

Carroll, J. J.—Cartilaginous Tumours of the Larynx. "Annals of Otol., Rhinol., and Laryngol.," vol. xx, p. 807.

Contains a good bibliography and tabulates ten cases from various sources, including one by the author, occurring in a man, aged thirty-four. Carroll pleads for uniformity of nomenclature, and suggests that enchondroses of the larynx are not real tumours, are benign in character, and doubtful in aetiology. *Macleod Yearsley.*

Wallece, W. T. (Berlin, Ontario).—A Case of Epithelioma of the Larynx. "The Canadian Practitioner," May, 1911.

The patient, male, aged forty-six, stout, heavily built, neck short and thick, was examined on July 20, 1906. He complained of hoarseness, pain, cough, dyspnoea and dysphagia.

Father died at the age of eighty, mother at the age of fifty. Causes of death indefinite. An elder brother died of malignant disease of larynx, which had its origin in one of the vocal cords.

Patient was a heavy smoker. No history of any previous trouble. Hoarseness of one month's duration, gradually increasing. On examination, a fusiform thickening of anterior part of left vocal cord presented itself, shading off gradually into normal cord substance. A few blood-vessels could be seen coursing over the tumour. Cord movements sluggish, but approximating as closely as the tumour would allow. Larynx otherwise normal.

Diagnosis of epithelioma was made by elimination, tuberculosis and syphilis being negatived. Section of growth was removed by endolaryngeal route and microscopical examination confirmed the diagnosis.

The patient consenting to thyrotomy, a long incision was made through the thick subcutaneous fat. And the thyroid split open with stout turbinate scissors, hæmorrhage being controlled by holding open the sides of the thyroid with retractors. Local application of cocaine and adrenalin were then substituted for the chloroform. The cord affected, together with one quarter of an inch above and below it, and a piece of the adjacent cartilage were next excised, and the wound sutured through the severed sections of the perichondrium of the thyroid, a small gauze drain being inserted.

Tracheotomy was not considered necessary.

Subsequent to operation there was little difficulty on swallowing. Liquid nourishment was given. The wound healed promptly and a fibrous band formed in place of the excised cord. The patient made a good recovery and has a strong guttural voice. *Price-Brown.*

NOSE AND NASO-PHARYNX.

Yearsley, Macleod.—A Case of Median Dermoid Cyst of the Nose. "Brit. Journ. Child. Dis.," vol. ix, p. 160.

A child, aged five. Swelling in median line of nose, noticed two years and increasing in size. Soft and elastic and measuring 1 in. by $\frac{3}{4}$ in. Dissected out and found to be attached to nasal bones at junction with lateral cartilages. Contained a greyish, putty-like material and was lined with fine white hairs. *Author's Summary.*

Freer, Otto T.—The Inferior Turbinate: Its Longitudinal Resection for Chronic Intumescence. "Laryngoscope," December, 1911.

The so-called hypertrophy of the inferior turbinate is in reality a condition of vascular distension due to a vaso-motor relaxation of the muscular coats of the cavernous venous spaces, as is shown by the retraction on the application of adrenalin. True hypertrophy is a much less common condition, and is recognised by the firm nodular condition of the mucous membrane with the absence of retraction with adrenalin.

This persistent venous engorgement is due to either—

- (a) A general sluggishness of the circulation;
- (b) Some local vaso-motor condition, such as hay-fever or vaso-motor rhinitis, or most frequently to
- (c) The presence of some fundamental nasal obstruction, so that during inspiration a suction action is exerted on the mucosa.

Where possible the causative obstruction should be removed, but if due to a general insufficiency of the nasal passages the turbinates must be reduced in size. This can be accomplished by the partial turbinectomy usually employed, but the author has for years used the following method, which has the advantage of not leaving a ragged stump to cause crusting and epistaxis.

A vertical incision is made over the fore-end of the turbinal with a myringotome and the muco-periosteum elevated with the same instrument from the greater part of the convex turbinal surface. This elevation is completed to the posterior end with a sharp elevator, and the muco-periosteum is then incised along the whole of the lower margin down to the bone, thus making a flap. This flap is turned up, the turbinate bone removed close to its attached margin with a chisel, and the flap replaced and kept in position with tampons for two days. Healing is by first intention, and the final result a free nasal passage from end to end with the stump forming a miniature turbinal.

