THE EAR.

Pooley, Thomas R. (New York).—*Perichondritis Auriculæ Affecting both Ears.* "Med. Rec.," Feb. 6, 1892.

A FEEBLE woman had been under treatment for furuncles in the meatuses of both ears for four weeks, when the conchæ began to swell. The swelling—on both sides—spread till it involved the whole front of the auricle, and then extended to the posterior surface as well. The lobules alone escaped, and the ears became rounded, uneven swellings of boggy consistency. The most elastic part was at the posterior border, and incisions there gave vent to a little thin matter with yellow shreds. A probe could be passed over both surfaces of the cartilage, which was rough. Antiseptic injections were practised through the openings and recovery ensued with the typical deformity. *Dundas Grant.*

Vali, Ernst (Buda-Pesth).—*Attempt to make an Artificial Auditory Meatus in a Case of Congenital Absence of Auditory Meatus and Bilateral Defective Development of the Auricle.* "Arch. für Ohrenheilk.," Dec., 1891.

A BOY of twelve, of feeble development, hypso-dolicho-cephalic, presented in the normal situation of the right ear a piece of helix, about two and a half cm. long, closely applied to the cranium. At its upper part was a small skin-covered, fatty nodule, beneath which was a small opening about three mm. deep. At the lower part could be felt the ill-developed tragus and antitragus, and behind the tragus was a small depression representing the meatus. The lower jaw was small and the angle formed by the body and rami 105°. On the left side, the place of the auricle was occupied by a thickened helix one and a half cm. long and one cm. broad, distinctly in-rolled, the cartilage being obvious to touch. At the lower part of this abnormal growth there was seen both on the outer and inner surface a depression of the size of a lentil. Below was a lobule two cm. in length united to the helix by a narrow bridge. The upper and lower borders of this lobule were inclined towards the face so as to form a funnel-shaped pouch about one and a half cm. deep. Behind the defective helix was a gristly skin-covered growth of the size of a bean, through which a small depression (ext. aud. meat.?) could be felt.

At about four mm. directly backwards from the left angle of the mouth was a small tab of skin the size of a lentil, with no corresponding abnormality on the inside of the cheek. There was no facial paralysis. The left half of the velum palati was thicker than the right and immobile during phonation. The lower third of the left tonsil was marked by a deep furrow and the posterior part of the left inferior turbinated body was similarly marked. The orifice of the left Eustachian tube was a little expanded, cleft-like.

Hearing-power was fairly developed. On the right side he heard a watch tick at 23 cm., whispering close behind him, and ordinary conversation at 1·30 metres. Rinne's experiment was positive. On

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Politzerization he felt the air go to his ears, but Vali could not detect it with the otoscope. On the left side, watch-tick was heard at 23 cm.; whispering close behind the ear; ordinary conversation at 1·10 metres. Rinne's experiment was also positive. Politzerization the same as on the right side. It was fairly certain that in this case the middle and internal ears were normal. The arrest in the development must, therefore, have occurred not earlier than the fourth month, and was probably due to trauma as from compression by the umbilical cord.

Under the circumstances it was thought justifiable to operate tentatively on the right side. An incision was made behind the auricle and it was dissected forwards. The depression in which the meatus was expected to be found led only to a hard bony mass, which could not be perforated, and any further operation had to be abandoned.

Dundas Grant.

Eitelberg (Wien).—*Diseases of the Ear following Nasal Irrigations and Nasal Operations.* "Wiener Med. Presse," 1891, No. 23.

THE author advises the greatest caution in application of nasal irrigation. He has observed suppuration of the ear due to irrigation, after removal of polypi and vegetations, and cauterization of the nasal mucous membrane with chromic acid. *Michael.*

Parker, Rushton (Liverpool).—*Two Cases of Pyæmia following Suppuration of the Middle Ear, treated by Ligature of the Internal Jugular Vein and Cleaning out of the Lateral Sinus.* "Liverpool Med. Chir. Journ.," Jan., 1892.

A BOY, with chronic suppuration of the middle ear, was attacked with local pain, followed in a few days by rigors and daily vomiting. He was giddy, drowsy, and occasionally delirious. The chief features were: deafness, and fœtid discharge from the left ear, swelling and tenderness of the neck just below, and double optic neuritis. Plugging of the jugular was diagnosed, the mastoid appearing normal. The symptoms continued in spite of approved local treatment, and an incision was made exposing the jugular vein and the mastoid region. The vein was ligatured and cut, and found to be plugged in its upper part and surrounded by a mass of swollen lymphatic glands. The sinus was exposed by gouging in the mastoid region, and was found to contain green purulent lymph and clot for a short distance, pure blood coming from above on probing. The diseased piece was cleared, scraped, and irrigated, and the part above plugged with antiseptic wax. In two days the temperature rose again, the wax was removed, releasing some fœtid pus, and the mastoid antrum opened, allowing the removal of a small quantity of cheesy material. [It seems strange that the antrum was not opened in the first place.] The patient recovered, and even the optic neuritis became ultimately less.

