influence of excessive alveolar development in the formation of high palates.

Drs. MAYER and MYLES spoke on the subject.

Dr. QUINLAN referred to the situation of deflections; they occurred at the sutural line of the plates of the ethmoid and vomer, the weakest part of the triangular cartilage. Frequent traction of the buccinator forces the sides of the maxilla together and so pushes up the septum. He referred to thumb sucking, as also did Dr. Goodwillie.

Dr. GLEITSMANN briefly replied. *R. Lake.*

AMERICAN LARYNGOLOGICAL ASSOCIATION.

("Med. Rec.," May 22, 1897.)

(*Continued from page* 368.)

Second Day—Wednesday, May 5th.

Tumour of the Nose. Dr. J. H. BRYAN (Washington) exhibited a case of *Intranasal Tumour.*

The patient was a man of twenty-two, who had had a growth in the nose, causing stenosis, for four years. It first appeared in the left anterior naris, but was now visible in the right posterior. As the septum was intact in the naso-pharynx, it was evident that the neoplasm had attacked and perforated the septum. An examination of a bit removed showed fibro-sarcoma, though from simple inspection he had made a diagnosis of simple fibroma. Within the past few weeks giddiness and double vision had appeared. There was no spontaneous hæmorrhage, but the growth bled freely upon manipulation. Dr. Bryan invited the opinion of those present as to the most feasible operation for removal.

Dr. M. R. WARD (Pittsburg) had operated in one case of fibro-sarcoma of the nose four years ago. His patient was well at the present time. In view of current views as to fibro-sarcoma, he thought that this long continuance of life somewhat invalidated the original diagnosis.

Dr. J. E. BOYLAN (Cincinnati) thought that mere continuance of life ought not of itself to invalidate the accuracy of diagnosis.

Dr. W. E. CASSELBERRY (Chicago) had reported a case of simple fibroma some eight years ago. It was impossible to remove the tumour entire, so he had slit it up into segments with the galvano-cautery knife, and then snared it off piecemeal. It was harder to the feel than was the growth in Dr. Bryan's case.

Dr. JONATHAN WRIGHT (Brooklyn) thought that the fact that in Dr. Bryan's case the naso-pharynx was not invaded would point to fibro-sarcoma rather than simple fibroma, which, confined to the middle or anterior part of the nose, was practically unknown.

Dr. J. SOLIS COHEN (Philadelphia) would advise, in the present case, the performance of Rouge's operation.

Dr. THOMAS HUBBARD (Toledo) thought that the eye symptoms in

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

the present case should suggest the query whether it was advisable to operate at all.

Dr. C. C. RICE (N.Y.) had seen one case during the last winter. He would strongly condemn cobbling in these cases.

Dr. J. N. MACKENZIE (Baltimore) said that the Rouge operation frequently failed to afford the necessary exposure of the involved area. He would therefore advise the modified Langenbeck operation, whereby the superior maxilla is separated from its median attachments and rotated outward.

Suppuration of the Frontal Sinus. Dr. J. H. BRYAN.

The writer thought that frontal sinus suppuration was much more common in this country than was generally supposed. Recent *grippe* epidemics had brought to light a large number of cases. Many were undoubtedly due to propagation from the maxillary sinus, owing, in some instances at least, to an abnormal communication between the two cavities. Phillibroun, of Boston, had recently reported the results of examination of skulls in which the infundibulum had been prolonged to the actual entrance of the antrum, as a half-tube terminating in a valve-like fold, so that secretions from the frontal sinus would pour into the antrum and secondarily involve the latter.

Dr. Bryan then described the anatomy of the frontal sinus, and exhibited photographs illustrating its peculiarities. He said that the size of the supraorbital ridges was no guide to the size of the sinuses. He would advocate in such cases the operation known as Luc's.

He then gave the clinical history of a case occurring in a woman, aged fifty-eight years, in which the Luc operation had been done. The antrum was also affected, and was previously operated upon by the alveolar method. After the operation the course had been uneventful for a while, but the drainage tube slipped out of the nose and soon evidences of sepsis began to show themselves. The dressing over the forehead wound was removed and a small abscess found. Pus was evacuated, and the wound was stuffed with gauze and allowed to heal by the open method.

