

not quickly lower the pulse, the patient should be put into the vertical, feet-down posture. The dilated right heart is thereby completely and easily emptied of blood. Artificial respiration is maintained during this manœuvre, and the patient is brought once more into the horizontal posture. By rhythmic compression of the chest an efficient circulation is maintained through the coronary arteries; by first emptying and then filling the heart a fresh supply of blood is brought into that organ. If this does not prove successful on the first trial, it can be repeated.

8. Inversion—that is, placing the subject in the feet-up position or compression of the abdomen—will increase the paralytic dilatation of the heart. In this kind of syncope both these forms of treatment are worse than useless.

9. In the condition of shock or emotional fear the compensatory mechanism for the effect of gravity is almost abolished, and chloroform may easily be the last straw to completely paralyze the circulation.

10. Vagus inhibition of the heart is of no importance as an agent in the production of chloroform syncope.

11. Ether is in every respect a far safer anæsthetic than chloroform. According to Binger's experiments on the heart, ether is fifty times less dangerous than chloroform.

12. With the practical conclusion of the Hyderabad Commission, that the chloroform inhaler should be removed during the struggling of the patient or when the respiration is of irregular depth, I am in absolute agreement; but I consider their interpretation of their own experiments and tracings concerning the origin of chloroform syncope to be mistaken.

Not only the work of all physiologists, but also the tracings of the commission, when rightly interpreted, prove that paralysis of the circulatory mechanisms, and not of the respiratory centre, is to be dreaded by the anæsthetist.

**Uretero-pyelo-neostomy.**—Among the tendencies of modern surgery the true conservatism of the aseptic and antiseptic era is the most marked of all advances.

BAZY (*Revue de Chirurgie*, May 10, 1897) draws particular attention to this fact in connection with operations on the kidney, in which, instead of performing nephrectomy, the attempt should be made in many cases to preserve the kidney in all its functional activity, illustrating the fact that if it is a great surgical feat to remove a viscus or a portion of the viscera it is a greater scientific achievement to preserve it and restore its function.

He reports two cases in which there was a large hydronephrosis. In the first he was enabled to re-establish a communication between the pelvis of the kidney and the bladder by resecting the ureter and implanting the distal portion into the most dependent portion of the dilated pelvis. This was accomplished in the following manner: Through a median laparotomy the tumor was reached, the fluid withdrawn by an aspirator, and the pelvis of the kidney incised. The orifice of the ureter was found far up on one side. It had been flattened out by the pressure of the pelvis and occluded in this manner. A fine catheter was passed through it nearly or into the bladder. The ureter was then resected. One side was cut open for a little way to enlarge the entrance and procure a larger surface to implant into the pelvis. An opening was made in the most dependent portion of the pelvis. A soft

catheter, from which the tip had been removed, was passed a short distance into the ureter, while the other end passed out of the abdominal wound and gave, through an opening situated in the catheter within the pelvis of the kidney, exit to the urine in both directions. Drainage being provided in this manner, the ureter was stitched to the pelvic wall by interrupted catgut sutures, while a Lembert suture of silk was placed externally, care being taken not to penetrate the mucous surface so that the silk would come in contact with the urine. The wound in the pelvis of the kidney was stitched to the abdominal parietes, which were then closed by the ordinary layers of interrupted catgut and silk-worm-gut sutures. The patient made a slow but complete recovery, the urinary fistula closed, and the complete function of the ureter was restored.

The second case was one of single kidney of the bi-lobar form. Nephrectomy was impossible, and, although the patient's condition was very poor, the attempt was made to restore the ureter. The kidney was, however, the seat of an infection, and the patient succumbed to a general infection, although the ureter was readily found, the operation performed, and the flow of urine re-established into the bladder.

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**Wire Hooks for Holding Open the Edges of Abscesses.**—As a substitute for gauze tampons or drainage-tubes, BRAATZ (*Centralblatt für Chirurgie*, 1897, No. 16) recommends the employment of retractors formed of wire, which he finds hold the lips of the wound open more certainly and give better drainage than either gauze or rubber tubes, both of which are compressed by the edges of the wound, so that they do not fulfil the purpose for which they were employed.

These retractors are made of different sizes, and are held apart by a band of wire which passes from one to the other. They may also be made in spiral form for deep drainage, or gauze and rubber drainage-tubes may be employed at the same time, being inserted between the retractors. The author has employed them in numerous cases with gratifying results.

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## DISEASES OF THE LARYNX AND CONTIGUOUS STRUCTURES.

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UNDER THE CHARGE OF

J. SOLIS-COHEN, M.D.,  
OF PHILADELPHIA.

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**The Progress of Laryngology and Rhinology.**—DR. ST. CLAIR THOMSON, of London (from the Diamond Jubilee Commemoration number of the *British Medical Journal*, June 19, 1897), presents a succinct summary of the progress of laryngology and rhinology in the sixty years of the Victorian age, which is adorned with the reproduction of a signed photograph of

Mannel Garcia, the still living distinguished nonagenarian singing master of London, whose use of the dental mirror, for the purpose of studying the mechanism of voice, gave, in 1854, the initial impulse to laryngology of the present day.

