

DISEASES OF THE LARYNX AND CONTIGUOUS STRUCTURES.

UNDER THE CHARGE OF

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Topographical Anatomy of the Crypts of Hypertrophied Tonsils.—Under this title DR. A. COURTADE presents an elaborate and illustrated paper (*Archives internationales de laryngologie, d'otologie et de rhinologie, Mars-Avril, 1903*) showing that the crypts, which are more numerous than they are supposed to be, exist upon the top and the bottom of the tonsil as well as in the sides and front, and that they all converge toward the interior instead of having an indefinite or irregular course. He was led to this study by finding caseous masses expressed from the tonsil beneath the anterior pillar, and so minute that they could not be penetrated by an ordinary probe.

Foreign Body in the Œsophagus Removed by Gastrotomy.—At a meeting of the Clinical Society of London (*British Medical Journal*, October 31, 1903) DR. PATTERSON exhibited an inhaler removed by gastrotomy from the œsophagus of a male phthisical patient. It measured four and one-half inches in length and almost three-quarters of an inch in diameter. Inside the metal case was a glass inhaler containing a drachm of creosote. A skiagraph showed the case lying to the left of the spinal column and almost parallel to it. It produced no symptoms whatever, as after swallowing it the patient had not taken food. When the stomach was opened, one inch of the case was projecting from the œsophagus into the stomach, whence it was removed. The patient made an uninterrupted recovery.

Removal of Nasal Polypi.—DR. ALBERT RUVAULT describes and depicts (*Annales des maladies de l'oreille, du larynx, etc.*, February, 1904) his improved intranasal polypotome, in which, by pressure of the thumb, the guard is pushed down over the wire loop. This instrument would appear to be much steadier than other forms of polypotome.

Vasenlar Rhinopharyngeal Fibroma.—At a meeting of the Clinical Society of London (*British Medical Journal*, October 31, 1903) DR. HERBERT TILLEY showed a lad, aged sixteen years, from whose rhinopharynx he had removed a fibro-angioma by various operations. When first seen, two years before, the patient had complete nasal obstruction, with blood-stained discharge from the left nostril of five months' duration. A large, sloughy, easily bleeding mass completely filled the left nasal fossa. In November, 1901, but half the growth could be removed by Ollier's method. In December, after a preliminary laryngotomy, division of the soft palate and removal of the left side of the hard palate, all visible growth was removed, also in March, 1902,

after recurrence. In July, 1902, there was again extensive recurrence, and after preliminary laryngotomy the soft parts of the nose and face were turned upward; a large opening was made in the left canine fossa, and the lower half of the ascending process of the left superior maxilla was removed. The growth was seen to arise from the external surface of the antrum and ethmoidal region, and was completely removed. There had been no further recurrence. The boy had grown four inches, and early in the year the soft palate had been sutured.

Mucocele of the Ethmoid.—GUIZEZ reports (*Annales des maladies de l'oreille, du larynx, etc.*, February, 1904) an interesting case of ethmoidal mucocele of very large dimensions—say 3 cm. in every direction. It did not communicate with the nasal passage, and probably developed from one of the anterior cells of the prefrontal group. It was exposed by external excision and resection of the greatest part of the anterior wall, and found filled with a viscous, yellowish-brown liquid, rich in cholesterol. After curetting and careful scraping of the entire internal face of the osseous walls a solution of chloride of zinc one part to ten was applied and a drain left at the inferior angle of the wound. Recovery was prompt, without deformity, and with very little cicatrix.

Maxillary Sinusitis Due to a Dental Ectopia.—GUIZEZ reports (*Annales des maladies de l'oreille, du larynx, etc.*, February, 1904) a case in which the suppuration of the maxillary sinus was found to be due to a large molar tooth in its interior, the roots being implanted partly in the alveolus and partly in the floor of the sinus itself. This tooth was carious at the union of the neck and roots. For its liberation it was necessary to resect a portion of the alveolar process and the palatine vault. A slight buccal fistula presented for several weeks, but the purulent discharge and the subjective odor completely disappeared.

Chronic Suppuration of the Maxillary Sinus.—DR. CLAUDE, of Bordeaux, describes (*Annales des maladies de l'oreille, du larynx, etc.*, March, 1904) his new operation for gaining access to the sinus through the nasal passage in order to secure a thorough drainage, which he considers the chief feature of surgical treatment, more important even than careful curettage of the cavity. The operation is performed without general anaesthesia and consists of three stages, the last two of which may follow after the first immediately, or be postponed for a day or two, according to requirements.

1. The anterior two-thirds of the lower turbinated bone is removed close to the nasal wall with scissors, and the section is completed with the cold snare.

2. With a hand trephine, which is preferred to the motor, two perforations are made in the wall of the sinus about 2 cm. from the anterior extremity of the turbinate which had been removed; the intervening bridge is removed with the punch. The orifice thus made is then enlarged until it is nearly the size of the pulp end of the thumb.

3. The sinus is copiously washed out and then explored. If any diseased tissue exist sufficient to have kept up the suppuration, it is scraped with a curette with a flexible handle. A minute curettage is not