Dr. CASSELBERRY was pleased to hear such strong advocacy of the Luc method. Intranasal management of these cases had in his hands proved very unsatisfactory.

Dr. MACKENZIE thought that strong antiseptic solutions should be carefully avoided in all such cases. It had been shown that bichloride solution as weak as 1 to 10,000 caused a necrosis of a thin layer of tissue. He would prefer Thompson's fluid as used in the bladder, or even a normal salt solution. The same thing could be said of drainage tubes They should be avoided as much as possible, as they are liable to act as pus producers and carriers of infection.

Dr. WRIGHT thought antrum disease from sinus disease a very common sequence.

Dr. J. E. NICHOLS would agree with Dr. Mackenzie as to the danger of using strong solutions. He thought it possible to make a differential diagnosis between primary antral disease and that secondary to frontal

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

sinusitis. In the latter, the antral pus appeared as long worm-like shreds, while in the former it was compact or in small masses.

Discussion on Atrophic Rhinitis.

The nature and symptoms of this affection were considered by Dr. W. E. Casselberry. No one theory of causation would account for all the cases observed. The disease as seen in the young child seemed to contravene Fraenkel's theory, which, however, was borne out by the appearances found in old people. There were fœtid and non-fœtid cases. The atrophy might be due to one cause and the fœtor to another. Two groups might be made—one of simple dry cases and the other of ozæna or fœtid cases, as had been done by Greville McDonald. All stages of atrophy were observed, from a very slight grade up to a condition characterized by degeneration of the mucous glands and crust formation. The non-fœtid variety occurred more frequently in old people. Ozæna was seen in early life, and as a rule the fœtor was persistent, but in some instances the two types seemed to blend. There might also be a local affection of the peripheral sensory nerves. The nostrils became less sensitive to all irritants and the pharyngeal reflexes were sluggish. In some cases the process seemed to involve the nasal bones and cartilages as well as the turbinates, so that there was a suggestion of the saddleback nose. The tip of the nose is elevated, so that the anterior nares look forward rather than downward. Again, there might be a primary central trophic neurosis. A deviated septum might cause the change to be more marked on the concave side, but a correction of this deformity would often cure the affected nostril. Congenital malformations seemed to be a causative factor in some cases. They led to atrophic rhinitis from poor nasal ventilation, and consequent stagnation of secretion. Syphilis, tubercles, alcohol, and gout undoubtedly played a predisposing part. In both types of the disease the trophic changes varied in degree and distribution. Some cases were undoubtedly the sequels of preceding hypertrophy, but hypertrophy need not exhaust itself before atrophy begins. The middle turbinate might be hypertrophied and the inferior atrophied. Grünwald had referred the condition to preceding sinus disease; Bosworth to an earlier purulent rhinitis. More recently Belfanto and Della Vedova had found in the mucosa bacilli resembling those of diphtheria; Fraenkel and Loewenberg, a coccus; Abel, a bacillus named by him bacillus mucosus; Wyatt Wingrave, various hyaloid bodies. As regarded symptoms, in addition to those referable to the nose proper, impaired hearing and voice were often the first things noticed. The speaker would advise against a too free use of the cautery in hypertrophic cases, as atrophy might thereby be induced.

Dr. J. N. Mackenzie spoke of the pathology. In considering this topic one should consider, first, the nature of the structural changes; and, second, the order of their occurrence. It must be remembered also that we are dealing with changes in a respiratory organ as well as in a mucous membrane. At present there is a haze of opinion regarding the matter, because of the loose manner in which the term atrophy is used; and, second, because we fail to discriminate between the different forms

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

of atrophy, and the causes which produce them. We may have simple atrophy, and the atrophy of degeneration. The best term to indicate the condition we have in mind when we speak of atrophic rhinitis is sclerosis. This may result from a blood infection, such as tuberculosis or syphilis, or may come from an intoxication, particularly that of alcohol. It probably does not arise from purulent catarrh, for we have nothing parallel to such a sequence in any pathological process with which we are acquainted. The task of the future is to determine the origin of this sclerotic process. It is possible that the process may be sclerotic *ab initio*, and that it may begin in the periosteum. It is impossible to prove this. It is improbable from the lack of proof in clinical history, from the lack of anatomical observations on this point, and also from the fact that we frequently see a rapid transition in a given case from a hypertrophic to an atrophic condition.

