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FATAL CASE OF ACUTE ŒDEMA GLOTTIDIS.

By HUGH MONTGOMERIE, M.D.,

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THE comparative rarity of œdema glottidis following acute pharyngolaryngitis leads me to hope that this case may be of some interest to the profession.

On March 30th of this year I was asked to perform a *post-mortem* examination by my friend Dr. Davy. I learned that the deceased was a locomotive engine driver, forty-three years of age, who, with the exception of slight sore throat, had always enjoyed robust health. He had once consulted Dr. Davy—a year ago—in one of these attacks, who found slight pharyngitis.

The wife informed me deceased came home that morning (March 30th) on the engine from Falmouth, where, the previous day, he had to leave off work owing to sore throat. The morning, though fine and dry, was chilly, with north-east wind. As he seemed so uncomfortable from pain in swallowing and hoarseness, she sent for the doctor at 10 a.m., who, finding the patient's pharynx inflamed, sent him to bed and prescribed. The advice was followed with alleviation of the symptoms till about 2 p.m., when the hoarseness becoming worse, and stridor setting in, the doctor was sent for, but on arrival very shortly found the patient dead.

On close inquiry of the wife, we found that there had been some stridor for about an hour previous to the death of the patient, but that severe dyspnœa only lasted some five minutes or so before the fatal termination took place.

A *post-mortem* examination was held the same evening, about four

hours after death. On removing the larynx and part of the trachea, the lumen of the glottis was found to be quite closed by œdematous swelling of the walls. In colour the swelling was pale yellow and glistening; on palpation it was soft. The epiglottis and aryteno-epiglottidean folds were comparable to sausages in shape. On separation of the parts the false cords were also found to be much swollen, and the true cords red but not swollen.

As we could not get permission, a further examination of the body was not made, but there was no reason to suspect any organic mischief which might have caused the rapid œdema.

EMPHYEMA OF THE MAXILLARY SINUS,

And its Relation to Diseases of the ANTRUM OF HIGHMORE.

By Dr. MOREAU R. BROWN, Professor of Rhinology
and Laryngology, Chicago Polyclinic.

(Presented to the *American Laryngological Association* as a Candidate's Thesis.)

THE past year has been fruitful of more progress in the line of study of diseases of the antrum of Highmore than any previous time. We are only beginning to clear up some of the many occult pathological conditions which have been overlooked in the past. To be the better enabled to substantiate my arguments for the proper treatment and the better understanding of antral diseases, I will introduce my subject by a brief sketch of the anatomy of the maxillary sinus.

Anatomy.—The superior maxillary sinus or antrum of Highmore is an irregularly pyramidal cavity. The walls are quite thin, and correspond to the facial, zygomatic and orbital surfaces. The base is directed to the nasal side, and the apex extends into the malar process of the superior maxilla. The lateral walls correspond to the orbital cavity and lateral plates of the superior maxilla. Its base or inner wall which separates it from the nasal cavity consists of a portion of the superior maxilla, palate, inferior turbinated and unciform process of the ethmoid. The opening which communicates with the nasal fossa is closed in the normal state to a considerable extent by the unciform process of the ethmoid, palate, and the inferior turbinated bones, reduced by the pituitary mucous membrane to one or two small apertures.

On *post-mortem* examinations, we frequently find bony projections and laminae similar to those in the cranial sinuses, sometimes dividing the cavity into compartments more or less complete, being both transverse and perpendicular. The floor is more or less irregular, being according to Reschreiter, always below the level of the floor of the nasal cavity in men, which fact was corroborated in a number of sections made, being assisted by my associate, Dr. J. F. Oaks, to whom I am indebted for the sections from which the accompanying photographs were prepared, in which we found the same fact to hold