Abstracts

Laceration of Meatus and Tympanic Membrane produced by a Celluloid Knitting Needle—H. J. BANKS-DAVIS, M.B.—A woman, aged 40, with severe hæmorrhage, continued for several hours: the meatus had to be tightly plugged in order to arrest it. It was venous bleeding, and the question is: "What was the source?" Blood came down the Eustachian tube. The patient is well now, except for vertigo. It is unlikely that the jugular bulb was injured.

Mr J. F. O'MALLEY referred to a similar case of injury to the tympanic membrane, in which there were symptoms of the same kind, though the hæmorrhage was not so severe as in Mr Banks-Davis's case. There was, however, considerable vertigo. He (Mr O'Malley) had often wondered what was the pathological lesion which caused the vertigo.

Sir CHARLES BALLANCE (Chairman) said that he remembered the case of a nurse at St Thomas's Hospital, long ago, whose ear had been syringed by another nurse with a long-pointed syringe, which slipped and went through the tympanum, impinging on the inner wall. The patient fell down as if she had been shot, and had very severe vertigo for a long time; she could not resume duty for eighteen months.

ABSTRACTS

EAR.

Beethoven's Deafness. GEORGE CANUYT, Strasburg. (*Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx*, January 1923.)

In a long and sympathetic article the writer tries to throw some light on this subject by an analysis of Beethoven's personal letters. He touches on the great musician's birth at Bonn in 1770, on his early life and achievements, and describes his characteristics. In 1796, at the age of 26, his ears began to be affected. Tinnitus constantly assailed him, day and night, but until 1800 he kept his affliction secret from even his dearest friends. After this period he sought solace and sympathy by writing to his friends of his trouble, but he became more and more of the recluse. Eventually he was forced to use artificial aids to hearing, and these are still preserved at Bonn. In fifteen years from the onset of his deafness, he was totally deaf. He died in 1827 of an abdominal complaint.

Autopsy revealed much ascites and a hobnailed liver. The pinnæ of the ears were large and irregularly formed, with deep and spacious external auditory meatuses. The Eustachian tubes were open, and

the middle ear and mastoid process were more than usually vascular. The 8th nerve on each side was atrophied and the accompanying blood-vessels were sclerosed. The fourth ventricle at the root of the nerve was also hypervascular. The skull bones were very thick. Differential diagnosis between syphilis and otosclerosis is entered upon, the author concluding in favour of the latter.

Canuyt decides that the great man's genius as a composer, far from being hindered by his deafness, was greatly aided by his being cut off from his kind, allowing his art fully to be developed.

GAVIN YOUNG.

Further Communication on the Symptom of Diminished Calcium-content of the Blood in Otosclerosis, and the Influence of Therapeutical Treatment. HANS LEICHER, Frankfurt a. M. (*Zeitsch. f. Hals-, Nasen-, und Ohrenheilkunde*, Bd. IV., p. 74.)

In most cases of otosclerosis there is a small but definitely manifest diminution in the calcium-content of the blood serum, and in those in whom the calcium-content is not diminished a fall is brought about by the administration of primary (? neutral) phosphate of soda for one or two weeks which does not take place in normal subjects. Calcium diminution, especially when the ionised calcium is very defective, is accompanied clinically by symptoms of mechanical and electrical hyper-excitability and also by disturbances of the vegetative nerve-system, such as nervous stomachic and intestinal difficulties, heat of the head with coldness and moistness of the hands. The original causes appear to be disturbances of the internal secretions or constitutional anomalies. The occurrence of calcium deficiency suggests, as prophylactic measures, the avoidance of pregnancy, chills, sore throats and mental excitement, also the examination of the serum of the children of "otosclerotics." In regard to treatment a distinction is to be made between those in whom the fixed calcium is diminished (with absence of hyper-excitability) and those in whom the defect is in the ionised calcium (usually with Choostek's phenomenon of hyper-excitability). To raise the total calcium-content the writer recommends phosphorus for months or years, and homo- or hetero-plastic transplantation of the parathyroid. For deficiency in ionised calcium the same means are advised with, in addition, calcium by the mouth in the form of large doses of the chloride or (in case of tinnitus) the bromide, and by the veins the chloride or Afenil, or the bromide. Chloride or phosphate of ammonium and ammonium bromide are also recommended. JAMES DUNDAS-GRANT.

Abstracts

Is Nystagmus from Caloric Weak and Strong Stimulation, induced Physically or Physiologically? A. ECKERT, Jena. (*Zeitsch. f. Hals-, Nasen-, und Ohrenheilkunde*, Bd. II., p. 165.)

