

Whether the entrance of foreign bodies may be attributed to the paralysis of the mucous membrane consequent upon the unavoidable division of the superior laryngeal nerve is a moot question, as portions of the larynx in two of the cases (the arytenoid and a portion of the cricoid cartilage in one, the arytenoid and a portion of the right vocal cord in another) were removed at the same time. Dr. von Langenbeck has moreover seen this nerve divided in other operations, but has not found its division followed by the same untoward results.

Looking to the cause of the failure of the operation, it seems questionable whether it would not have been better to remove the whole larynx. In the case in which the tampon-canula was kept in after the operation, the patient unfortunately died in a few hours. It therefore remains uncertain what influence the retention of this canula might have had in guarding the air-passages from the entrance of foreign matter, and whether the larynx might not subsequently have so far recovered its functions as to prevent foreign matter from passing into it.

The first case in which the operation was performed was that of a man 48 years old. The growth involved the right half of the pharynx and larynx, extending as high as the hyoid bone, and as low as the false vocal cords, while posteriorly it reached to the vertebral column. After the removal of the growth, together with the pharynx, the right arytenoid and part of the right half of the thyroid cartilage, the upper portion of the wound was closed with five sutures, and a drainage-tube introduced into the lower. The tampon-canula was taken out, and replaced by an ordinary one. The patient was fed by a tube introduced through the mouth. He survived the operation three days, and appeared to have died of pneumonia and gangrene of the lung, from the escape of the saliva and secretion of the wound into the air-passages. A *post-mortem* examination was not allowed.

The second patient was a man 58 years old. Here the whole pharynx with the upper part of the œsophagus was removed, and a small portion of the inferior cornu of the left thyroid cartilage. The cut end of the œsophagus was sewn to the wound in the skin, and a soft India-rubber tube introduced into it. The upper portion of the wound was secured by sutures, the lower left open. The tampon-canula was left in the trachea. The patient died the same night of exhaustion.

In the third case, the patient was a woman, 52 years old. The growth was of the size of a walnut, and had invaded the whole right half of the front wall of the pharynx, the right arytenoid cartilage, and a portion of the cricoid. These parts were cut away with the growth. The wound was left open. The patient was fed by a tube at times through the mouth, at times through the wound. On several occasions, the administration of food was followed by vomiting. Portions of the food thus rejected, escaping into the air passages, produced pneumonia and bronchitis, of which the patient died on the eighth day after the operation. At the *post-mortem* examination, the right cornu of the hyoid bone was found bared of periosteum, as was also the hinder portion of the right ala of the thyroid cartilage.—*London Med. Record*, Feb. 15, 1880.

#### *On Resection of the Ribs in Chronic Empyema.*

Dr. J. A. ESTLANDER contributes to the *Nordiskt Medicinskt Arkiv*, 1879, Bd. XI. Tredje häftet, an instructive paper on this subject, of which the following is an abstract:—

Although the antiseptic method may have rendered great service in the treatment of empyema, there exist many cases in which suppuration is indefinitely prolonged in spite of antiseptic lotions, and finally produces the death of the patient, usually by amyloid degeneration of the kidneys. These unfortunate cases are due to the fact that there exist no adhesions between the lung and

the thoracic wall, so that the former retract completely, and thereby cause in the pleural cavity a space which it is impossible to fill, as the ribs have not the power to retract sufficiently. The author does not deny, however, that constitutional causes cannot thus act, and cause the death of the patient independently of the existence or non-existence of adhesions. In fact, in ordinary cases, it is principally the contraction of the thickened pleura, shrivelled by the tension of the thoracic muscles, which causes little by little the diminution of the suppurating cavity, and finally its disappearance. The ribs have to follow this movement, and consecutive scoliosis shows that they do so; but if the cavity is very large, neither the contraction of the pleura, nor that of the bony wall, suffices to bring together the pleural surfaces, and the lung is found at the bottom of the cavity, pushed back towards the spinal column. It is for such cases that the author proposes resection of several ribs, from three to six, or perhaps even a greater number still. But the disease must be of long standing, and the pleura very much thickened, in order that the latter may retract forcibly, the resistance of the ribs having been diminished by the operation. This circumstance is, moreover, at the same time favourable, necessary even, to the complete performance of resection.

The point to choose is that portion of the thorax which is situated beneath the axilla, as that region is destitute of large muscles; if there exists a fistula, it may serve as a *point de repire*; without that we must make a counter opening. Ordinarily the author has made transverse incisions, corresponding to the costal interstices; by a single incision he has laid bare two ribs, sometimes three, and has thus effected the desired operation. It is needless to say that the resection was subperiosteal, and that the whole of the operation and dressing was executed with the modern antiseptic precautions.

The fragments removed were from three to six centimetres in length. The general condition, more or less bad, of the patients, does not present any contraindications against resection—quite the contrary, provided the exhaustion of the subject has not reached a point rendering success impossible.

The author gives a detailed account of six cases in which he has employed his method. The age of the patients, five men and one woman, varied from twenty-one to fifty-six years; the duration of the disease from three months to a year and ten months. In all these cases suppuration was very abundant; the usual antiseptic expedients, and even the resection of a single rib, were attempted in vain, and the general condition of the patients was bad—in the case of one of them almost beyond hope. After an evident improvement, this latter patient died. All the other patients were cured, although three had left the hospital before the final closing of the fistulæ or of the counter openings.

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*A Case of Abscess of the Kidney, in which Nephrotomy, with Subsequent Free Drainage, was attended with Satisfactory Results.*

Mr. CHAUNCEY PUZEY, Surgeon Northern Hospital, Liverpool, records an extremely interesting case, in which stricture of the urethra of twelve years' standing with resulting chronic retention and cystitis was followed by suppuration in the kidneys, in a coloured seaman, forty years of age.

The patient first came under observation on Aug. 12th, 1878; at which time he was unable to pass any urine by the penis, but every fifteen or twenty minutes he was out of bed straining an ounce or two of thick ammoniacal urine (mixed with pus, mucus, and blood) through a very small opening in the perineum. Mr. Puzey did a perineal section, and, having passed a full-sized elastic catheter through the penis into the bladder, was enabled to keep up constant siphon drainage, by