

portionate number affected with paralytic and other disturbances of the larynx, (2) the nature of such disturbances, and (3) the period of their occurrence in the course of the disease. Out of the sixty cases, nine, or 15 per cent., presented undoubted laryngeal complications. In six (10 per cent.) there was paralysis of one or both cords. Seven (12 per cent.) had laryngeal crises. These crises occurred among the earliest symptoms, and two of them led to the detection of the tabes. Both these cases are described in full. *Macleod Yearsley.*

### ŒSOPHAGUS.

**Neumayer, H.**—*The use of the Œsophagoscope in Diagnosis and Treatment of Foreign Bodies in the Œsophagus.* "Monats. für Ohrenheilkunde," July, 1905.

The author gives a carefully detailed account of twenty-four cases of foreign body in the œsophagus which have occurred in his practice during eight years.

In treating them, he first, by a thorough examination of the neck, chest, pharynx, and larynx, endeavours to locate the foreign body; if it is of metal or bone, X rays are used; in many cases, however, the shadow made by the vertebral column prevents a definite result by this method. For the introduction of the œsophagoscope in adults, local anæsthesia of the pharynx, obtained by painting or spraying with a 10 per cent. solution of cocaine, is generally found to be sufficient; in children a general anæsthetic is necessary.

The patient lies on his back with his head hanging over the edge of the table, and supported by an assistant. For adults the Mikulicz-Hacker tube is used, for children Killian's tube for bronchoscopy; a soft bougie may be used as a pilot. Any mucus or vomit which may obstruct the view is removed by wool swabs, or by tilting the table on which the patient lies so that the fluid flows out through the tube.

The patients were of all ages from sixteen months up to seventy years. Of the twenty-four cases, the foreign body was definitely located in twenty-one. In all the other three it had passed into the stomach either before the examination or during the vomiting movements caused by the introduction of the tube. Of the twenty-one cases in which the foreign body was located, extraction by means of the œsophagoscope was successful in nineteen. In several cases the foreign body was too large to be removed through the tube; when, therefore, it had been firmly seized with forceps, the tube and foreign body were withdrawn together. In two cases only could the impacted foreign substance not be removed: (1) A man, aged twenty-five, with a large piece of bone impacted opposite the cricoid cartilage; owing to the extreme swelling of the walls of the œsophagus it could not be dislodged. Œsophagotomy was performed and the mass removed with some difficulty. Five days later the man died of secondary hæmorrhage. (2) A man, aged twenty-eight, swallowed a tooth-plate during sleep, and was seen by the author three days later after some effort had been made to push the plate into the stomach. Patient's temperature was 103° F. The plate was seen imbedded in the œsophageal wall, surrounded by intense inflammation. An attempt at removal was unsuccessful. Œsophagotomy was performed, and the plate extracted. The patient died in twenty-four hours. At the autopsy septic pericarditis was found, and the entire mediastinum was infiltrated with pus.

The author finds it much more difficult to deal with foreign bodies

lodged at the level of the cricoid cartilage than when lower down, as in the former position the presence of the tube invariably caused reflex movements, which are absent when this region has been passed. No bad after-effects were seen in any case from the use of the œsophagoscope, and unless the wall of the œsophagus had been damaged the patient was able to swallow solid food immediately after the removal of the foreign body. Œsophagoscopy is, therefore, not only the safest method that exists for diagnosing the presence of foreign bodies in the œsophagus, but also, under the guidance of the œsophagoscope, in by far the majority of cases a satisfactory removal of the foreign body may be secured.

*Knowles Renshaw.*

### E.A.R.

**Hammond, P.**—*Brain Abscess, Operation, Recovery.* "Boston Med. and Surg. Journ.," January 25, 1906.

Male, aged forty. A straightforward case of temporo-sphenoidal abscess of otitic origin. Operation was carried out through the ear, and the abscess was drained by means of gauze by that route.

*Macleod Yearsley.*

**Crockett, E. A.**—*A Case of Acute Meningitis, Operation, Recovery.* "Boston Med. and Surg. Journ.," January 25, 1906.

Female, age not stated. Right discharge from childhood. Nine months previous to consultation severe head pain, with mastoid tenderness. Second attack three months later, with nausea, vomiting, and vertigo. Nine weeks before consultation pain in ear and paracentesis attempted. Two days before admission severe headache and loss of consciousness, lasting twenty minutes. On admission she was semi-comatose, with nausea, vomiting, and severe occipital, frontal, and right parietal headache. Temperature 102° F. Double optic neuritis. Foul pus coming from right ear, which contained a large polypus. Operation was at once undertaken. Communication between middle ear and middle fossa was found, and on opening the dura mater pus could be seen on the vessels on the brain surface. Nothing was found on probing the brain. The cranial cavity was drained through the ear with gauze, and the patient made a rapid and uneventful recovery.

*Macleod Yearsley.*

**Hitz, H. B. (Milwaukee).**—*Double Mastoiditis complicated by an Intercommunicating suboccipital Abscess.* "Arch. of Otol.," vol. xxxiv, No. 6.

Acute otitis in one ear called for the Schwartze operation, and pus disappeared, except from one spot on the floor of the tympanum. Stiffness of the neck appeared, and deep pressure caused the pus in the tympanum to well up. A suboccipital abscess of the Bezold variety was discovered and opened. During manipulation in the suboccipital region a discharge appeared in the opposite ear, and the abscess was found to communicate with both ears, the onset of the inflammation in the second ear having occurred without any of the classical symptoms.

*Dundas Grant.*

### THERAPEUTIC PREPARATIONS.

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