Kobrak's "weak-stimulation" consists in inducing nystagmus to the opposite side by syringing so small a quantity as 5 c.c. of cold water into the ear. After a varying reaction time (ten to thirty seconds from the beginning of the syringing) the nystagmus appears and lasts for a varying time (sixty to two hundred seconds). Kobrak considers the stimulus as less physical than physiological. Eckert, while attributing considerable interest and value to the weak stimulation, postulates that it must only be used along with other tests. He insists, in opposition to Kobrak, that the stimulus is essentially physical, and in support of this view refers to Maier and Lion's experimental proof of the movement of the endolymph in the semi-circular canals under adequate caloric stimulation.

JAMES DUNDAS-GRANT.

Vaccine Treatment of Affections of the Eighth Nerve and its Terminals. R. LEIDLER and E. STRANSKY. (*Wiener Klinische Wochenschrift*, 11th Jan. 1923.)

The authors comment on the large amount of work that has been done in vaccine-therapy, but the little in which it has been applied to the acoustic system, considering all the many conditions of the acoustic nerve of which Menière's syndrome is often an expression.

The authors have treated a series of fifteen cases with intramuscular injections of Dollkens' vaccine (a form of protein-body therapy). Of these, two were also given intravenous injections of a vaccine of typhoid bacilli starting with a dose of five millions.

Only non-acute cases were treated, and most of them were purely internal ear conditions, but two also had middle-ear catarrh. The dizziness was the first symptom to improve and did so rapidly. It completely disappeared in a third of the cases and markedly decreased in a further third. Tinnitus was much improved in most of the patients, but hearing was only improved in very few and even deteriorated in one or two.

F. C. ORMEROD.

A Labyrinth Poison in Hair Dye (*Paraphenylenediamine*). Dr PAUL LAURENS, Paris. (*Bulletin d'Oto-Rhino-Laryngologie*, July 1922.)

Dr Laurens draws attention to poisoning of the labyrinthine apparatus, both acute and chronic, due to paraphenylenediamine. This is a frequent constituent of hair dyes, usually described as "vegetable," and is known among barbers as "Para." Experiments on animals have shown its poisonous nature, and also that it is

absorbed by the skin: it has apparently a selective action on the labyrinth.

Acute cases usually begin with vague giddiness, sometimes accompanied by nystagmus: tinnitus appears later and is incessant. In the chronic form the same symptoms occur, and gradual deafness ensues, such cases resembling closely classical otosclerosis. In a further group, arterio-sclerosis is associated with the use of the dye.

The author gives notes of eighteen cases. He remarks that this poison must not be forgotten when treating obscure cases of "toxic" labyrinthine disease. The condition improves slowly when the dyeing is stopped. E. WATSON-WILLIAMS.

Osteitis of the Temporal Bone, with Meningitis. H. LAWSON WHALE. (*British Medical Journal*, 24th Feb. 1923.)

For ten days before the case was transferred to the surgeon's care, the classical signs of meningitis were present, with turbid cerebro-spinal fluid containing polymorphonuclear cells but no organisms.

Operation disclosed a perisinus abscess, sinus thrombosis, and an osteitis of the adjacent bone. The jugular vein was not ligated. The patient made a good recovery with slow improvement of a double optic neuritis which had been present from the beginning.

The reporter attributes to the use of bipp much of the credit for the good result. T. RITCHIE RODGER.

The Operative Treatment of Septic Meningitis. H. L. MARTYN (*The Lancet*, 1923, Vol. i., p. 485.)

The author freely quotes Jenkins's paper at the Tenth Otological Congress in reporting the case of a woman, aged 37, with septic meningitis following acute influenzal middle-ear suppuration. The Schwartze operation was performed, the mastoid being of the cellular type. Symptoms of meningitis appeared about nineteen days later. Lumbar puncture showed fluid under pressure, but not turbid. The mastoid incision was then extended by a horizontal incision backwards and the flaps turned down. A wide area of bone was removed upwards and downwards and backwards from the mastoid cavity to expose the outer surface of the temporo-sphenoidal lobe, lateral sinus, and dura mater below the tentorium. The fluid in the posterior fossa was turbid. The dura was incised over the temporo-sphenoidal lobe, and below the horizontal part of the lateral sinus and a narrow spatula passed below and in front of the cerebellum to the cisterna pontis; this resulted in a free gush of cerebro-spinal fluid, turbid and under pressure. Gauze drains were inserted. Immediate improvement resulted and progress was uneventful. Lumbar puncture was repeated three days later. MACLEOD YEARSLEY.

Abstracts

Acute Meningitis of Otitic Origin, with Unusual Complications. J. D. De Lamothe. (*Archives Internat. de Laryngologie*, January 1923.)

The author was called to see a case presenting all the features of a suppurative labyrinthitis with diffuse meningitis of otitic origin. The cerebro-spinal fluid was under tension, was turbid, and contained diplococci. A radical mastoid operation with labyrinthectomy (Neumann) was carried out. An abscess was evacuated in the situation of the saccus endolymphaticus.