A second case was that of a boy of seven, similarly affected. The mastoid antrum was opened, and the sinus exposed. The latter, when pricked, gave vent to pure blood. Relief was obtained for a few days, but fever returned, and the jugular vein having been ligatured, the sinus was found to be lined with putrid lymph and filled with putrid pus. There

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was local improvement, but the patient died shortly, with symptoms of meningitis. *Dundas Grant.*

Bates, W. H. (New York).—*A Case of Traumatic Deafness.* "New York Med. Journ.," Jan. 16, 1892.

A MAN of thirty-two was thrown down by a dynamite explosion, and rendered unconscious for a short time. There occurred a bloody discharge from the ears at the time of the accident, a beating noise in the ears, and complete deafness. The discharge became serous, then purulent and offensive. Both membranes were ruptured. After five weeks, examination with the tuning-fork (pitch not mentioned) showed air- and bone-conduction both lowered, but air-conduction better than bone-conduction. This the writer accepted as diagnostic of nerve-deafness. A month later bone- was better than air-conduction, although hearing remained the same. Inflation now improved the hearing power considerably, though not for any length of time, whereas at first it had had no beneficial effect. Ultimately the membranes healed, chiefly under Politzerization, and naso-pharyngeal medication and audition became once more normal. [There was probably concussion of the labyrinth in addition to the tympanic trouble. It would have been important to know that the ears were previously normal. In comparing aërial and perosseal conduction it is necessary to use a very low-pitched tuning-fork ($C_{\prime} = 256$ v, or better $C = 128$ v), as with higher-pitched forks the air-conduction may be better than the bone-conduction, even in presence of considerable middle ear catarrh.] *Dundas Grant.*

Vaughan, J. C. (Jhelum).—*Aural Vertigo following an Injury to the Head.* "Indian Med. Gaz.," Feb., 1891.

A HEALTHY officer, aged thirty-nine, was thrown from his horse, striking the right side of his head. There was a slight contusion above and in front of the meatus. He was slightly dazed for a few minutes, but recovered to all appearances completely. *A fortnight later* he first experienced an attack of giddiness when turning from his back on to his right side in bed. Similar attacks occurred several times. He had no tinnitus and no conscious deafness. There was, however, diminution of hearing distance for the watch-tick, and when a watch was slid over his cranium it was heard all over the left side and top, but not on the right till within an inch of the auditory meatus. He next noticed "a sound as of water," and occasionally a peculiar ticking in the ear. The vertigo then began to abate and recovery ensued. The area supplied by the vestibular, as distinguished from the cochlear branch of the auditory nerve, seemed to have sustained a shock followed (after a fortnight) by a period of irritability. *Dundas Grant.*

Mills, Charles K. (Philadelphia).—*On the Localization of the Auditory Centre.* "Brain" (winter number), 1891.

A CASE is narrated of a right-handed woman long affected with valvular disease of the heart. After an apoplectic attack, which occurred fifteen years before her death, she was "word-deaf," but not paralysed. Nine years before death she had a second attack, after which her deafness

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increased for sounds as well as for words and her *left* arm was partially paralysed. When seen a few days before her death she could understand nothing, and was to all tests absolutely deaf.

At the autopsy the first left temporal convolution was shrivelled to a thin strip, except at its anterior extremity. There was a depression at the posterior fourth of the second convolution, the result of embolic softening. In the right hemisphere the first and most of the second temporal gyri were destroyed.

Mills concludes that the centre for word-hearing is situated in the hinder thirds of the first and second left temporal convolutions. The field for all auditory memories covers a much larger cortical area. For complete brain-deafness (sounds as well as words) the destruction of the two upper temporal convolutions on both sides is necessary. Several other conclusions of great interest are drawn. *Dundas Grant.*

ASSOCIATION MEETINGS.

BERLINER MEDICINISCHE GESELLSCHAFT.

Meetings, Feb. 3, 10 *and* 17, 1892.

Baginsky.—*Etiology of Diphtheria.*

BACTERIOLOGICAL researches which the author made in 154 cases of diphtheria showed that in 118 cases Loeffler's bacilli were found. Of these 45 (equal 38 per cent.) died. In 44 cases tracheotomy was necessary. Of the other 39 cases, only four died. The author concludes that we have two forms of membranous pharyngitis. That which is caused by Loeffler's bacilli is much more severe; the other form is relatively harmless. It is caused by cocci. All cases of scarlatinal diphtheria showed only cocci, and no Loeffler's bacilli; the cases of membranous rhinitis showed the bacilli.

Discussion on Dr. BAGINSKY'S *Paper.*

RITTER has made bacteriological examinations in eighty-two cases suspected to have diphtheria. He found Loeffler's bacilli in twenty-nine cases. In no cases did he find them in the blood. In cases of true septic diphtheria no micro-organisms are found in the blood. It is produced by the ptomaines of the bacilli. If streptococci are found it is a case of mixed infection. Paralyses also can be produced by infection of streptococci alone.

ZARNEKOW regards as of special interest the presence of diphtheria bacilli in cases of rhinitis fibrinosa. Such cases prove that some people are protected.

TROJE believes that the pseudo-diphtheria bacillus is only a modified form of Loeffler's bacillus, which is not pathogenic, and it is not possible to make cultures. In mixed infections the streptococci are of great influence.

B. FRAENKEL said that he described, ten years ago, a membranous inflammation which is not at all diphtheritic.

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