Carter, W. W.—Transplantation of Bone for the Correction of Depressed Deformities of the Nose. "Laryngoscope," February, 1911, p. 94.

The author has treated successfully three cases of depressed nasal deformity with loss of bone by autoplastic transference of bone. A piece of the ninth rib free from periosteum and about 2 in. in length is removed from the patient and a suitable piece of the outer compact layer split off and shaped. Through a transverse incision over the naso-frontal suture the skin and subcutaneous tissues are elevated with a thin curved two-edged knife and the graft inserted. The inserted fragments can be shown by the X rays to persist. *John Wright.*

LARYNX.

Citelli, Prof. (Catania). — Intubation and Tracheotomy in Acute Laryngeal Stenosis in Children. "Zeitschr. f. Laryngol., Rhinol., etc.," Bd. iii, Heft 3.

This is a contribution to the old question, intubation *versus* tracheotomy. The author thinks that those who uphold one method only go too far, and that the operations are not really opposed—they are complementary; in fact, Citelli believes in the combination of both methods in many cases. In urgent cases of diphtheria the author believes in intubation, but says that in many cases this proceeding must be followed later by tracheotomy on account of stenosis of the larynx remaining after the disease has passed off. Tracheotomy is also indicated in cases of repeated spontaneous extubation. The most common cause of stenosis is swelling of the subglottic region with or without ulceration; if the tube be removed in these cases the dyspnœa recurs as a rule in a few hours, but it may not come on for five or eight days. In cases of chronic stenosis laryngotomy may be indicated, but Citelli advocates his own method—tracheotomy combined with the introduction of a small laryngeal tube through the tracheotomy wound. Citelli again calls attention to the fact that after tracheotomy stenosis is usually due to the incision having been made through the cricoid cartilage; this leads to subglottic œdema or to granulation-tissue formation. He narrates a diphtheria case in which tracheotomy was performed by another surgeon; after eight days the tube was removed, but had to be replaced. The tube was again removed, but the child soon began to have dyspnœa. On laryngeal examination Citelli saw a cicatricial ring below the cords at the lower border of the cricoid which had been cut at the operation; he treated the case by introducing an intubation tube, and only removed it fourteen days later; complete recovery.

In cases of stenosis following diphtheria, measles or typhoid, Citelli recommends intubation. The tube should be left in position for twenty-four hours. If symptoms recur the tube should be again introduced, and then tracheotomy slowly and carefully performed, the incision passing through the second and third tracheal rings; by this method the intubation tube can be introduced through the tracheal wound if necessary. In other cases in which the intubation tube is spontaneously coughed out on several occasions, it is advisable to perform tracheotomy at once. Finally, if the surgeon cannot remain near the case, both intubation and tracheotomy are indicated. By these methods laryngostomy with its troublesome after-treatment may often be avoided. *J. S. Fraser.*

Blumenfeld, Felix (Wiesbaden).—The Pathological Anatomy of the Vocal Cords "Zeit. f. Laryngol., Rhinol., etc.," Bd. iii, Heft 3.

The author first describes a rare *post-mortem* specimen of carcinoma of the vocal cord. The tumour had extended in the antero-posterior direction, following the edge of the cord. Blumenfeld points out that epithelial tumours follow the lymphatics and that this accounts for the peculiar method of spread in cases of cancer of the true cord such as the one he records. The free border of the vocal cord consists of a tough elastic network covered with squamous epithelium. There are no glands and very little submucous connective tissue. Below the cords, however, and also in the region of the ventricle these structures are freely present. The lymphatic spaces of the vocal cords themselves are bounded above and below by the superior and inferior arcuate lines of Reinke, along which the fascia of the thyro-arytænoid muscle is attached to the cord. In the case recorded by Blumenfeld the boundaries of the tumour corresponded to these arcuate lines. Logan Turner has shown that the upper surface of the vocal cord can be injected, and that, if the pressure be increased, the subglottic part of the cord also becomes swollen, the same thing happens in the reverse order if the injection be made into the lower surface of the true cord. Most states that the lymphatics of the cord are very scanty and that they seem parallel to one another along the cord. The free edge of the cord cannot be injected. Blumenfeld states that rare cases are met with in which cancer of the vocal cord rapidly extends beyond the limits of Reinke's lines (which also correspond to the junction of squamous with cylindrical epithelium). As a rule, however, the growth extends round the anterior or posterior commissure to the other side, thus giving us the "ring" form of cancer. A similar ring-like spread of cancer is seen in the œsophagus and intestine, but it is never so circumscribed as in the case of the vocal cords. It is well known that cancer affecting the ary-epiglottic folds, the inter-arytænoid region, or the pharyngeal surface of the larynx is of bad prognosis because of the rich lymphatic system in these parts. Blumenfeld goes beyond Krishaber and divides cases of intrinsic carcinoma into (1) those affecting the vocal cords, and (2) those affecting the other intrinsic parts of the larynx. The latter are much less favourable, not only on account of the freer lymphatic circulation but also because the type of growth is different. B. Fränkel and others have operated successfully by intra-laryngeal methods on cases of cancer of the vocal cord. Blumenfeld believes that a case such as he has recorded would be suitable for this method. He also states that pedunculated adeno-carcinomata and cases in which only the free border of the epiglottis is affected are also suitable for endo-laryngeal removal. Finally, the author notes that the anatomical conditions to which he calls attention may be of importance in cases of laryngeal tuberculosis. The paper is well illustrated. *J. S. Fraser.*