In reply to Dr. Casselberry's objection to the theory of this transition, he would say that ozæna and atrophy are not convertible terms. In regard to the ozæna neonatorum, so-called, this might be due to intra-uterine changes with the nature of which we are unacquainted. It is true that hypertrophy does not always terminate in atrophy, and in a given microscopical section we may see the two side by side. Atrophy is, as a rule, more pronounced when the catarrh has originally developed.

Dr. C. C. RICE (New York) discussed the treatment. He would divide therapeutic measures into constitutional and local. Under the former he would include climate and general hygiene. He had seen several cases greatly improved by a transfer of residence from the city to the country. Sea air was undoubtedly better than mountain air. As to local measures, cleanliness and stimulation were probably the methods most generally employed. Great care should be taken to avoid destruction of tissue. The oily preparations were of great service, both as vehicles and as lubricants. He would therefore cleanse and polish the nose with the oils. In very young children with excess of thin secretion powders might be used.

Dr. JONATHAN WRIGHT called attention to the fact that the disease was far more common in women than in men, and that its development seemed coincident with the menopause. After the menopause the condition generally improved. It had been suggested that the bacteria found in the nose in this affection might produce some ptomain, which by continued action on the nasal mucosa produced eventually the condition with which we are all so familiar.

Dr. S. O. VAN DER POEL (New York) alluded to the serum therapy of Belfanto and Della Vedova. He had seen one subject of atrophic ozæna who contracted laryngeal diphtheria. Antitoxin was injected at three different times, and the patient recovered. It was a remarkable fact that thereafter the ozæna was also greatly improved, the amount of discharge having been most markedly lessened.

Dr. J. H. HARTMAN (Baltimore) had for some years used the galvanic current, and was disposed to attach great value to it. It was, however, a tedious method of treatment, and it was difficult to make patients persist in its use.

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

Dr. JAMES E. LOGAN (Kansas City) had found the middle turbinate more frequently atrophied than the inferior, and was disposed to attach much importance to pre-existing sinus disease as a causative factor.

Third Day—Thursday, May 6th.

Simulated Sarcoma of the Tonsil, with Case.

Dr. BRYSON DELAVAN (New York) reported a case of a man of forty-three years, with a good family history and no suspicion of syphilis. For two months he had had a soreness in the left tonsil, with a moderate enlargement of the same. Later there ensued a breaking down of the tissue, leaving a central erosion, while the remainder was indurated. The cervical glands below the tonsil were somewhat enlarged. There was pain on palpation and deglutition. The patient was placed on the iodide of potassium, while a small piece of the tonsil was removed and submitted to Dr. Hodenpyl for examination. Several other pathologists also examined the growth and pronounced it a sarcoma. Dr. Hodenpyl, however, was not sure of this, and was inclined to doubt the correctness of this view. The glandular enlargement cleared up under the iodide, while the tonsil still remained enlarged. It was removed with the cold snare. The microscope showed chronic hyperplastic changes, with a large number of endothelial cells. There was a strong suggestion, in the arrangement of the histological elements, of sarcoma; but the tonsil was only a little enlarged. Under the continued administration of the iodide the disease entirely disappeared, and the patient has remained well.

A New Method of Permanent Relief of Certain Enlargements of the Turbinated Bones.

