THE DEAF

Their Education—Improvement of Conditions— Responsibilities and Participation of the Profession.

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The aim of this department of THE LARYNGOSCOPE will be to bring to the notice of its readers from month to month, facts that may be helpful to physician and patient in dealing with the life-problems involved in deafness. Suggestions from readers will be gladly received and all questions answered to the best of our ability.

THE EDUCATIONAL NEEDS OF THE DEAF.

(Continued from the July, 1914, issue, page 698.)

We now come to Class II. Adults. Group A. Adults with hearing but slightly impaired by conditions that will yield to treatment: While at first sight it may seem that the educational phase need not be considered with these patients, yet training in lip-reading may be of considerable assistance in solving the problem. If the process of cure is likely to be somewhat prolonged and to require all the nervous energy available on the part of the patient, a great relief from nervous strain and an added contentment can be secured by acquiring some ability to assist the ear with the eye. Then, also, there is always the possibility that in time the patients may find themselves in Group B.

Group B. Adults with hearing slightly, but permanently impaired, with or without the probability of a progressive increase in deafness: For these people, the educational training of the brain to interpret language by the movements which accompany speech is a great aid. By facilitating their intercourse with people it encourages them to mingle more freely in society. This, in turn, leads them to pay more attention to what is said around them, and so gives their hearing more use. As a matter of fact, we hear with our brains. If the organ of hearing is not in perfect working order the brain must exert more effort to interpret the sounds; just as one must listen with great intentness when using a defective or faint telephone. If the brain can receive a little assistance through the eye, in supplement to the faint impressions that reach it through the ear, then there is less brain-fag, less nervous tension, and the whole bodily machine works better. It is easier to hear language

than to see it, and even the slightest sounds of speech that are heard enormously help the eye to comprehend and are eagerly sought. The result, therefore, of adding the help of the eye to that of the ear is to increase the amount of use the patients make of their hearing, and curiously enough they not infrequently report that their hearing appears to have benefited from the educational training of lip-reading. The intelligent teacher will use, in giving the lessons, such a volume and pitch of voice as will exercise the hearing to the utmost, while supplementing it with sight. So that, with the eyes closed, the patient could hear the voice, but not be able to make out the words, and with ears stopped could see the words, but not quite make out their meaning, though with both ears and eyes open the sentences were readily understood. Thus the two senses are trained to work in supplementary harmony.

Group C. Adults with hearing seriously and permanently impaired: All that has been said of Group B is applicable to patients belonging to Group C, and in proportion as their situation makes social intercourse more difficult for them so much the more is the educational training a help and a comfort to them.

In three or four months ordinary persons can get a sufficient start in lip-reading to enable them to make steady progress in increasing their facility under the social conditions of every-day life without further special aid or instruction.

Unfortunately, the United States is the one great stronghold in all the world of silent, that is manual methods of educating the deaf. These silent methods are responsible for the term "deaf-mute" that is so strongly entrenched in our language, although in thousands of instances it has become a misnomer through the education of the deaf by purely oral methods. In Europe the greater part of the schools are purely oral schools, but in the United States the greater part of the schools use silent methods to a considerable extent. To be sure, they have gradually been compelled, by the arrival and persistent growth of the oral method, to adopt it in part, and call themselves "combined" schools. But, so far as the output of the schools is concerned it is not possible to combine the two methods. The pupils leave the so-called "combined" schools practically deaf-mutes, and so long as "combined" schools exist there will be need in the language for that term.

By providing a small, separate building in which the entering children could be housed, taught and cared for by speech methods, and year by year increasing the accommodations assigned to the orally taught pupils and decreasing the portion needed for the

silently taught, each of the state "combined" schools could, in a period of from eight to ten years, be transformed into purely oral schools. But absolute segregation must be secured of the manually taught from the orally taught, not only in the class rooms but also in recreation, shop, dining hall and dormitory. If the modern and enlightened cottage plan were adopted by the State institutions for the deaf this much to be desired transformation would present very little difficulty.

Physicians and their organizations are always an influential factor in each State and community, and if they would steadily, year after year, exert their influence on behalf of the transformation of the State institutions for the deaf from so-called "combined" to real oral schools, they would help to hasten the arrival of the change.

Four Cases of Leeches Adhering to the Larynx. HENRI
ABOULKER. *Rev. hebdomadaire de Laryngologie*. May 23, 1914.

The first patient applied because of a sudden hemorrhage from the throat and was relieved by the removal of a leech which had entered his throat while drinking at a public fountain. The leech was found adhering to the left arytenoid, but the patient had found no inconvenience from its presence either in breathing or swallowing.

In the second case, a beggar declared that he had swallowed a leech while drinking from a pond. Some hours afterwards, he developed a violent attack of suffocation for which he was sent to the hospital. The dyspnea became intense but was relieved by the removal of a large leech which was found attached to the vestibule of the larynx.

In the third case, a man complained of the loss of voice and slight dyspnea which he attributed to a leech which had entered his throat some days ago while drinking from a pool. As in the other cases, the leech was removed by forceps, the point of implantation being one of the superior vocal cords.

In the fourth case, the patient also declared that he had swallowed a leech. There was no spitting of blood or difficulty of respiration, but only a slight discomfort in the throat, as from a foreign body, in the effort of swallowing. The leech could be easily seen, but while the right side of the vestibule appeared edematous, the point of attachment could not be found.

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