lye. After a year the patulousness of the œsophagus was restored by electrolysis and sounds. The œsophagus has had to be twice dilated since, owing to neglect of treatment by the patient. She now returned to have the stomach opened again, stating that she was more comfortable so. Dr. Park, in the course of his remarks, states that he has performed celiotomies and repeated gastrostomy simply under cocaine. The patient eighteen days after the operation was walking about the wards and doing very well, wearing an improved tube in the gastric fistula.

The author makes some remarks upon tubage of the œsophagus, which he evidently does not approve of, and he says "I have not yet seen the case that I thought just fitted for such treatment."

R. Norris Wolfenden.

NOSE AND NASO-PHARYNX.

Wagner (Halle-a-S.). — *Application of Mirrors in Anterior Rhinoscopy.* "Münchener Med. Woch.," 1893, No. 10.

THE author introduces the mirrors used for posterior rhinoscopy into the vestibulum nasi, and can see the under portions of the atrium nasi. If the turbinateds are swollen he diminishes their circumference by cocaine.

Michael.

Shield, Marmaduke.—*Some Common Affections of the Nose.* "The Practitioner," April, 1893.

FOR the proper examination of the nasal cavities, a good light, a mirror, and a suitable speculum are required. Thorough cleansing of the nasal passages, by means of alkaline and antiseptic lotions, is frequently required to remove crusts and inspissated secretions. For posterior rhinoscopy a small mirror bent at a suitable angle is required. The palate may or may not have to be drawn forward by means of hooks, etc. The point of the index finger gently insinuated behind the soft palate will often give more information to the surgeon than the most painstaking examination with the post-rhinal mirror.

In advanced cases of hypertrophic rhinitis the author uses the galvano-cautery or chromic acid fused upon the end of a probe to cauterize the redundant tissue. For posterior hypertrophies he uses the steel wire loop, and subsequent applications of chromic acid.

In atrophic rhinitis the persistent use of alkaline and antiseptic solutions is required. Iodoform or iodol makes a good subsequent application. Packing the nostrils for a short time daily with pledgets of wool, powdered with antiseptic powders or impregnated with antiseptic solutions, gives relief in some cases.

In ozæna it is important to make sure that no foreign body exists in the nasal passages.

In the treatment of ordinary nasal polypi the author uses the cold wire snare for their removal, and subsequent applications of chromic

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acid or a galvano-cautery point. He strongly condemns the "haphazard" method of introducing a pair of forceps into the nose, and pulling away everything the forceps grasps. *W. Milligan.*

Heymann, F. (Berlin).—*Headache in Nasal Disease.* "Deutsche Med. Zeit.," 1893, No. 26.

HEADACHE can be produced by nasal diseases (1) by irradiation, (2) by false localization, (3) by reflex neuroses, (4) by compression of the vessels of the nose. From the existence of such various causes it is natural that many diseases of the nose become capable of producing headache.

Michael.

Macdonald, Greville.—*On Prognosis in Hay Fever.* "The Practitioner," April, 1893.

THE most unsatisfactory cases to treat are those in which no objective disease or malformation of the nasal fossæ can be detected, and conversely the greater the amount of objective mischief the greater the likelihood of benefit following treatment. A favourable condition is where ecchondrosis or exostosis of the septum, or where hypertrophy of the inferior turbinated body is present. Operative interference in these cases frequently proves very beneficial. The treatment of acutely hyperæsthetic tumefactions of the mucous membrane covering the septum also gives good results. The treatment of vascular engorgement of the inferior turbinated body, although not so satisfactory, still affords justification for encouragement.

True polypi are seldom met with as concomitants of hay fever, and when present must be considered the consequence rather than the cause. The symptom most frequently relieved is sneezing, and the accompanying flow of mucus. The restoration of nasal respiration relieves such symptoms as dryness of the throat and hoarseness. The relief of any accompanying asthma is, unfortunately, not so frequent. *W. Milligan.*

Stoker, George (London).—*Soft Fibromata from Nasal Fossæ.* "Brit. Med. Journ.," Mar. 25, 1893.

THE author refers to a lady, past middle life, who, after suffering from pleurisy and pneumonia, became subject to spitting of blood; this, though diagnosed to be of pulmonary origin, really came from the nose. Examination disclosed a papillary growth attached to the middle and inferior turbinals. Removal by cold- and galvano- snare took away all trouble. *Wm. Robertson.*

Spender (Bath).—*On the Immediate Arrest of Hæmorrhage from the Nose.* "Brit. Med. Journ.," April, 1893.