Dr. DELAVAN also presented a short communication with this title. He said that the use of the cautery often produced too great loss of mucous membrane, while affording no permanent relief. Our aim should be to reduce the volume of the congested turbinates. He, therefore, would advocate the method of submucous incisions. For this purpose he used a small knife, first applying cocaine in the usual manner and then passing the blade under the mucosa, making a sweep through the submucous tissues and then withdrawing it, care being taken to avoid any additional enlargement of the original opening. The instrument employed was a needle rather than a knife. It was better to repeat the operation than to overdo it. There was but little pain and only slight bleeding. It was a good plan to keep the cocaine in contact with the tissues for several hours and to let the slight hæmorrhage stop of its own accord. This method of operating possessed the advantages of ease of execution, freedom from bad effects, preservation of the mucosa, and a practical adaptability to the desired end. In advocating this measure, Dr. Delavan would lay no claim to originality, though he had never heard it before described. As to its ultimate results he could not speak positively. He had one case now under observation, in which the good results had persisted to the present time and were all that could be desired.

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

Dr. WRIGHT thought that this was a very reasonable procedure. He presumed that the good effects were due to the breaking up of the vascular coats, and the causation of clotting in the cavernous tissue was analogous to what was sometimes sought to be brought about in cases of aneurism.

Dr. CASSELBERRY saw many cases in which the congestion was posterior. In such this operation would hardly do. He was willing to admit, however, that sometimes the removal of an anterior enlargement would cause a posterior one to disappear without further treatment. He also alluded to the method of submucous linear cauterization recently advocated by Norval H. Pierce, of Chicago.

Dr. WRIGHT said that the importance of Dr. Delavan's first case should not be overlooked.

A Case of Subglottic Tumour causing Great Dyspnœa; Removal by Tracheotomy and Curetting.

Dr. JOHN W. FARLOW (Boston) reported the case of a woman of thirty-seven years who four years before had suffered from severe dyspnœa. Three years ago she had come under the observation of Dr. H. W. Loeb (St. Louis), who found a thickening of the nasal septum. The dyspnœa was so severe that a tracheotomy was done, and it was found that there was a tumour, sessile, about one and one-eighth inches long, and three-eighths of an inch in transverse measurement, situated on the posterior wall of the trachea, and bulging into the œsophagus. It had the thickness of a pencil, and was of a brownish colour and soft consistency. After the tracheotomy the dyspnœa greatly improved, and she remained fairly well. She came under Dr. Farlow's observation in January, 1897. She then had dyspnœa and great wheezing in respiration. She had lost thirty pounds. The voice was not hoarse, and the vocal cords moved freely. There was a tumour visible below the cords, filling up the trachea to a great extent, so that there was only a very small passage for the tidal air. The tumour presented as two masses on the right side, and as a single one on the left, and was apparently connected with the trachea. A diagnosis of non-malignancy was made, and the growth was regarded as an enchondroma. On February 4th a tracheotomy was done, and the trachea opened above. Free access to the tumour was thus obtained, and it was removed with the curette. In closing the wound the skin was sutured, while the tracheal rings were not. Examination of the growth showed it to be a fibroma. Dr. Farlow alluded to the possibility of some relation existing between the thickened septum and the tracheal growth.

Papillary Œdematous Nasal Polypi and their Relation to Adenomata.

Dr. JONATHAN WRIGHT (Brooklyn) discussed a series of tumours, some of which had come under his own observation, and others of which had been reported by writers. Full details of histological structure were given, and the general aim of the paper was to show that all grades of transition could be seen, from the simple nasal polyp up to the true adenomata.

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

A Case of Adeno-Carcinoma of the Nose was reported by Dr. F. E. HOPKINS (Springfield, Mass.).

His patient was a man of eighty-three years. For twelve years he had had nasal obstruction with a watery discharge, but no pain or bleeding. A tumour was discovered in the nose, and a rough attempt at removal was made. The attempt had to be given up on account of the hæmorrhage it caused. Later, some masses were removed by the forceps. These were regarded as polypi. He was seen by Dr. Hopkins in April of the present year. He was now suffering from a sanious discharge, occasional epistaxis, and offensive odour. The eye was displaced outward. The septum nasi was forced over to the right side posteriorly. The mass was removed with the cold wire snare. Bleeding was profuse. The microscope showed cylindrical cells in tubular arrangement, but here and there arranged as acini. There were a few irregular cell masses. In general, it could be said that there was a tendency to a concentric arrangement. The amount of connective tissue was scanty.

