

**Nicolle and Hebert.**—*Sore Throat due to the Pneumo-bacillus of Friedländer.* "La Presse Méd.," May 31, 1902.

The pneumo-bacillus is seldom found in the throat, even in the saprophytic condition. Netter found it 9 times in 105 examinations, Nicolle and Hebert have found it 24 times in 3,670 specimens of pharyngeal exudation examined in their laboratory. In 11 cases it appeared to them to play an important part in the production of false membranes; in the remaining cases it probably existed in the throat merely in a saprophytic condition.

Twenty-two cases have now been reported in which this bacillus produced sore throat with false membrane closely resembling diphtheria in appearance, though not in symptoms.

The authors report the following case: A child, aged twelve, complained of slight pricking sensation in her throat. Her father (a doctor) examined the throat at once, and noted a whitish, diphtheritic-looking patch on the right tonsil. Next day there was a false membrane on the tonsil, which was tough, adherent and left a bleeding surface when removed. There were no other symptoms beyond slight pharyngeal discomfort; no fever, pulse normal, no eruption, excellent appetite. The false membrane persisted without spreading and without causing any other symptom for several weeks, then disappeared. Direct examination of the membrane and examination by means of cultures established the diagnosis of angina due to Friedländer's pneumo-bacillus.

Arthur J. Hutchison.

#### E A R.

**Hopkins, G. W.**—*Superheated Compressed Air in the Therapeutics of Chronic Catarrhal Otitis Media.* "Med. Record," September 6, 1902.

The author recommends an electric heater as the ideal appliance for this purpose. A pad of gauze is placed over the ear, and by means of an ear speculum the gauze is pressed into the meatus. The ear tip of the heating apparatus is then carried well into the canal, leaving just a small space between its tip and the outer surface of the membrana tympani for the escape of air. The following are the author's conclusions:

1. That as an exclusive treatment it is rarely of much value in bad cases.
2. That when indicated and judiciously employed, in conjunction with other measures of recognised value, it will give results which would be utterly impossible without its aid.
3. That when employed with care it is absolutely safe unless contra-indicated.
4. That it is of little value in old subjects who have extensive labyrinthine involvement.
5. That it stimulates absorption of articular deposits, removes atrophy, and relieves rigidity of the tensor tympani.
6. That it acts more favourably on the ossicular chain than on many other articulations, because of their exceptional proximity to the surface.
7. That arterio-sclerosis, serous effusions into the tympanum, and perforations of the tympanum are usually contra-indications, and always contra-indications to the inexperienced operator.

W. Milligan.

**Marage.**—*The Scientific Treatment of Deafness.* "Archives Internationales de Laryngologie, d'Otologie, et de Rhinologie," July—August, 1902.

The author describes an instrument on the principle of a syren, with a dial which exercises the sense of hearing, and at the same time records the degree of deafness.

He holds that this treatment is superior to the ordinary massage, and gives cases in which improvement has followed after other means have failed.

*Anthony McCall.*

**Reverdin and Vallette.**—*Two Cases of Intracranial Abscess.* "Revue Méd. de la Suisse Romande," April 20, 1902.

The interest of the two cases here reported consists chiefly in the misleading nature of the symptoms. In the one case the symptoms were such as to lead to the diagnosis of abscess of the cerebellum, whilst the abscess was found post-mortem in the occipital lobe. In the other case the localizing signs were not very definite; the temporal lobe was explored with negative results, the abscess being really situated in the cerebellum.

