mouth and throat, not only was preliminary tracheotomy performed, but also preliminary ligature of the corresponding common carotid artery, and to these measures he attributes much of the success which followed each of the operations.

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In the discussion which followed the reading of this paper (before the Medico-Chirurgical Society of Edinburgh, January 19, 1887), Drs. Duncan and Scott-Lang, and Mr. Cathcart took part, and enunciated views which agreed, in the main, with those entertained by the writer of the paper. HUNTER MACKENZIE.

NOTA, ANNIBALE.—Two Tracheotomies. *Gazzetta degli Ospedali*, No. 36.

THE author relates two cases of tracheotomy,—the one, in a girl three years old, for a foreign body in the windpipe; the second, in a child four years old, suffering from croup. Both were successful. Dr. Nota adduces the following conclusions:—(1) that the low operation is preferable; (2) that it is advisable to remove the canula as early as possible. MASSEI.

LUC.—Laryngeal Intubation Applied to the Treatment of Croup and Acute Laryngeal Stenoses. *Bulletin Médical, May* 8, 1887.

A BIBLIOGRAPHIC review. The author concludes that there is a certain number of special cases in which intubation can be advantageously employed, for example, children under three and a half years of age suffering from croup, and in whom tracheotomy is refused by the parents. JOAL.

DUBRUEIL, A.—Intubation of the Larynx. *Gazette Hebd. de Montpellier, April* 2, 1887.

A BIBLIOGRAPHICAL article, containing a review of O'Dwyer's work. JOAL.

FERGUSON, E. D.—An Accident in Intubation of the Larynx. *New York Med. Jour., March* 5, 1887.

IN a case of diphtheria the O'Dwyer tube became detached, and carried in advance the false membrane, thereby occluding its lower orifice. Tracheotomy was done, and the patient died on the third day. J. N. MACKENZIE.

YOUNG, D. S.—A New Treatment for Incised Wounds of the Throat Penetrating the Air-passages. *Lancet-Clinic., March* 5, 1887; *Med. News, April* 9, 1887.

AFTER the hæmorrhage is controlled and the injuries to the internal appendages are attended to, he proceeds to close the wound both internally and externally (to render it impervious to air and fluids) by uniting the incision in the windpipe with catgut sutures passed through the cartilage, including the mucous membrane, one-eighth inch apart, firmly tied, and the ligature cut close to the knot. When

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the air-passage is completely or extensively divided, two or three silk sutures may be placed, one on each side and one in front, to sustain better the parts in position, as they will not be affected by moisture as the gut is liable to be. The external wound is cleansed, its margins brought together and secured with pins or wire sutures. The head is brought slightly forward, and held by a cap with tapes fastened to a band around the chest. In cases of violent delirium, Christopher's plaster of Paris dressing is invaluable, as it secures rest to the parts and leaves the throat freely exposed. No special dressing is required. The patient speaks and swallows immediately after the wound is closed, but should be restrained. The external sutures may be removed in five or ten days; the internal are allowed to be absorbed or thrown off. No irritation or spasmodic coughing has been excited by their presence. J. N. MACKENZIE.

AGNEW, D. HAYES (Philadelphia).—**Excision of the Larynx and Pharynx.** *Med. News, April* 9, 1887.

TUBULAR epithelioma filling the larynx and also the pharynx to such an extent as to require the entire removal, saving a very narrow strip of its posterior wall. An incision was made from the hyoid bone to the middle of the suprasternal fossa over the median line of the neck, the thyroid isthmus divided between ligatures, the adjacent muscles separated from their insertions and dissected away. The trachea was separated from the œsophagus sufficiently to admit a grooved director, when the former was severed by a probe-pointed bistoury carried between the cricoid and its first ring. A rubber cork, through which was passed a syphon tube, was made to fit accurately in the lumen of the trachea. The larynx was next excised, and the diseased portion of the pharynx. Before the last dressings were made, the secretions ran down in a stream through the wound. Fearing that they might make their way through the loose tracheal tissue to the mediastinum, an aseptic sponge with cord attached was passed through the upper part of the wound into the fauces. The second day following the operation the patient showed signs of exhaustion, and on the third day died. No autopsy was allowed, but death occurred probably from congestion of the lungs and heart failure. J. N. MACKENZIE.

GARDNER, W.—Excision of the Larynx. *Lancet, May* 7, 1887.