**Hard Fibroma of the Maxillary Sinus, with Pyæmia of the Frontal Sinus.**—DR. L. J. HAMMOND reports (*Phila. Polyclinic*, August 7, 1897) this interesting case, which is illustrated with instructive wood-cuts. An Irishman, aged thirty-eight years, laborer in chemical works, suffered violent pain in the left side of his face and forehead, which had resisted all manner of treatment—even the removal of his teeth on the left side of the upper jaw. There was a suppurative discharge from the left nostril and from the site of the second bicuspid tooth. The cartilaginous septum was gone, the loss attributed to the handling of vitriols. The pain was found to be largely due to pressure upon the dental and infra-orbital nerves by a growth in the maxillary sinus. This was removed after access to the parts from the exterior. An additional operation was necessary to trephine and drain the frontal sinus, and an incision was selected over the promontory roof of the nose and continued far enough to allow the flap to expose the inner edge of the superciliary ridge, at which point the sinus was trephined. The treatment gave complete relief, which had been permanent up to the date of the report. The record of this case is exceedingly instructive in its details.

**Paralysis of the Larynx in Typhoid Fever.**—M. BENOUD (*Lyon Medical*, March 28, 1897; *Boston Medical and Surgical Journal*, April 29, 1897) recently reported to the Lyon Society of Medical Sciences a case of paralysis of the posterior crico-arytenoid muscles occurring in the course of typhoid fever, which came on during the third week of the disease and was followed subsequently by paralysis of the soft palate. It is stated that in a recent monograph by Bouley and Mendel seventeen cases of paralysis in typhoid fever are reported, in six of which the posterior crico-arytenoid muscles were involved.

**The Causes of Paralysis of the Recurrents.**—M. LERMOYER (*Revue Internationale de Rhinologie, Otologie, et Laryngologie*, August, 1897) recently read an admirable and elaborate paper upon this subject before the French Society of Otology, Rhinology, and Laryngology, which we would commend to the careful study of those who have access to the original article, but which is too extensive even for an abstract in these columns.

In concluding his report three principal types of paralysis of the recurrents were presented for discussion:

First, incurable grave paralysis leading to death in consequence of the lesions which have produced it.

Second, incurable benignant paralysis, the cause of which often escapes us, but which is ordinarily simply an infirmity compatible with a prolonged life.

Third, curable and benignant paralysis, in which recovery takes place without any trace of its existence, and which seems to be but the result of a primitive neuritis, of which catching cold is one of the factors.

**Laryngectomy.**—M. DEPAGE reports (*Revue Internationale de Rhinologie, Otologie, et Laryngologie*, August, 1897) one case of total laryngectomy and one of partial laryngectomy—both successful. In the former the mouth was entirely shut off from the air-passages, and the patient for a while showed great distress for the want of a voice, and insisted upon having the communication between the mouth and the windpipe restored; but little by little he learned to articulate sounds sufficiently satisfactory to make himself understood, and since then has become satisfied with his condition.

**Tracheotomy in Emergencies.**—In an article on "Ideal Anæsthesia" (*Medical Record*, September 25, 1897), by DR. RAWLINGS NICHOL, of New York, he commends the method proposed by Dr. von Donhoff for performing tracheotomy in an emergency. "A curved needle, threaded, is passed through the trachea; then the tracheal rings are cut, and the thread is caught by a blunt hook; this thread is divided in the middle and the two strands it forms are loosely tied at the back of the neck."

**Œsophagotomy and Removal of Dental Plate with Upper Central Incisor Tooth.**—This case was reported (*N. Y. Medical Journal*, 1897, No. 981) by DR. A. A. SNYDER, of Washington. The operation was performed under chloroform narcosis with the loss of less than a drachm of blood, and the patient made a good recovery.

**Sloughing of the Mucous Membrane of the Œsophagus.**—DR. J. C. BROWN, of Smithport (*N. Y. Medical Journal*, 1897, No. 981; *Buffalo Medical Journal*, September), reports a case of corrosive poisoning in a robust man, thirty-two years of age, in which the mucous membrane of the œsophagus and of a part of the stomach was vomited as a complete cast. The œsophageal portion was in perfect shape, with the exception of a few small holes which might have been made in the effort to expel it. The stomach portion was somewhat torn in strips, due perhaps to a more pronounced effect of the corrosive agent. The whole was about sixteen inches in length. The case terminated fatally.

**Incomplete Fracture of the Left Cornu of the Thyroid Cartilage, Resulting from Self-Inflicted Violence.**—DR. A. DE ROALDES reports (*N. Y. Medical Journal*, 1897, No. 949) a case in which violent manipulation of the larynx in an endeavor to get rid of an olive-seed which had been inspired, resulted in an incomplete fracture of the left cornu of the thyroid cartilage.

(The laryngoscopic picture looks as though it might be a duplicate of a picture made some years ago for one of the compiler's cases in which the projection was attributed to a similar lesion.)

**Pharyngeal Teratoma.**—DR. A. DE ROALDES reports (*N. Y. Medical Journal*, 1897, No. 949) a remarkable case of fibro-chondroma of branchial origin removed from the throat of an infant six weeks old. It is accompanied by illustrations of the microscopic and macroscopic appearances. The growth was extirpated with a wire snare and forceps, and the child made a satisfactory recovery.