Dr. SWAIN (New Haven) called attention to the similarity of structure between the papillary adenomata seen in the nose and that of the ordinary aural polyp. He believed that the fibrous tissue present in these growths, as well as the cell elements, contributed to the papillary appearance.

Primary Lupus of the Larynx.

Dr. EMIL MAYER (New York) reported two cases that had been under his observation.

Case 1. Male, aged thirty; born in Russia; presented himself for observation on July 18th, 1896. His history was that he had been in good physical condition, excepting an attack of malaria seven years ago, until one year before the date of presentation. At that time, after a very short cough, he brought up about a wineglassful of blood. There were no further signs of hæmorrhage until July 10th, 1896. While sitting up at night he had a short cough, and brought up half a cupful of blood. From this time he had daily hæmorrhages until he presented himself. During this time he was under the care of his family physician. There was no cough, no pain in deglutition, no pyrexia, no hoarseness. His physician, finding no evidence of pulmonary disease, referred him for laryngoscopic examination. There was a large ulcer in the centre of the epiglottis, extending over the entire laryngeal face. The edges of the ulcer were granular, covered with a greyish white deposit, many small nodules existing on the free edge, the whole presenting a gnawed appearance. The width of the ulcer at the upper border was about eight millimètres. In the deepest portion of the ulcerated surface there was an eroded spot, presenting the appearance of the open mouth of a vessel. There was a tumefaction on the upper border of the epiglottis on each side of the ulcer. The arytenoids and the interior of the larynx were normal. Careful examination and investigation gave no evidence of syphilis. Sputum examined showed no bacilli. There was a slight consolidation at the apex of the left lung.

Diagnosis: Primary lupus. Under applications of lactic acid,

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

alternating with menthol, and internal applications of creosote, he improved markedly, the hæmorrhage ceasing on the third day and never returning. His weight increased and he resumed his daily vocation, passing from observation August 5, 1896.

April 16, 1897, patient present at my urgent request. States that he has been entirely well these eight months past, that he has steadily gained in weight, and excepting a slight cough of a few days' standing has no complaints. His voice is clear and strong, appetite good; he has no pyrexia and no pain, and there is no difficulty in deglutition.

Examination.—The epiglottis is thickened in every diameter; a piece is excavated out of its central portion, extending to within one-eighth of an inch from its free border. The portion of the epiglottis that is visible in this excavation is nodulated in appearance, a fresh nodule being visible on the site of the old cicatrix. The mucous membrane of the border of the epiglottis adjacent to the ulcer is puffy and very œdematous. Its œdematous folds form pouches hanging over the arytenoids, and tend to obstruct the view of the larynx. No abnormality can be detected in the larynx.

Examination of the Lungs.—Besides a slight bronchial catarrh, and the consolidation at the apex of the right lung, which is *in statu quo*, there is no other pulmonary affection.

Case 2. This case was one of primary lupus of the pharynx and larynx, and was reported to this Association in the year 1881 by Dr. Morris J. Asch, through whose courtesy the patient has been under the observation of the writer ever since. The history then given was:—

Nora H. came to me in February, 1879, complaining of sore throat and hoarseness. For four years she has suffered with it during the winters. During the past winter she has been much worse, deglutition becoming difficult, fluids passing out through the nose on her attempting to swallow them. There was a pricking sensation in the parts.

Examination.—The uvula was destroyed. The free border of the velum and the posterior pillars were ulcerated; the anterior pillar of the right side, the right tonsil, and the roof of the mouth were thickened and covered with small fleshy tubercles and nodular masses. The anterior pillar of the left side was thickened, while the whole diseased surface presented a deeper tint than normal. On the posterior wall of the pharynx was a large radiated cicatrix, of the origin of which the patient could give no history. Patient is dysphonic; hearing is diminished. The epiglottis is thickened, with ulceration on the left side and with its cushion much infiltrated. The aryepiglottic folds and the ventricular bands are covered with small tubercles and thickened, so as to prevent a view of the vocal cords. There is also a large papillated mass at the base of the tongue on the right side.

