

large polypus was present in the right ear, while a purulent discharge issued from the attic of the left tympanum.

Under a general anæsthetic some carious teeth were removed on both sides, and the alveoli perforated and drainage-tubes inserted. The ethmoidal regions were curetted and the adenoids removed, together with the right aural polypus and the auditory ossicles on the side, which were found to be carious.

The treatment since the operation has consisted of bi-daily irrigation of the outer and nasal cavities with an alkaline antiseptic wash, and three times a week I have thoroughly irrigated the frontal sinuses with boracic lotion, followed by hydrogen peroxide, followed by iodoform emulsion. The discharge from all the accessory nasal cavities has diminished, and the patient is very much better in her general health, and is now taking a sea voyage.

It is scarcely necessary to add that such a treatment as this will not cure the disease, and the question arises, Are we to content ourselves with diminishing the discharge, and thus making the patient altogether more comfortable, or should we advise her to submit to some three or four radical operations on the nasal accessory sinuses, which, even if successful, must inevitably leave some slight scarring over the frontal sinuses, and as the patient is very fair, these would be more noticeable than in a person of darker complexion. It would be useless to curette the maxillary sinuses alone, because they would be reinfected by the discharge from the frontal sinuses. If the latter be operated upon, they must both be dealt with at the same operation, because they freely communicate. Such an operation would take the best part of two hours to complete, but there would be practically no risk from the operation itself.

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#### **EXPLANATION OF APPEARANCES IN SOME CASES OF ACUTE LACUNAR TONSILLITIS WHICH SIMULATE EXCAVATING ULCERS.**

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OCCASIONALLY the medical attendant and friends of patients affected with acute tonsillitis are considerably alarmed by the appearance on the upper and posterior part of the tonsil of what appears to be a deep excavated ulcer of oval shape, the floor of which is covered with a white slough-like membrane. Such cases are often described

by the observers, and a very typical one came under my notice recently.

Mrs. Y—— came under my observation on July 4 complaining of intense sore throat. At the upper part of the right tonsil was a large excavation, the walls of which were covered with a white detachable exudate. A probe was introduced into this, and it could be seen that the exudation came from the mouths of small lacunæ in the tonsil tissue situated above and behind and below and in front of the opening. The appearance at the time was extremely alarming, but the lacunæ on the rest of the surface of the right tonsil, as well as on the left one, presented the appearance typical of lacunar tonsillitis. I looked upon the excavation as being formed by the furrow which normally exists in the tonsil in its postero-superior part, though probably in this particular instance rather larger than usual. The case was treated as one of simple lacunar tonsillitis, namely, by the administration of salicylate of soda corrected by the addition of bromide of potassium, and in a week's time every vestige of exudation had disappeared, and the patient was perfectly well.

This presents in an interesting way some points brought out by Killian in vol. vii. of *Archiv für Laryngologie*. He points out that in the new-born child the tonsil consists of three masses of tonsil tissue, between which are two furrows; the uppermost mass and the furrow next to it are the most persistent. The lower furrow gradually disappears, and the tissue which forms the bulk of the adult's tonsil is covered to a considerable extent by a triangular fold of membrane running downwards and backwards from the anterior pillar of the fauces. In the case above described the upper furrow is unusually patent.

Killian recommends for the better examination of the tonsil that the head should be turned towards the affected side, the tongue pulled out towards that side, and the opposite angle of the mouth retracted while the patient utters the sound "hay." In this position the tonsil is looked at more nearly from the middle line, so that the furrow and the marginal cushion (*Randwülst*) above and behind it can be readily recognised. This furrow is quite distinct from the supra-tonsillar fossa, the opening of which is above the anterior portion of the tonsil and between its apex and the uppermost part of the anterior pillar of the fauces. I have generally found it necessary to use a tongue depressor to enable me to see the tonsil satisfactorily by Killian's method.

I am not prepared to state that the cases of combined ulcerative tonsillitis described by Sendziak, or the chancriform tonsillar ulcers

described by Moure, consist simply of the natural excavation to which I am referring, but I think it extremely probable that the furrow has been frequently mistaken for excavating ulcers by others, as I believe they have by myself.

### **HYPERTROPHY OF THE ANTERIOR LIP OF THE HIATUS SEMILUNARIS.**

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WHEN the anterior part of the middle turbinated body is not very highly developed, and still more if, as the result of atrophic rhinitis, it is diminished in bulk, the groove of the hiatus semilunaris is often very plainly visible. More often it is concealed from view by its own anterior lip, which may form a fairly sharp ridge, shelving gradually towards the observer. This ridge, which is really the membrane covering the unciform process of the ethmoid, is sometimes the seat of considerable hyperplasia, and it very frequently comes in contact with the middle turbinated body, so that what is normally a groove is thereby converted into what is practically a tube leading more or less directly from the ostium of the maxillary sinus up to the frontal infundibulum. In extreme cases this hyperplasia is very considerable, and it may enlarge so as to form a rounded bolster-shaped swelling on the outer wall of the middle meatus, curving from above downwards and backwards so as to simulate an extra turbinated body. It is sometimes so rounded and so large that it may overgrow and acutely conceal the real middle turbinal, and present an appearance so like that body that it may be very readily mistaken for it, and indeed impossible to be distinguished from it by its ocular appearance, except in so far as the typical neck of the middle turbinal may seem to be wanting. By the use of the probe, however, that difficulty is removed, as it is then found impossible to pass this between the swelling and the side-wall as one could do if it were the middle turbinated body.

It is impossible to examine any very large number of noses without coming across this condition, but unless the singularity of the appearance and the nature of the swelling are kept before the mind, it is very apt to be overlooked; hence in studying the topography of the parts in any given nose it is essential to check the ocular appearances by means of the probe. The swelling I refer to