face of the petrous bone and middle ear. In the case to which M. Laurens referred the recovery of the patient was due entirely to dissection of the deep surface of the muscles of the neck.

M. Cauzard had had the opportunity in the previous June of operating on a deep phlegmon of the neck of mastoid origin, extending from the border of the trapezius to the hyoid bone under the sterno-mastoid. The ear had run for a short time, but had got well, and the tympanum had closed. The mastoid, which was to all appearance normal, was scarcely sensitive. M. Cauzard had to make an almost complete resection of the mastoid, then two incisions for the purpose of drainage, the first behind the root of the neck, between the trapezius and the sterno-mastoid, and the second in the sub-hyoid region. Recovery took place in two and a half months.

G. Veillard (D. G., transl.).

# Abstracts.

## PHARYNX.

**Williams, P. Watson.**—*Note on a Case of Fenestration of the Anterior Pillars of the Fauces.* "Lancet," January 25, 1908.

The writer considers the condition congenital on account of: (1) The absence of any cicatrices or unevenness in the margins of the fenestræ; (2) the bilateral symmetry of the malformation; (3) the arrangement of the strands of mucous membrane and the muscle-fibres, and that they obviously correspond to the anterior pillars of the fauces; and (4) the fact that although the posterior faucial pillars do not show fenestration, yet the palato-pharyngeus muscles are collected into a separate bundle of fibres on each side, with only a thin layer of mucous membrane in continuity with the lateral walls of the pharynx. Thus, in front the palato-glossus muscle forms a separate bundle, passing down to the tongue, and forms the inner boundary of a fenestra on each side, while the palato-pharyngeus forms the inner boundary of a thin web of mucous membrane.

A possible explanation of these fenestrations is that the condition of the anterior faucial pillar was similar to that shown in the posterior pillar until scarlatinal angina caused the thin web of mucous membrane to ulcerate, leaving the strands of palato-glossus muscle seen in later life.

*StClair Thomson.*

**Gleason, E. B.** (Philadelphia).—*Treatment of Hypertrophy of the Faucial and Pharyngeal Tonsils.* "Med. Bull.," December, 1907.

Gleason deprecates removal of adenoids when there is good nasal respiration after the nose and naso-pharynx have been cleansed of mucus, or when there is only occasional obstruction to nasal respiration from swelling of the third tonsil as the result of a coryza. In such cases he

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advises breathing exercises. When the growths are not large they should be painted with iodine by the surgeon two or three times a week, and the parents shoul l cleanse the nose night and morning with an atomiser containing an alkaline wash, and then place in the nostrils a piece of gallic acid ointment (1 or 2 per cent.) while the child lies on its back. When the hypertrophy is great he operates but avoids chloroform.

*Dundas Grant.*

**Howell, C. M. H.**—*Case of Paralysis of Palate and Vocal Cords in Tabes Dorsalis.* "Neurol. Sect., Roy. Soc. of Med.," March 12, 1908.

The patient, a labourer, aged twenty-six, married, had two children, his wife had no miscarriages. He admitted syphilis seven years ago, and was treated for two years with pills and gargle. Otherwise healthy. For the last year had noticed his speech had changed, *i. e.* become more nasal. For some time the left eyelid had "drooped" more than usual, though it had always had a tendency to do so. Occasional regurgitation of fluid through nose. For the last nine months had had occasional attacks of dyspnœa; woke at night sometimes and had difficulty in getting his breath. Occasional diplopia for last two years. Legs easily tired. The patient was a thin man with bilateral ptosis, most marked on left side. The pupils were equal, and they reacted briskly on accommodation, but not to light. No defect in visual acuity and fields normal. Ocular movements good. Ninth, tenth, eleventh cranial nerves: double palate paralysis, double abductor paralysis of vocal cords. Sterno-mastoids and trapezii were unaffected. Upper and lower extremities possessed fair power, no incoordination or ataxy; gait natural. Reflexes: knee-jerk could be obtained on right side with reinforcement; easily on left; ankle-jerks not obtained; sphincters natural. No pains beyond some aching in the back of his neck; analgesia of legs; no tactile anæsthesia.

*Dundas Grant.*

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## NOSE AND ACCESSORY SINUSES.

**Wingrave, Wyatt.**—*Spirographs of Nasal "Breath Pictures."* "Lancet," January 26, 1907.

The practice of testing nasal patency by breathing upon a prepared surface is by no means new, but its usefulness has been somewhat restricted by the want of a satisfactory material. Slate, glass, and polished metals all have their shortcomings, but I have now found that vulcanite, with a medium polish, gives a very reliable and faithful image. By placing the plate horizontally on the upper lip half an inch from the nostrils, and giving one short and steady expiration, a well-defined steam impression results, and evaporating affords reliable and striking evidence of the actual and relative patency of the nostrils. The image may be temporarily fixed or rendered more conspicuous for demonstration purposes by lightly powdering it with calcined magnesia or fine starch. Small sheets of vulcanite, with a suitable surface, and of a convenient size, are supplied by the Medical Supply Association, 228, Gray's Inn Road, London, W.C.

*StClair Thomson.*

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