On the seventh day after the operation a large portion of cerebral tissue herniated through the dura mater covering the temporal fossa. Lumbar puncture gave a clear cerebro-spinal fluid under low tension and sterile.

In spite of this complication the patient made good progress until the twenty-fourth day, when acute headache supervened, the temperature shot up to 104°, and the patient died.

The author ascribes the cause of death to acute encephalitis and draws attention to the following points:—

1. That the original septic meningitis was cured.
2. That this was probably due to the evacuation of the empyema of the saccus endolymphaticus.
3. That the subsidence of the meningeal phenomena does not necessarily indicate a favourable prognosis.
4. That the cause of the spontaneous perforation of the dura mater was unexplained.

M. Vlasto.

NOSE AND ACCESSORY SINUSES.

Trans-septal Suture in Operations for Ozæna. Dr A. Seiffert, Berlin. (*Zeitsch. f. Hals-, Nasen-, und Ohrenheilkunde*, Bd. I., Heft. 1 and 2, 1922.)

After free opening and clearing out of both maxillary antra through the canine fossæ, a special needle is passed through the upper part of the inner wall of the left antrum and the septum till it enters the upper part of the right antrum; it has a hook at its point, and on to this a silk thread is looped, and one end of it pulled through; the needle is then re-introduced in the lower part of the inner wall of the left antrum and pushed through the septum and into the lower part of the right antrum, where the other end of the thread is looped on to the hook and drawn through into the left antrum. The two ends are then firmly tied together and cut short. They may be left *in situ* for several months if required. This does away with the necessity

for continuous plugging. With this operation can be combined the formation of the intra-antral fistula from the parotid, as devised by Lautenschläger and Wittmaack. JAMES DUNDAS-GRANT.

Contribution to the Treatment of Ozæna. G. SPIESS. (*Zeitsch. für Hals-, Nasen-, und Ohrenheilkunde*, Bd. IV., p. 273.)

This consists in taking blood fresh from the arm-veins and injecting under the mucosa (or perichondrium) of the turbinated bodies and septum. The blood forms a hæmatoma which is not readily absorbed and which assists in narrowing the lumen as well as stimulating the atrophied mucous membranes.

JAMES DUNDAS-GRANT.

Maxillary Sinusitis in the New-Born. By F. J. COLLET. (*Archives Internationales de Laryngologie*, November 1922.)

The author, taking one of his own cases as the text and reviewing a number of others, with references, describes the symptoms, prognosis, and treatment of the above condition.

He states that the maxillary antral infection is always secondary to an alveolar necrosis involving the dental follicles and leading to fistula formation in the alveolar margin.

Treatment should be carried out by incision through the alveolar process and never through the nose, taking care to work as medial as possible so as to avoid injury of the dental germ follicles not involved in the inflammatory process. M. VLASTO.

(*Note.*—Presumably this is the condition which is generally regarded as "Acute Osteomyelitis of the Maxilla in Infants."—ABS. ED.)

PERORAL ENDOSCOPY.

Paralysis of Œsophagus in Botulism. G. WORMS and GAUD, Val de Grâce. (*Bulletin d'Oto-Rhino-Laryngologie*, Paris, January 1923.)

The authors record and illustrate a case of paralysis of the œsophagus occurring in a young soldier, suffering from botulism. Five days elapsed before onset of symptoms, and difficulty in swallowing solids was the first. Diplopia and constipation followed, then paralysis of ocular accommodation. The throat was very dry, but laryngoscopic appearance normal, without paralysis of palate or larynx. The œsophagus was flabby and quite inert. Bismuth paste spread uniformly all down the tube and remained there, showing only the bronchial indentation. Repeated gulps of water were required to wash the

paste down. There was no spasm; bougies and tubes passed more readily than usual. The condition cleared up after two months.

E. WATSON-WILLIAMS.

Foreign Bodies in the Air and Food Passages. C. A. SCOTT RIDOUT, (*Brit. Med. Journ.*, 10th March 1923.)

Five cases are here reported, the first being half of a tooth plate in the right bronchus, the other half having passed through the intestinal tract. The patient was an epileptic.

The other cases were those of foreign bodies in the upper part of the œsophagus, viz., a drawing-pin, a mass of fish-bones, a meccano wheel and a tooth plate with pointed lateral extremities.

The last-named could not be removed by endoscopy and was extracted by external operation by an unusual route. The incision was made in the middle line of the neck, the thyroid isthmus divided and the left lobe of thyroid retracted, the œsophagus being entered on its antero-lateral aspect. T. RITCHIE RODGER.

Report on an Upholsterer's Tack in the Right Main Bronchus for Seven Years. Removal by Peroral Bronchoscopy. Drainage of Lung Abscess. Recovery. J. D. KERNAN, New York. (*Laryngoscope*, Vol. xxxii., No. 2, p. 102.)