Under cod-liver oil, iron, and applications of nitrate of silver the patient improved until October of that year, when she complained of a choking sensation in damp weather. There was pain in the throat. The growth had increased and there was an appearance of ulceration on the right side of the larynx. There was a white spot on the right posterior pillar, and the granulations, which had almost disappeared from the roof

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

of the mouth, had returned. Under applications of perchloride of iron the patient improved steadily, and in May, 1881, there were no further indications of active disease.

Two years after the case was described it was found that the epiglottis was sunken and flattened. This was believed to be due to subsequent cicatrization. About five years ago a new nodule appeared, extending from the centre of her distorted epiglottis and directly upon a cicatrized spot. This remains and protrudes like a spur. Before this an attack of pneumonia, and later an attack of pleurisy, occurred, from which recovery was complete. No other throat affections save those noted have presented in all these years. Her life history has been that she has been twice married. Her first husband died of endocarditis. She has been pregnant twelve times and aborted seven. The abortions were all due to causes referable to the uterus. The children that were born were normal in every respect. Her skin and body were carefully examined from time to time. Her teeth were singularly perfect, nor has there appeared any diseased state of the eyes, ears, or scalp. No mercurials or iodides have ever been given or required. In the month of February, 1896, she began to cough, and failed rapidly. Tubercle bacilli were found in large numbers, and cavities at the apices of both lungs. Under creosote and rest she improved sufficiently to go to Sullivan County, N.Y., on April 15, 1897. From time to time there appears over the right temple a lupus eruption, sometimes very red and at others almost gone.

The writer quoted from the literature of the subject, calling especial attention to the statements made that primary lupus of the larynx does not exist. The literature, however, contains fourteen other cases besides the ones here presented. These cases are all reported by competent observers, one of whom states that lupus may originate as a primary deposit in the mucous membrane without any external disease whatever. This is now established beyond all doubt. It was also shown that lupus is dependent upon the tubercle bacillus for its origin.

The most important point is the question of diagnosis. Lupus must be differentiated from tuberculosis, syphilis, carcinoma, and leprosy.

Symptoms.—Primary lupus produces no symptoms for a long time—often occasions no inconvenience; no fever; only after a time, and frequently after a long time, the voice becomes husky, and sometimes dyspnœa may occur, and these bring the patients under observation; hence Marty truthfully said that lupus of the larynx must often be divined. The glands may or may not be involved. Clinically speaking, the primary disease resembles the secondary in appearance. There are four processes in this affection: the mucous membrane is pale, it is œdematous, there is ulceration, and cicatrices form. These may all be present at the same time.

The course of the disease is chronic, without fever; a cure may be spontaneous, and often the disease reappears in the scar. The course of the disease may be rapid. Death ensues from complications, rarely from œdema of the glottis.

Prognosis is good as far as temporary recovery is concerned.

In regard to the cases here presented, the most important question

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

is that of diagnosis. In the first case there were no symptoms of a throat affection; the epiglottis presented a worm-eaten appearance, with nodules. There were no bacilli and no cough, no fever, no evidence of syphilis; and finally a subsequent cicatrization and formation of the nodule in the cicatrix led to the diagnosis of lupus.

In the second case the main point of interest is that at the time of its presentation the diagnosis of lupus was questioned, and it was declared to be syphilis. After careful observation for sixteen years, no evidence of syphilis presented in any way. The presence of a large nodule directly on the site of the old cicatrix and the eruption on the temple so absolutely excluded syphilis that the writer believes that the original diagnosis has been amply verified.

The writer's conclusions were :—1, That primary lupus of the larynx does exist; 2, that it is a painless affection and may go on for years unnoticed; 3, that tubercle bacilli are present in small numbers, although difficult to find; 4, that its similarity to syphilis in appearance is greater than to that of tuberculosis; 5, that the absence of adhesive bands is characteristic of lupus, while they were always present in late syphilis; 6, that the prognosis as to life is reasonably good.