A. J. Wright.

Friedrich, Prof. (Kiel).—Post-operative Rhinitis Sicca. "Zeits. f. Laryngol.," Bd. iv, Heft 3.

There are three causes of post-operative rhinitis sicca: (1) The galvano-cautery; (2) removal of the inferior turbinal; (3) resection of the middle turbinal and lateral mass of the ethmoid.

(1) The electric cautery should only be used in cases of intermittent engorgement of the turbinal, and should never be employed to destroy new-formed pathological tissue. Cauterisation, further, should be linear and not widespread; even linear cauterisation should not go too deep. If the nasal mucous membrane be too dry air-hunger may be present although there is plenty of room in the nose.

(2) In cases of marked hyperplasia Friedrich is in favour of the removal of the free border of the turbinal with scissors and snare; the bone, however, should be left untouched. Friedrich calls attention to a paper in which one surgeon states that 627 turbinal resections have been performed within four years in his private ambulatorium! Friedrich believes that the ease and quickness with which the operation can be performed are accountable for its popularity, and reminds us of the strong opinions expressed at the London Congress in 1897 by Sir Felix Semon and others.

(3) The author is also against removal of the middle turbinal along with the lateral mass of the ethmoid. He holds that such an operation alters the formation of the nose and the character of the nasal secretion.

In one case in which too much tissue had been removed by another surgeon, Friedrich injected paraffin into the septum and turbinals with great benefit to the patient. He agrees with Alexander that the secretion present in cases of rhinitis sicca is, in some way, due to bone disease. [Although one cannot help agreeing with the author that much harm is done by "turbinal snatching" owing to the air reaching the pharynx and larynx in an unwarmed, unmoistened, and unfiltered condition, he appears to go too far when he altogether objects to the removal of the lateral mass of the ethmoid; it would be interesting to know what treatment he suggests in cases of marked ethmoidal suppuration.—REF.]

J. S. Fraser.

E.A.R.

Hyslop, Theo. B.—Intra-cranial Murmurs in their Relationship to Tinnitus Aurium. "Lancet," October 14, 1911, p. 1062.

This paper deals with the possible intra-cranial origin of tinnitus capitis. He asks—"What is the nature of the protective mechanism which prevents our subjective perception of actual intra-cranial movements?" He has long sought explanations of some of the auditory phenomena in the insane, an investigation necessarily requiring many years of patient labour and observation. He believes that direct stimulation of the auditory nerve is rare except in cases where degeneration of that nerve is taking place. There are various sources of error in the subjective localisation of sounds, and a full account of the phenomena of intra-cranial murmurs requires full consideration of factors which are either exoneural, entotical, esoneural, or psychical. Briefly describing the comparative anatomy of the cerebral lymphatic system, he deals with the physiology of the intra-cranial circulation. In the brain, the venous outflow is regulated so as to prevent its becoming unduly slow or rapid. The absence of valves in the intra-cranial veins would tend to prevent the occurrence of venous murmurs, and possibly the trabeculae not only regulate the flow of venous blood but also prevent the conduction of sound vibrations. It is assumed that the flow of blood in the venous sinuses is continuous, but, with dilated capillaries and high blood-pressure, pulse-waves may be propagated into the beginnings of the veins. Extra-vascular pressure thus causes extra-venous pressure, and a venous sound so generated may not improbably be propagated in the direction of the venous flow. "Cerebral pressure" really means either undue preponderance of one or other of the cranial contents, partial displacement of one or other constituent, acceleration of the arterial or retardation of the venous circulation, or alteration in the compensatory movements of the cerebro-spinal fluid. Perfect balance of the relative quantities of the cranial contents presupposes certain activities or movements, which are also essential to proper metabolism. The fluid contents of the lymph cisterns may serve to prevent the conduction of intra-cranial sounds to the internal table of the skull; this may fail under abnormal conditions. A point to recognise is that fluid from the subarachnoid lymph-spaces, when forced from the brain by increased intra-cranial blood-pressure, not only passes into the perilymphatic space of the labyrinth and thereby tends to modify the pressure of the endolymph, but it also serves as a more direct² conducting medium for sound vibrations arising in connection with the pulsatile or other movements of the brain. These brain