The patient's symptoms suggested tuberculosis, but no tubercle bacilli were found. Two X-ray examinations failed to assist diagnosis. Eventually hæmoptysis developed, and on being questioned the patient admitted having aspirated a foreign body seven years ago. Another X-ray examination revealed a shadow suggesting a tack, with its point upward, near the base of the right lung, close to the spine, and behind the heart shadow. On peroral bronchoscopy under local anæsthesia, the right bronchus was found to be almost occluded by granulation tissue. Forceps were introduced, the lumen dilated, and a 7-mm. tube pushed into an abscess cavity. Here the tack was found and removed. Operation lasted forty minutes. Hæmoptysis ceased and recovery followed. ANDREW CAMPBELL.

Combined Transpleural and Transperitoneal Resection of the Thoracic Œsophagus and the Cardia for Carcinoma. CARL A. HEDBLOM, M.D., F.A.C.S., Rochester, Minnesota. (Section on Surgery, *Mayo Clinic.*)

In May 1922, Hedblom resected the thoracic œsophagus and the cardiac portion of the stomach for carcinoma. The patient, a male aged 52, survived, and a month later was reported to be taking food slowly by the mouth with the aid of an anastomotic tube. The

operation was performed in two stages under local and nitrous-oxide-oxygen anæsthesia on both occasions.

First Operation.—Resection of the fifth to the eleventh ribs from the angle to the costal cartilage on both sides.

Second Operation.—An incision was made to the left of the middle line below the level of the costal cartilages and extending outward and upward to the level of the fourth rib in the mid-axillary line, and the pleural cavity was opened. The diaphragm was split down to the hiatus, and the pleura incised and opened; the right vagus was separated and the left divided. The lower portion of the œsophagus was mobilised, and it, together with the cardiac portion of the stomach, was resected by the actual cautery. The stomach was closed off and brought into the lower part of the wound and opened a few days later. The œsophageal stump was sutured to the depressed skin edges and the skin closed over, with drainage. Subsequently the two fistulous openings were joined by a rubber tube during feeding.

In discussing the case the author draws attention to the impossibility of bringing the divided upper end of the œsophagus down to the stomach and notes that all recorded cases of an attempted end-to-end anastomosis have failed. He also notes the difficulty in mobilising and resecting the œsophagus sufficiently to bring it out through the skin, but fortunately the vascular supply was sufficient to maintain its nutrition in this case.

The article is completed by a good bibliography.

E. MUSGRAVE WOODMAN.

MISCELLANEOUS.

A Feather in the Parotid Duct. Sir J. DUNDAS-GRANT, K.B.E., M.D. (*Brit. Med. Journ.*, 10th March 1923.)

The patient, a small child, had a large painful swelling in the right parotid region, and could not open the mouth. The tip of a feather, presumably from the child's pillow, was found protruding from Steno's duct. The feather, when removed, was an inch long. The abscess was incised, and healing took place quickly.

T. RITCHIE RODGER.

Dental Cysts of the Mandible. By Dr JACQUES, Nancy. (*Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx*, January 1923.)

The type of cyst is benign and fluid-containing, and develops in the body of the mandible in connection with a tooth. There are two types, showing different relations to the teeth; one is associated

with a diseased tooth and is the product of inflammation, being in relation originally to the root. The other is formed at first on the crown of a sound tooth, and is the result of a developmental error. Clinically the types are indistinguishable. Less than 5 per cent. of all dental cysts seen by Jacques were in the mandible.

Treatment consists in evacuating the cyst contents along with the lining membrane. In the case of cysts of small or medium size, a certain amount of the surrounding bone is also removed. Where the cyst is large, æsthetic considerations arise, and due care is taken to preserve as much of the bony framework as is possible. Operation in these cases consists in an intrabuccal incision over the salient part of the swelling, removal of sufficient bone to evacuate the contents, puncture through the most dependent part of the cavity into the subgenial region, and closure of the buccal opening. Good results are said to be obtained in from one to three months. Two typical cases are instanced. GAVIN YOUNG.

An Experiment in Graduate Training in Oto-Laryngology. By GEORGE E. SHAMBAUGH, M.D., Chicago. (*Journ. Amer. Med. Assoc.*, Vol. lxxix., p. 5, 29th July 1922.)

The writer outlines the preliminary training in Oto-Laryngology which is given at the Rush Medical College to students who desire to take up this specialty. The course lasts one year, and the student is then advised to take an appointment as *interne* at a special hospital. Facilities are offered to him to do work at the University of Chicago in the afternoons, on the subjects anatomy, physiology, pathology, etc. It is suggested that the other Class A Medical Colleges should take up the training of specialists and grant a degree to show that these men have completed a definite training in Oto-Laryngology.

PERRY G. GOLDSMITH.