A REFERENCE of some length to a rubber bag (Watson's), inflated after introduction into the nostril. *Wm. Robertson.*

Haring (Manchester).—*Oæna.* "Brit. Med. Journ.," April 8, 1893.

THE treatment recommended was alkaline douches and Gottstein's plugs. Relapses were frequent, it is stated, on discontinuing the treatment.

Wm. Robertson.

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Mayer.—*Complete Occlusion of both Nostrils by Webs of the External Orifice—Operation—Cure.* "New York Eye and Ear Infirmary Reports," Jan., 1893.

ABOUT one and a half inches from the meatus of each nostril a firm membrane was found, causing complete occlusion. The patient, a girl of twenty-two, was suffering from syphilitic ulceration and destruction of the soft palate, and the webs were of specific origin. These were cartilaginous in consistency, and were cleared by the electric trephine. There was no appearance of cicatricial tissue about them. The obstruction had lasted about six months. *R. Norris Wolfenden.*

Mayer.—*Congenital Occlusion of the Right Nostril Posteriorly by a Bony Plate—Operation—Cure.* "New York Eye and Ear Infirmary Reports," Jan., 1893.

OBSTRUCTION of the right nostril occurred in a girl of seventeen. An ecchondrosis of the septum was removed by drilling. Though apparently free from any obstruction to sight, the occlusion was still absolute. A bony wall was then found to run directly across the nasal opening, two and a half inches from the external orifice. Two holes were drilled through it and the obstruction was overcome, breathing being then perfectly free. The two orifices made by the trephine, with an intervening band of bone about one-eighth of an inch wide, could be seen by rhinoscopy. No further measures were considered necessary.

R. Norris Wolfenden.

McCaskey.—*Case of Antral Disease—Electric Light in Diagnosis of Antral Disease.* "Clinical Studies," Vol. I., No. 1.

AN ordinary case in which electric transillumination was of diagnostic value. Two similar instances are mentioned. *R. Norris Wolfenden.*

Scheinmann.—*Cases of Empyema of the Accessory Cavities of the Nose.* Berliner Med. Gesellschaft, Meeting, Mar. 20, 1893.

HE could not confirm the statement that, by illumination of the mouth, the pupil of the diseased side is darker than that of the healthy side. In one case exhibited, a patient for eight years had headache and protrusion of the bulbus. Opening of the frontal sinus was performed. Through pressure by the pus the under wall of the orbital cavity was protruded and carious. Cure resulted. *Michael.*

Beckmann.—*The Nose and Naso-Pharynx, and their Relation to certain Diseases, especially Asthma and Scrofula.* Berliner Med. Gesellschaft, Meeting, Mar. 22, 1893.

RESPIRATION by the mouth in patients whose noses are obstructed from catarrhs or neoplasms renders the respiratory air much less moist than in persons with normal respiration. Diseases of the lungs, therefore, such as bronchial asthma or catarrhs of the pharynx, and extension of these to the ears, are the consequence. *Michael.*

Zaufal (Prague).—*Manual Extraction of an unusually large Fibrous Naso-pharyngeal Polypus.* "Prager Med. Woch.," 1893, No. 11.

A PATIENT, thirty-seven years old, for seventeen years had such trouble in speaking that she could only with the greatest difficulty be understood.

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For fourteen days also she had been unable to swallow. The whole naso-pharynx was filled with a grey, yellowish tumour. By the introduction of two fingers the author was able to remove the whole tumour. No bleeding followed, but some days later hæmorrhage occurred which made tamponing necessary. The tumour had a weight of 112 grammes, a length of 16 centimètres, was 6 centimètres broad, and $3\frac{1}{2}$ centimètres thick. The microscopic examination showed it to have a fibrous structure. It is the largest tumour that has as yet been removed. *Michael.*

Bronner (Bradford).—*Naso-Pharyngeal Disease.* "Brit. Med. Journ.," Mar. 25, 1893.

Dr. BRONNER read a paper on this subject, and insisted on the permanent effects of even passing disease, pointing out that many adult cases of middle-ear deafness showed, in photographs taken in early life, unmistakable evidence of post-nasal growths, which had since vanished. *Wm. Robertson.*

Clarke, Bruce (London).—*Treatment of Lupus of the Face by Free Removal and Skin Grafting with Large Flaps.* "Brit. Med. Journ.," Mar. 18, 1893.

