New Instrument.

**A SMALLER SEEHEAR.**

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In a larger form this instrument was described in the *Electrical Review* for February 8, 1899, and in other journals. The instrument contained two principles new in stethoscopes, one a sound chamber, the other a fluorescent screen in connection with such a sound chamber. The former has since been adopted in one of the stethoscopes in common use. The latter awaits recognition. There is an advantage in using both eyes and ears in studying the interior of

Dr. Farlow: I have seen several cases of retropharyngeal abscess in the adult, but never of tubercular origin unless there was tuberculosis of the spine. Several years ago I was called to see a lady of about fifty, who complained of some soreness of the throat and difficulty in swallowing for a few days. I was much surprised to find a marked bulging of the posterior pharyngeal wall, with elastic, fluctuating feeling to the finger. There was no evidence of tubercular or specific disease and the cause of the trouble was not clear. There was no pulsation, no neoplasm, and it seemed to be a very unusual case of non-tubercular retropharyngeal abscess in the adult. I proposed to make an incision, but was not allowed to do so, and the case passed into other hands. I do not know the outcome.

There is a condition not very infrequently met with which, at first glance, might lead one to think of retropharyngeal abscess, and that is an asymmetrical position of the pharynx. If the pharynx is not directly in front of the vertebral column, the projecting vertebra may give the impression of an inflammatory bulging, until the examining finger shows that the projecting side of the pharynx is hard and bony.

As regards peritonsillar abscess, I quite agree with Dr. Cobb in not considering a rheumatic origin well substantiated. I am always in the habit of looking about the tonsil and exploring the crypts, and especially the supratonsillar fossa, for some possible seat of infection. I have seen 2 cases recently in which the inflammation was behind the posterior pillar, a most unpleasant region in which to make the incision, especially when one bears in mind the possibility of meeting one of the large, abnormal ascending pharyngeal arteries, which are occasionally found in this situation. According to Dr. Moritz Schmidt, the abscess points in the anterior pillar in 98% of the cases, and in the posterior pillar in 2%. In order to prevent an early closure of the opening and to ensure a better evacuation of the pus, I pass a probe in various directions so as to open up the various pockets of pus, break the trabeculae, etc., and then dilate the opening with a pair of strong forceps. This leaves a gaping wound which is much more likely to stay open than where only an incision is made. This is scarcely applicable, however, when the incision is in the posterior pillar.

A great difficulty in the treatment of many of these cases is the inability of the patient to open his mouth. I have seen 2 cases so severe that chloroform was given to get the mouth open, not only to make the diagnosis, but also to carry out the treatment. Some of the distress is caused by secretion behind the posterior pillar which is tenacious and hard for the patient to expectorate. A warm, alkaline solution sprayed gently through the nose helps the patient to rid himself of this mucus. A hot poultice to the neck is very soothing when pus is forming.

Dr. Knight: In regard to the first paper—"Retropharyngeal Abscess in the Adult"—I must say I have never seen what has been considered an idiopathic case. All the cases I have seen have been those in connection with disease of the vertebrae. The general practitioner is liable to mistake not only a congenital deformity of the vertebrae for an abscess, but also what may be the natural prominence. I have had a good many cases brought to me by practi-