THE case is the third operated on in the British dominions in which the patient has lived over four months. The disease was cornifying epithelioma, and recurrence was very rapid. The author recommends the use of a rectangular canula, fitting the full diameter of the trachea,

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as a preventive of hæmorrhage into the air-passages and of septic pneumonia. He prefers "the hanging head" position. He concludes that Gussenbauer's original artificial larynx is the best.

GREVILLE MACDONALD.

THORNER (Cincinnati).—**Removal of a Cockle-burr from the Larynx by Voltolini's Sponge Method.** *Cincinnati Lancet and Clinic*, 1886, No. 17.

THE nature of the case is sufficiently indicated in the title of the paper. J. N. MACKENZIE.

MASSEI, Prof. F.—On a Case of Laryngeal Papilloma. *Lezione Bollettino, Anno* v., No. 2.

A GIRL of thirteen had complained of hoarseness for a year without other disturbance. Laryngoscopic examination disclosed a little elevation, pale red and movable, situated on the anterior third of the left vocal cord. The rest of the cavity was normal, except that the cords, slightly swollen and reddened from the presence of the tumour, could not approximate during phonation. The mirror explained the aphonia, and removed any doubt as to anatomical diagnosis. The author took the opportunity of illustrating the physiology of voice-formation. Then he passed on to discussing the nature of the tumour. He spoke of papillomata in general, of their frequency, structure, course, recurrence, and rapid growth, but more especially of the age of the patient; and on these points he established the prognosis in general, and of the case in question. As for treatment, the author prefers repeated excision to cauterization. In general one should avoid irritating the growth, while we must remove exuberance of the tumour, and so gain time. In the case in question tracheotomy was performed. MASSEI.

FERRERI, Dr. G.—Treatment of Laryngeal Papillomata. *Lo Sperimentale, fasc.* 2, *February*, 1887.

THE author insists on the distinction between papillomata and simple granulations. He confirms the opinion of laryngologists as to their frequency, the age of the patients, their situation, &c. As for treatment, the clinic at Rome have desired to get rid of the ordinary instruments, complicated and costly, often practically untrustworthy, to obtain more rapid execution with greater safety and certainty. In the first place De Rossi has adopted a small spoon, the concavity of which may be turned either to the right or the left, of an olivary form, with the edges somewhat sharp, attached to a curved stem with a metal handle. The mode of use is plain from its con-

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struction. But the bulk of the tumour removed, there remains the base; or else one has to do with a small tumour projecting into another region, subglottic, where it is difficult to convey the ordinary instruments. For such papillomata De Rossi adopts his scarifier, a kind of forceps, with a flat extremity articulated between them, the upper surface of which is roughened. Introduced closed, they diverge and extract with rapidity. Finally, to prevent recurrence of the tumour, he recommends cauterization with a special instrument. His *porte-caustique* consists of a curved metallic rod, ending in an olivary body of platinum. On a depression in its surface, fused nitrate of silver is introduced in sufficient quantity. MASSEI.

MASSEI, Prof. F.—A Case of Laryngeal Paralysis from Cortical Lesion. (Clinical lecture reported by Signor N. Palazzolo.) *Archiv. Ital., Anno* vii., *fasc.* 2.

THE patient was an adult, who for five years suffered from right temporo-frontal headache, often combined with vertigo and slight dysphagia; and for the last year from dysphonia and attacks of dyspnœa. Examination of the nervous system disclosed a falling of the left cheek and a deviation of the tongue to the left. The ophthalmoscope revealed binocular choroiditis. The laryngoscope showed that the left vocal cord was almost immovable during inspiration, while during phonation it advanced to the middle line. The movements of the right cord were disorderly and sluggish.

In the first place the author spoke of laryngeal diseases related to defective abduction of the cord, then of the muscles involved, and ascribed the symptoms in the case to paralysis of the left abductor. Then he discussed the etiology, first of myogenic, then of neuropathic paralysis, and enumerated the causes which produce the one or the other. In regard to the present case, he confined himself to enunciating, as a general theory, that when there is unilateral paralysis affecting the crico-arytenoideus posticus, there are two possible contingencies, viz., pressure on the recurrent laryngeal, and, second, central lesion. He discussed the theories, referring to the various experiments and hypotheses of authors, and concluded as follows: It is possible with the laryngoscope to distinguish paralysis of the abductor from spasm of the adductor; it is always a question when the abductor becomes paralysed first; the phonatory position of the cord, whether one accepts the hypothesis of Semon or that of Krause, always indicates either a lesion of the recurrent or a central disturbance. He excluded, in the case, pressure on the recurrent; and seeing that the cerebral symptoms preceded the laryngeal, he concluded in favour of a central lesion. He believed lesions of the

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nuclei on the floor of the fourth ventricle might be excluded, and so inferred a cortical change. He held that from experimental and clinical observations, there are two cortico-motor centres for the larynx. MASSEI.