Carter, W. W.—An Unusual Case of Papilloma of the Larynx. "Laryngoscope," February, 1911, p. 102.

The patient, a male, aged forty-seven, had suffered from "croup" on several occasions as an infant, and also had warts on his hands. From the age of five his voice had been reduced to a whisper, and he suffered from dyspnœa on taking any active exercise. At intervals he coughed up small pieces of tissue "like cauliflower." His condition was looked upon as asthma until he reached the age of forty-five, when his larynx was examined and found to be almost filled with papillomatous masses, the

largest acting as a ball-valve. No treatment was employed until he came under the care of the author two years later with an acute attack of dyspnœa, which was relieved by steam and adrenalin inhalations. The growths, which grew from all parts of the larynx, including the commissures, were removed with a snare by the indirect method and the bases cauterised. When the case was shown the voice had not returned, and it was too soon to say if there would be a recurrence, but the author emphasised the length of time which the condition had persisted, and also the ease and safety with which the growths were removed with the snare. *John Wright.*

Dencker, H. (Frankfurt-a-Main).—A Foreign Body in the Right Pyriform Sinus simulating Tuberculosis or Tumour. "Zeitschr. f. Laryngol.," Bd. iii, Heft 3.

The patient was a man, aged fifty-one, who complained of pain on swallowing and hoarseness of six weeks' duration; cough and expectoration were also present, but the dyspnœa was slight. The cause of the trouble was unknown. Laryngoscopy showed marked œdema of the posterior wall of the larynx and of the right arytænoid region; the false cords were also swollen and the lumen of the larynx narrowed, so that the vocal cords could not be seen. Auscultation revealed only slight bronchitis. Dencker thought that tumour-formation or tuberculosis underlay the condition, and therefore removed pieces from the swollen arytænoid region for microscopical examination; the report, however, only stated "chronic subepithelial inflammation." Direct examination showed only swollen ventricular bands. One month later the patient returned complaining of a marked tendency to cough, and on laryngoscopic examination a yellowish-brown body was seen in the larynx lying in the sagittal direction. On removal this turned out to be a wooden peg used in preparing rolled herring. The patient then remembered that he had celebrated the Kaiser's birthday six weeks before his first visit, and had, along with a considerable quantity of alcohol, partaken of rolled herring. Dencker thinks the peg must have been in the pyriform sinus; if it had been in the ventricle the patient would have had more cough.
J. S. Fraser.

Evans, Arthur.—A Subsequent Report on a Case of Excision of the Larynx, Lower Part of the Pharynx, and Upper End of the Œsophagus for Malignant Disease (Squamous celled Carcinoma) of these Structures. "Proc. Roy. Soc. Med.," April, 1911 (Clinical Section).

The case was at first considered inoperable, but later Mr. Evans was prevailed upon to attempt the removal of the growth. Details of the first operation were given in the "Proc. Roy. Soc. Med." (Clinical Section) 1910, pp. 44–47. At the time of the second operation the patient had in the lower part of the neck a fistula, which showed a tendency to leak and caused discomfort. Mr. Evans closed this fistula and made a new one immediately below the hyoid, lining the walls of the new sinus by means of four skin-flaps. The new opening worked well, and seven months later the patient got married. She can now take a meal in a crowded dining-room without attracting observation, and can make herself understood in a forced whisper. *J. S. Fraser.*