tonsils in the acme of disease by means of the tonsillotome. This operation was absolutely without ill effect to those patients, which also would speak against the diphtheritic origin of this disease. If excision of the hypertrophied tonsils during the existence of the pathological process must be generally considered as contra-indicated, so this operation, as a prophylactic method, in my opinion, is not to be condemned.

In most of my cases previous tonsillotomy, or excision of the tonsils by means of the galvano-caustic snare (*vide* my paper, "Quelques "remarques sur l'emploie de l'anse galvano-caustique dans l'hypertrophie "des amygdales"— Rev. de Laryngol., 1893), was successful. If sometimes after this operation acute lacunar tonsillitis occurred, it was always of slighter degree, which could be best observed in cases where only one tonsil was removed.

LARYNGEAL STRAIN.

By N. C. HARING, M.B. (Lond.), etc.,
Hon. Assist. Phys. Manchester Hospital for Consumption and Diseases of the Throat.

IN reading the interesting discussion on "A Case of Diplophonia" (Dr. Dundas Grant, Brit. Laryng. and Rhin. Associat., Jan. 11th, 1895, and reported in this Journal, March, 1895, p. 209), it certainly seemed to me that certain muscular pareses in relation to voice-overstrain were not fully recognized.

I have observed in many cases of overstrain of the voice the following physical signs[1]: The free edges of the vocal cords are bent towards the middle line, with their convexities presenting to each other. This is only noticeable on phonation, when also it is seen that the cords touch each other at a point just anterior to the middle of their length, and that the anterior and posterior portions are not perfectly approximated. As the anterior portions of the cords are often under cover of the epiglottis, and thus only the posterior gaping of the rima is to be seen, these cases are often classed under the heading of paralysis of the arytenoideus muscle.

The point at which the margins of the cords first touch is exactly the position in which nodes are found, and it is certain that, if there is much use of the cords when in such a condition, the mechanical impact would be sufficient to cause a node, and thus further impair the voice.

The explanation of this condition appears to me to be: that the crico-hyroid muscle, the tensor, is the first muscle to suffer in overstrain of the voice, and that in its weakened condition it cannot fully antagonize its opponents (principally the thyro-arytenoid), and thus, instead of being kept straight, the edge of the cord is allowed to bulge towards the median line.

I think this laryngeal picture of the cords presenting convexities to each other in conditions of laryngeal overstrain is as well marked as that of their concavities in paresis due to catarrh or to neurosis, and should be as well known.

[1] Haring—Nodes of the Vocal Cords. "Manchester Medical Chronicle," Feb. 1895.

https://doi.org/10.1017/S175514630015317X Published online by Cambridge University Press