

Deviation of the Trachea.—In three of these cases deviation was not marked, such slight deviation being the usual condition found in malignant disease. The greatest was 1 inch. In the fourth case—the (?) giant-celled sarcoma—the deviation of the trachea from the midline was 2 inches. Pain was not a prominent sign in either of these cases; two patients complained of slight neuralgic pain situated in the neck, and radiating up towards the ear and down towards the chest. Dysphagia and dyspnœa were present in three cases.

Ingrowth into the Trachea.—This is comparatively common, and takes place usually from $\frac{1}{2}$ to 1 inch below the cricoid cartilage. In the second of these cases the larynx had been invaded and the mucous membrane was ulcerated. In the fourth (the myxœdematous) case there was distinct infiltration of the submucous tissue of the larynx and the trachea. This extended for a distance of $1\frac{1}{2}$ inches, and resulted in a fusiform elevation; it extended above and below the cricoid, and seemed to have enveloped, if not to have destroyed, the cartilage. There was no obvious loss of tissue—*i.e.*, ulceration—over it.

The consistence of sarcoma generally is softer than is that of carcinoma of the thyroid. One of these cases was described as stonily hard, one as firm and elastic, and the other two as hard.

Complete fixation of the mass to deep structures was found in three cases.

The Carotids.—In two cases the carotids were embedded in the growth. In the third case the vessel lay at the posterior border. In the fourth case the vessel lay at the outer border, below the growth.

StClair Thomson.

E A R.

Mounier.—*Suppurating Glands of the Neck simulating Otitis.* "Archives Internationales de Laryngologie," etc., May–June, 1902.

The author describes a case as follows: A child, two years old, recovering from scarlet fever, had pain and swelling over the mastoid, causing the ear to be very prominent, also discharge from the ear.

After cleaning out the external meatus the membrane was found intact, but in the anterior inferior wall an opening was found which communicated with some suppurating glands of the neck.

The treatment, which cured the patient in about a fortnight, was gentle pressure on the source of the suppuration to expel the pus and repeated antiseptic washing.

Anthony M'Call.

E. W. Roughton.—*Exploration of the Cerebellum and Drainage of a Cerebellar Abscess during Artificial Respiration.* "Lancet," July 26, 1902.

The reason for calling attention to this case is that the diagnosis of cerebellar abscess is still a matter of difficulty, and the localization is of still greater difficulty. The whole operation was performed during the maintenance of artificial respiration, and the necessity for the performance of the latter was abolished as soon as the abscess was opened. The interesting points of the case are as follows:

1. *The Difficulty of Diagnosis.*—For ten days the patient was under

observation, and his only constant symptom was abnormal slowness of the pulse. The headache, mental slowness, deafness, vomiting, and tenderness over the mastoid all improved; then vomiting, subnormal temperature, giddiness, and increased mental dulness came on.

2. *The Localization of the Abscess.*—The points given by Acland and Ballance, quoted in Jacobson's "Operations of Surgery," are: (1) Paralysis of the upper extremity on the same side; (2) conjugate deviation of the eyes to the opposite side; (3) lateral nystagmus; (4) exaggerated knee-jerk on the side of the lesion; (5) a tendency to face towards the side of the lesion in walking; (6) staggering gait, and a tendency to fall towards the side opposite to the lesion; and (7) attitude in bed, the patient lying on the side opposite to the lesion. Of these different symptoms, there were absent in the present case paralysis of the arm, conjugate deviation of the eyes, and lateral nystagmus. The patient was never examined as to his gait. So the only localizing symptoms were: (1) Exaggerated knee-jerk on the left side, and (2) inability to lie on the right side. The former turned out to be accurate, but the latter did not.

3. *The Anæsthetic.*—The fact of the pulse-rate increasing from 42 to 120 the author can only explain as due to pressure on the vagus centre, rendering it more easily inhibitable by chloroform than when it is in a normal condition. Whether a different result might have been brought about if no anæsthetic had been given is to be considered. Where there is so much pressure upon the medulla, it may be that the depressing influence of the anæsthetic is sufficient to upset the already precariously kept balance. On the other hand, it would not be easy to explore both sides of the cerebellum with local anæsthesia, though it might be worth trying. It has been asserted recently that chloroform always produces heart failure before respiratory failure. In this case there seems little doubt that chloroform precipitated the respiratory failure without interfering greatly with the action of the heart.

4. *The Respiration.*—The beginning and carrying through of the whole operation, in spite of the patient making no attempt at breathing, was amply compensated for by the immediate return of activity in the respiratory centre when the abscess was opened. One other point as to the cause of death is whether the cavity being emptied quickly caused œdema to occur in the medulla oblongata when the pressure was suddenly relieved; whether it would have been better to allow the cavity to empty very slowly, so that vessels with their walls paralyzed by pressure might have time to recover. *StClair Thomson.*

BOOKS RECEIVED.

- Ottokar Chiari, M.D.** *Die Krankheiten der Nase.* Franz Deuticke, Leipzig u. Wien. 1902.
- Robert Saundby, M.D.** *Medical Ethics: a Guide to Professional Conduct.* John Wright and Co., Bristol.
- Jonathan Wright, M.D.** *The Nose and Throat in Medical History.* The Laryngoscope Co., St. Louis, Mo., U.S.A.