4. *The Respiration*.—The beginning and carrying through of the whole operation, in spite of the patient making no attempt at breathing, was amply compensated for by the immediate return of activity in the respiratory centre when the abscess was opened. One other point as to the cause of death is whether the cavity being emptied quickly caused edema to occur in the medulla oblongata when the pressure was suddenly relieved; whether it would have been better to allow the cavity to empty very slowly, so that vessels with their walls paralyzed by pressure might have time to recover.

STCLAIR THOMSON.

Direct Endoscopy of the Upper Air Passages and Œsophagus; Its Diagnostic and Therapeutic Value in the Search for and Removal of Foreign Bodies.—GUSTAV KILLIAN, Freiburg
—*Journ. of Laryngology*, Sept., 1902.

By means of œsophagoscopy the gullet may be systematically searched from above downwards. The author records a case of a tooth-plate in the œsophagus of a female 52 years of age, which the Roentgen-rays failed to discover, but was found by means of the œsophagoscope. The foreign body was impacted and could not be removed with a pair of long tubular forceps. After three attempts with the galvano-cautery snare, the plate was cut through and the two pieces were then easily removed with forceps. A good recovery followed. In cases where one is able to see that the wall of the gullet has been deeply injured, extraction should not be attempted. Early œsophagotomy is indicated, and it is easier to locate the injured part while the foreign body is still fixed.

By means of straight tubes, introduced into the trachea and bronchi under cocain anæsthesia of 25 per cent solution, the author has been able to examine these parts, and at the same time has succeeded in removing foreign bodies from this locality. If there is much dyspnoea, a preliminary tracheotomy is necessary. When this has been performed, and the foreign substance has not been coughed up, a short tube may be introduced through the wound into the cocainized trachea and the search may be continued—lower direct tracheotomy—a method employed by Pilmazek.

When the asperated foreign body has become fixed in the bronchi below the bifurcation, longer tubes are employed, which are introduced into the cocainized bronchi. The author remarks that we may, without fear, press the bronchi, which are highly elastic tubes embedded in soft tissue, into the median line and bring trachea, large bronchus and branch into one straight line.

Bronchoscopy allows the whole bronchial tree to be searched. The view has to be kept clear by sponging the secretion away, or by sucking it up by means of a small pump, designed by the author. For illuminating purposes the Kirstein's forehead lamp is recommended. If a tube is introduced into a principal bronchus, which is entirely stopped up by a foreign body, respiratory difficulties will at once occur, as air cannot pass into the other healthy lung at the side of the tube; under such circumstances the tube introduced should have a lateral opening at some distance from its lower end.

For the removal of foreign bodies from the bronchi a good view, great care and quietness in procedure are essential. Slender tubular forceps, blunt hooklets (in the form of Lister's hook) are the instruments of most use. Their manipulation at so great a depth is not an easy matter but may be learned and practiced on a phantom which has been constructed for the purpose.

Bronchoscopy has been employed in twenty cases, of these eleven were those of the authors, a few of which are given in detail.

M. D. LEDERMAN.

The Diagnosis and Treatment of Malignant Stricture of the Oesophagus.—C. J. AYMARDS, London—*Journ. of Laryngology*, Sept., 1902.

In a classical paper upon this subject, the author summarizes the diagnosis as follows:

1. Among early symptoms we may base so-called "dyspepsia," nausea and repulsion for food; pain alone when the central district is affected.
2. That the passage of a bougie is the only way to clear up the diagnosis, and that its employment need not be feared.
3. That extra oesophageal diseases rarely gives rise to serious dysphagia.
4. That spasmodic obstruction, apart from the hysterical form, has always, when decided, an organic cause and that this would be better called intermittent dysphagia.

All organic obstruction in the upper third of the oesophagus may be considered malignant, but have a special tendency to cicatrize. In the central half of the gullet a sarcoma or a myoma, both rare diseases, may cause fatal obstruction; and here also, a pouch may give rise to difficulty in diagnosis. In the lower portion of the gullet a simple stenosis may occur, and it may be difficult to distinguish between such a condition and a cancer of the stomach, causing great reduction of the cavity (leather bottle stomach). Considerable attention is devoted to the treatment of the disease.

M. D. LEDERMAN.