GAREL (Lyon).—**Some Remarks on a Case of Hæmorrhagic Laryngitis.** *Rev. Mens. de Laryngologie, May*, 1887.

BY the term hæmorrhagic laryngitis is not meant the unimportant hæmorrhages, or simple filaments of blood which occur in some more or less acute forms of laryngitis. In these cases the symptoms are too slight to modify the clinical aspects of the condition. The term "hæmorrhagic laryngitis" should be limited to cases of laryngeal catarrh complicated with hæmorrhage, either superficial in position, or occurring in the deeper layers. The important sign is the occurrence of a hæmorrhage on the laryngeal mucosa, independently of any ulcerative lesion of the mucous membrane. The author quotes an observation of a patient with hæmophilia, whose general condition was bad. He had been troubled for many years with vocal affections, and for some months had rejected every morning blackish clots of blood. Laryngoscopically, there was observed on the free edges of the vocal cords, a sort of toothed border, formed of blackish blood-clots; clots were also observed on the arytenoids, and even upon the epiglottis. The mobility of the cords was intact, but the material obstacle formed by the clots hindered the free vibration of their edges, and affected the emission of sound. The voice, however, reappeared after the expulsion of the clots. The patient succumbed with albuminuria, œdema of the legs, and purpura with cardiac cachexia. Garel regards this observation as a true type of hæmorrhagic laryngitis, preceded by catarrhal laryngitis of simple rheumatic origin. Surgical intervention in such cases is likely to do more harm than good, and we must be contented with more or less astringent inhalations. JOAL.

SCHÄFFER AND NASSE (Bremen).—**Tubercular Tumour of the Larynx.** *Deutsch. Med. Wochenschr*, No. 15, 1887.

SCHÄFFER extirpated with the cold wire a large tumour of the left ligament, which sprang from the arytenoid cartilage. At the time of the operation the patient was in the best possible health. Half a year later he died with phthisis.

Nasse made a microscopical examination of the tumour, and found it to possess a fibrous stroma, with a great number of small cells, along with giant cells. There were also very many tubercular bacilli. MICHAEL.

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GOSSHELF.—Case of Ulcerating Broncho-tracheal Stenosis. *Deutsch. Med. Wochenschr.*, No. 38, 1886.

A CASE of broncho-tracheal stenosis of probable syphilitic origin. A specific cure could not be obtained because the patient was already too much enfeebled. Tracheotomy was performed, application of König's canula made, but without relief. Post-mortem examination showed two ulcers in the under portion of the trachea. These ulcers communicated with an abscess which compressed the left bronchus.

MICHAEL.

COMPAIRED Y CABODEVILLA (Barcelona).—**Importance of Etiology in the Treatment of Paralysis of the Vocal Cords.** *Revista de Laringologia, Otologia, y Rinologia, Marzo*, 1887.

THE author read an essay at the Spanish Laryngological Association, to show the value of etiological classification compared with a physiological or anatomical one.

RAMON DE LA SOTA.

ROQUER CASADESÚS (Barcelona).—**Multiple Papilloma. Very great Laryngeal Stenosis.** *Revista de Laringologia, Otologia y Rinologia, Abril*, 1887.

THE relation of a case which was remarkable for the great extent of the laryngeal surface occupied by the growth, and for the magnitude and multiplicity that it attained. After having extirpated the growth in three or four sittings, and having cauterized the origin of its growth, the patient breathed freely, and the voice reappeared, although not perfectly, still sufficiently to allow him to sustain a conversation. Microscopical examination showed the tumour to be a papilloma, without the presence of any bacilli.

RAMON DE LA SOTA.

MASON, G. W. (Bloomington, Ill.).—**Intubation of the Larynx.** *Med. News, March* 26, 1887.

REPORT of three cases of diphtheria in which intubation was practised, in one of which the patient's life was saved by the operation, whilst in another death from laryngeal stenosis was prevented. From his previous unfavourable results with tracheotomy and that so far with intubation, the author presents the following points in favour of the latter operation:—(1) It involves no cutting and is bloodless; (2) hence patients readily consent to it when they would not to tracheotomy; (3) it gives a larger percentage of recoveries; (4) there is no risk of systemic infection because of an open wound; (5) there is no perceptible shock; (6) it does not expose the lungs to inflammation; (7) it does not preclude a subsequent tracheotomy.

J. N. MACKENZIE.

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