NOTES.

THE Editors are desirous of making it known that owing to the corrections and additions received for Lake's "International Directory of Laryngologists and Otologists" being far more numerous than had been anticipated, they have decided to publish an entirely new edition instead of only an appendix. It is intended to have the new edition ready for issue at the beginning of next year; it will be published at 5s.

Dr. Dundas Grant has been appointed Honorary Surgeon to the Royal Academy of Music.

Owing to the plethora of papers communicated to the Sections of Laryngology and Otology in the Paris Congress, we are compelled to hold over until our next issue the greater portion of the report for which we are indebted to Mr. A. J. Hutchison.

Abstracts.

EAR.

Dieulafoy.—*Cerebellar Abscess.* "La Presse Méd.," June 27, 1900.

A man aged thirty-three was admitted to the Hôtel Dieu complaining of violent pains in the head, of twelve days' duration. The pain was worst in the occipital region, but radiated thence in all directions. Soon after the onset of the headache, attacks of vertigo (several in a day) supervened. The vertigo was most marked whilst the patient was standing or walking, was less marked whilst sitting down, and disappeared on lying down. Along with the vertigo came a staggering, drunken gait. Twice the patient fell suddenly—once to the right, once to the left. Some days later vomiting without nausea, and lastly sopor and coma-vigil, set in. There was no paralysis, anæsthesia, etc. Sight, smell and hearing were normal; speech slow; intellect clear, though acting slowly. The case was evidently one of a cerebellar lesion. For various reasons, which are fully discussed, Ménière's disease, meningitis, and cerebral lesions could all be excluded. The most probable cerebellar lesion was abscess, but the patient denied ever having had otitis, acute or chronic. Injections of biniodide of mercury were tried, with negative results.

As the patient was sinking rapidly, it was decided to operate. By this time the right fundus oculi showed retinal hæmorrhages, and the left optic neuritis; nystagmus also had developed. Slight paresis of the left external oculo-motor nerve and very slight paresis of the left facial were noted, these two symptoms being the only guides as to which cerebellar lobe ought to be operated on. During the operation the patient stopped breathing, and in a few minutes the pulse stopped.

The trephining was hurried and the meninges opened, but without any effect on either pulse or respiration. The surgeon, exploring with his finger in all directions, touched the posterior surface of the bulb; at once the patient drew a long breath. On removing the finger, respiration ceased again, but recommenced as soon as pressure was exerted on the posterior surface of the bulb. Gradually pulse and respiration returned. No abscess was found, and the patient died. After the operation, it was found from patient's wife that he had once, about a month before the onset of his illness, suffered from earache, followed by otorrhœa of three or four days' duration, in the left ear.

Post-mortem an abscess was found in the left cerebellar lobe, with no apparent connection with any other part. All other parts of cerebellum, cerebrum, etc., appeared perfectly healthy. The case is therefore interesting, as showing the complex of symptoms due to a lesion entirely limited to one cerebellar lobe.

Having related this case, the author studies the question of cerebellar abscess. The following are his conclusions:

1. With few exceptions, cerebellar abscess is always consequent to otitis.

2. Intra-cranial lesions due to otitis are multiple: cerebral meningitis, cerebro-spinal meningitis, pachy-meningitis, phlebitis and thrombosis of the sinuses, abscess of cerebrum and cerebellum.

3. Abscess of the cerebellum generally produces the cerebellar "syndrome": headache (chiefly occipital), vertigo, ictus, loss of equilibrium, staggering, drunken gait, vomiting, nystagmus, cervical contracture, optic neuritis, muscular asthenia, somnolence, sopor, coma. These may all be produced by a lesion in any part of the cerebellum, right or left lobe or vermix. Facial paresis and paresis of the external oculo-motor nerve are the only localizing symptoms.

4. Cerebellar symptoms must be distinguished from Ménière's symptoms. In the latter the headache is not so violent, nor so persistent, nor has it the same localization as cerebellar headache; somnolence and torpor increase from day to day in cerebellar cases, but not in Ménière's disease.

5. Abscess of cerebellum is to be distinguished from abscess of brain (temporo-sphenoidal and occipital lobes). In cerebral abscess the motor affections, pareses, contractures, spasms, affect the side opposite the brain lesion and the otitis; word blindness and hemianopsia are important signs.

6. Tumours of the cerebellum: glioma, gliosarcoma, tubercle, parasitic tumours, produce the cerebellar "syndrome," but usually mixed with other symptoms, due to pressure on neighbouring parts.

7. Syphilis of the cerebellum deserves separate consideration as regards both diagnosis and treatment.

8. The only treatment for abscess of the cerebellum is surgical.

A. J. Hutchison.

Obraszoff, H.—*Case of Eclampsia due to Paracentesis.* "Monatsschr. f. Ohrenheilk.," No. 7, 1899.

There was dilatation of the pupil, general muscular contractions, loss of consciousness, and paleness. This condition lasted several seconds, but did not recur. *Guild.*