

of the calf of the leg and lower portion of the abdomen show a tendency toward varicosity. Patient has some edema of the ankles. The scrotum is enlarged on the left side, a chronic hydrocele being present. The integument covering it is roughened and somewhat boggy to the touch. The superficial scrotal veins on left side are dilated and tortuous, and distributed along their course are a goodly number of hard, purplish, smooth, elevated nodules varying from the size of a grain of wheat to that of the head of a pin. On puncture of the larger ones a small drop of serous blood exudes. Some of the nodules are small and in process of development, while others are of a brownish red color and undergoing degeneration. The patient gives a history of chronic venous obstruction preceding the development of the angiokeratoma, the vascular tumors developing as a result of the increased blood-pressure in the superficial capillaries, the walls of which being insufficiently supported, allowing their formation. The chilblain history in this case being so vague, it, as the underlying cause of the vascular lesion may be ruled out.

breathe properly. She was told not to talk at all until she could do so by using only these tones as fundamentals, and, in the meantime, to practice the breathing exercises half a dozen times a day.

In four weeks she had a perfectly normal voice, although pitched considerably lower than formerly. The tired feeling in the throat was also gone because the patient had learned to use her voice in the different registers without keeping the larynx in a fixed position, thus relieving the extrinsic muscles of the heretofore constant strain.

For the removal of the nodule, besides changing the faulty voice production and faulty breathing, external massage of the larynx was practiced and by the end of the third month the node had completely disappeared. For the accompanying hypertrophic laryngitis, inhalations of the compound tincture of benzoin and camphorated tincture of opium were used while the local application of a 2 per cent. solution of silver nitrate was made three times a week.

I wish to emphasize the fact that the main treatment of chorditis nodosa is teaching the patient to use the voice and respiratory apparatus properly. This appears to me a much more satisfactory method than operative measures, as, in the latter case, the node will probably reappear in time, while if the patient has learned to use the voice properly, the cause is removed and there is no danger of recurrence.

“SINGER'S NODULE” (CHORDITIS NODOSA)
REMOVED BY VOCAL TREATMENT

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While these nodes usually occur in singers and public speakers, the following case will show that habitual misuse of the voice by anyone may cause this condition.

While faulty breathing is a factor, the breathing of itself will not develop nodes, the prime factors being overtension of the intrinsic and extrinsic muscles of the larynx which causes the *coup de la glotte* or stroke of the glottis, which, Garcia used to say, is death to the voice.

Kyle says that nodes are usually located near the junction of the anterior and middle thirds of the cords. My experience has proved just the opposite and I generally expect to find them near the junction of the middle and posterior thirds, for the following reason:

When the voice is used properly and the upper register is attempted, the posterior thirds of the cords are closely approximated and not in use and the larynx rises to a higher position, the extrinsic muscles being relaxed. Now, when the pitch of the voice is raised and the larynx is held in the same position as when speaking or singing in the chest or medium register, there is overtension of the extrinsic muscles and the arytenoideus muscle, which causes the cords to vibrate throughout their entire length, and as the posterior thirds are closely approximated, the super-attrition which causes the nodes to develop occurs just a little anterior to this point.

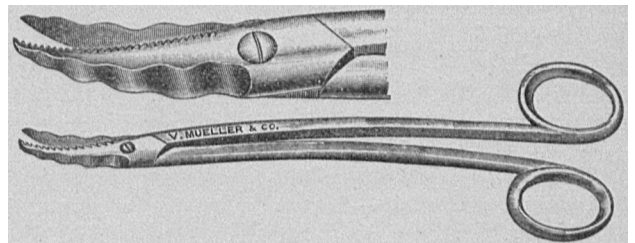
The patient, Mrs. E. J., had not been able to speak above a whisper for six months and had been treated during that time by her family physician with no result. She finally became discouraged and was sent by a friend to Dr. Vansant of Philadelphia who referred her to me. On examining the larynx, I found a nodule on the free border of the left cord near the junction of the middle and posterior thirds. The patient said she had a relative living with her who was very deaf and that during the day she talked very loud to her, pitching her voice higher than usual, and in the evening her voice was always tired and the muscles of the larynx very much fatigued. This is exactly what happens when a singer uses the chest register in singing the higher tones, and the result in this case was the same. The voice gradually became hoarser until it could be used only with great difficulty and there was almost complete aphonia.

On examining the cords during tone-production, I found that when singing the four tones C, B, A and G below the staff, the node did not come in contact with the opposite cord. Taking the patient to the piano, I then instructed her how to speak on these four tones and instructed her how to

NEW TONSIL SCISSORS

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With a view to combining the good points of three instruments in one, for enucleating the faucial tonsil,



Tonsil scissors with serrated blade.

I have devised the scissors here illustrated. They present these features:

1. The cutting edge of one blade is serrated and the other smooth; this facilitates the cutting of soft, slippery tissue.
2. The outer edge of each blade is wave-like in outline and beveled to a dull knife edge; this serves as a dissector. By inserting the closed scissors between the tonsil and pillar and then opening them forcibly at four or five points, the tonsil is rapidly exposed and prepared for the snare. The latter may be omitted and the operation completed with the scissors if desirable.
3. The closed scissors may be used as an Allport's or Swan's wave-edge knife for enucleating the tonsil.

Sanitation and the Hookworm.—As Boycott has clearly pointed out, three conditions are necessary for the spread of hookworm disease: (1) a certain degree of temperature, about 68 to 90 F.; (2) a certain degree of moisture; (3) fecal contamination of the ground; and these conditions are found only in tropical and subtropical regions. When the temperature here is suitable for the hatching out and development of the embryo hookworm, the weather is usually too dry; and while the sanitary arrangements, especially in the country districts of New York state, are probably not ideal, they are not to be classed with those in the tropics.—Nichols in *Medical Record*.