Dr. SWAIN related the history of one case. It occurred in a girl, who presented in the larynx old scar tissue, of the existence of which she was totally ignorant. Tuberculin was injected, and after each injection the scars took on a pinkish colour, though there was no adverse reaction and no therapeutic benefit from the tuberculin.

Dr. WRIGHT thought that it was difficult to draw any hard-and-fast line between lupus and tuberculosis. Cases seemed sometimes to run over from one to the other. Many cases at first supposed to be lupus would clear up under the iodide, thus showing their true specific nature. In one particular instance in which this was the case a few bacilli were found in the sputa, but later the case developed tuberculosis of the lungs and larynx and ran the usual fatal course. Such cases were regarded as cases of mixed infection, but the speaker was not a believer in the truth of this theory.

A Contribution to the Study of Laryngeal Phthisis.

Dr. T. MORRIS MURRAY (Washington) reviewed the various advances made in the treatment of this affection since the publication of a paper read by him in 1894. He called attention to the good effects of a digestive preparation called enzymol, which he had applied to the larynx for the purpose of digesting off the diseased tissue. In one instance the result had been quite remarkable. He advocated the use of creosote, which he regarded as a *sine quâ non* in the therapeutics of this affection.

Dr. E. FLETCHER INGALS (Chicago) stated that he had given up the use of creosote itself, and had substituted therefor carbonate of creosote. It was much better borne than creosote, and the dose could be run up even to one drachm three times daily.

Four Cases of Sarcoma of the Nasal Cavity.

Dr. J. E. H. NICHOLS (New York) reported the cases, giving the clinical histories in detail.

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press

The following papers were read by title :

"The General Health and the Upper Respiratory Organs," by Dr. J. C. Mulhall, of St. Louis.

"A Case of Angioma of the Tonsil, with Recurrence of the Same Three Years after Removal," by Dr. J. H. Hartman, of Baltimore.

"The Advantage of Bromide of Ethyl in Adenoid Operations," by Dr. T. Melville Hardy, of Chicago.

"Surgical Treatment of Acute Inflammation of the Tonsillar and Peritonsillar Regions," by Dr. H. L. Wagner, of San Francisco. *R. Lake.*

THE AUSTRIAN OTOLOGICAL SOCIETY.

Meeting of the 27th April, 1897.

(Translated and Abstracted by Dr. DUNDAS GRANT. "Monats. fur Ohrenheilk.," May, 1897.)

(Continued.)

Dr. FERDINAND ALT. *A Case of Suppurative Median Otitis complicating Epidemic Cerebro-Spinal Meningitis.*

The patient was a boy aged fourteen, who had suffered from meningitis since the 19th March, the diagnosis having been confirmed by spinal puncture. On the twelfth day of the disease the patient complained of pain in the left ear, and the membrane was found to be red, swollen, and bulging, the details being invisible. It was impossible to carry out the paracentesis in such a way as to get absolutely pure pus for bacteriological examination on account of the excitable condition of the patient, so that this examination had to be postponed until spontaneous evacuation had taken place. In fresh stained preparations of the pus from the deeper part of the meatus, Dr. Arthur Schiff found along with other bacteria a large number of the intracellular diplococci, which give rise to epidemic cerebro-spinal meningitis, such as had been found two days previously in the nasal secretion. It was impossible to get pure cultures. The ordinary treatment for suppurative otitis was carried out, and after seventeen days complete healing of the membrane took place with recovery of normal hearing.

Prof. GRUBER stated that he had only seen one case of the same kind.

Prof. POLITZER considered it obvious that the microbes had found their way from the naso-pharynx.

Prof. POLITZER. *On Symmetrical Exostosis of the size of Hemp Seeds, situated at the Inner End of the Meatus.*

The patient was a man affected with catarrh of the middle ear, and at the inner end of the osseous meatus, close to the membrane of

https://doi.org/10.1017/S175514630016562X Published online by Cambridge University Press