THIS method, employed in six cases, Mr. Bruce Clarke thinks an improvement on mere scraping, which cannot remove all the lesion. In connection with the above, Messrs. Watson Cheyne, Bidwell, Crocker and Balmano Squire reported cases similarly treated. Mr. Bidwell's case was that of a girl aged nineteen, who had a large patch of lupus on the inner side of the tongue, which had been freely excised, and the raw surface covered with Thiersch's grafts, and a good result had been obtained. *Wm. Robertson.*

Bull, C. T.—*Tumours of the Orbit and Neighbouring Cavities.* "New York Med. Journ.," Jan. 21, 1893.

IN a valuable paper, after the detailed relation of nineteen interesting cases, the author reaches the following conclusions:

Tumours of the sphenoid.—When a pathological process is limited to the sphenoid antrum, the subjective symptoms are either entirely absent or there may be severe pain in the head. If the disease spreads, symptoms arise pointing to the sphenoid as the seat of the disease, such as blindness, from compression of one or both optic nerves, and the visible appearance of a growth in the naso-pharynx, ethmoid, orbit, or skull. The entrance of the growth into the cranial cavity may occur without any subjective symptoms, or there may be severe headache. If very rapid, meningitis or cerebral abscess will result. Ophthalmoscopically are found papillitis or atrophy of the optic nerves. Tumours of the sphenoid may perforate the middle fossa of the skull without causing blindness, and this may be unilateral. If an orbital tumour rapidly causes blindness, and the latter starts from the temporal side of the field and leaves the region of the macula lutea unaffected to the last, and if at the same time a growth appears in the naso-pharynx, it is probable that the growth began in the sphenoid antrum.

Tumours of the ethmoid.—A morbid growth confined to these cells gives rise either to no symptoms, or merely to paroxysmal headache. The

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orbital symptoms are the same as those of tumours of the orbit. The motility of the eyeball is limited, vision may be slightly affected, or there may be complete blindness. The visual field may not be involved. If the tumour has entered the naso-pharynx the mouth is more or less open, and speech nasal; later there is loss of sense of smell, there may be more or less continuous dropping of clear fluid from the nose, even in solid tumours, and there may also be orbital or palpebral emphysema and hæmorrhage from the nostrils.

Tumours of the superior maxilla and maxillary antrum.—These may cause pain in the teeth of the upper jaw, dull pain in the antrum or region of the infra-orbital nerve, but not until they have attained considerable size, and nearly filled the antrum. Gradual absorption of the walls of the antrum follows, and a new thin scale of bone is developed from the periosteum. This may occur in the anterior orbital or alveolar wall, and the tumour soon grows towards the nose, and causes great enlargement of the hole communicating with the nasal meatus. These growths are often mistaken for nasal polypi. Subsequently diagnosis is easier, from projection forward of the anterior wall of the antrum, or displacement of the eyeball upward and outward, or inward, and protrusion of the flow of the orbit. A large tumour of the antrum would probably increase the breadth of the cheek, and push the nose towards the opposite side. If the tumour grows from the bone itself the inferior orbital margin is decidedly broadened. Tumours from the antrum itself tend to break through into the nose, mouth, or orbit. They early involve the nasal meatus, and extend into the spheno-maxillary and palatine fossæ and pharynx, and may finally perforate the base of the skull. They usually involve the orbit later, extending sometimes from the ethmoid cells even before the floor of the orbit is perforated. In no case is it possible to diagnose a tumour of the maxillary antrum early in its development.

Tumours of the naso-pharynx.—Tumours of the nasal and pterygo-palatine fossæ may enter the orbit through the intra-orbital fissure. They cause neuralgia of the infra-orbital or posterior alveolar nerves. They may involve the orbit, and extend into the cranial cavity in two branches. They eventually extend into all the neighbouring cavities. As to treatment, it is absolutely necessary that these growths should be completely extirpated early, together with all surrounding tissues, and the bony walls. If they have invaded the deep bones of the face and base of the skull, including the cavities, they are hopeless, and operation, though relieving temporarily, undoubtedly hastens the fatal termination.

R. Norris Wolfenden.

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