The first case was a boy of fifteen, who was struck by a stone on the occipital region in June or July, 1901. This gave rise to a suppurating wound, high fever, violent headache, and the exfoliation of several osseous sequestra, one of which was about 3 centimetres long. After a month the wound had healed, and the boy could return to his usual occupation, though he still had headache. In September he got a violent blow on the head, after which the headaches increased in severity. When brought to the hospital on October 18 he was somnolent, answered questions slowly but clearly, lay on either side, with legs extended, could move the head freely, showing no sign of stiffness of the neck. He could stand alone, but on trying to walk soon became giddy. There was marked external strabismus of the right eye, slight ptosis of the right eyelid, and dilatation of the right pupil. Whether diplopia was present or not could not be definitely ascertained. Later, a certain amount of ataxia was noted, and staggering gait with tendency to fall to the right. The pulse was slow throughout, and the temperature but little above normal. At the post-mortem examination a large collection of pus was found in the white substance of the occipital lobe, causing pressure on the cerebellum and on the nerves at the base of the brain; also some meningo-encephalitis in the same region. Owing to the patient's uncertain answers, it had been impossible to decide as to the presence or absence of hemianopsia.

The second case was a man forty-three years old, operated on by Reverdin in 1896. Three years earlier, after an attack of influenza, he had had right otorrhœa, which lasted six months. The discharge then ceased for two years, but commenced again in the winter of 1895-1896, and was then accompanied by mastoid swelling and violent pain in the head. On May 12, when he came to the hospital, the patient appeared very ill and weak, and complained of violent pains which came on in frequent crises, chiefly in the back of the head. He had vomited once or twice; bowels regular; pulse full, regular, 60 to 64; temperature 37.2° C.; movement of limbs normal; no facial paralysis; slight external strabismus of the right eye; difficulty in turning eyes to the left; nystagmus; diplopia, especially for near objects, owing to loss of power of convergence. Pupils reacted to light; slight ptosis of left eye-

lid. The patient stated that he sometimes had vertigo, but he could maintain his equilibrium even with his eyes shut. The mastoid was operated on, a large cavity being found extending up to the middle fossa. This gave very little relief; therefore, after five days, the skull was trephined 3 centimetres above the meatus. The dura mater bulged, and did not pulsate. No abscess, however, was found in the temporal lobe. This operation was followed by slight temporary improvement, but the patient died on the eleventh day. At the post-mortem examination the cerebellum was found to be adherent to one part of the posterior wall of the petrous bone. The adhesion covered an abscess about the size of a pigeon's egg in the upper part of the right cerebellar hemisphere. No sinus or track of any kind could be made out connecting the mastoid abscess with that in the cerebellum.

*Arthur J. Hutchison.*

### THYROID, Etc.

**Cristiani.**—*On Thyroid Grafts.* “*Revue Méd. de la Suisse Romande*,” October 20, 1902.

In previous papers on this subject Cristiani has reported the results of his experiments on rats and other mammals, birds and reptiles, and has shown that it is possible not only to get thyroid grafts to take and to become reorganized, but even to hypertrophy. Eiselsberg followed some of his grafts up to six months without finding signs of degeneration; Cristiani followed his up to five years and found them then true active thyroid glands, richly vascularized, and with very numerous alveoli containing colloid matter. Earlier experimenters made the mistake of using too large grafts, using, for example, a whole lobe of the thyroid of a sheep, cat, etc. In all animals the thyroid, in order to perform its function properly, requires an immense blood-supply in proportion to its size; therefore a large graft, even if it takes well, has comparatively small chance of ever becoming an actively functional gland. As a matter of fact, large grafts do not take well, their deeper parts never properly reorganize, and if implanted subcutaneously they do not take at all, but degenerate and are absorbed. Now, in man the only form of grafting justifiable is subcutaneous grafting, intraperitoneal grafting being too dangerous. The chances of success are much greater if the thyroid is taken from the same species of animal that it is to be grafted on; therefore in man it is best to have a small piece of thyroid taken from a healthy human gland. This can easily be obtained during many operations on the neck.

The patient having been prepared by a course of thyroid feeding, several small incisions are made through the skin, then with a blunt-pointed instrument little pockets are burrowed in the subcutaneous tissue—six or eight may be made, radiating from each incision—and into the bottom of each pocket is placed a small piece of healthy thyroid gland about the size of a grain of wheat. It is obvious that each piece of gland, being so very small, can be easily supplied from the vessels of the subcutaneous tissue with a relatively very large blood-supply, and can therefore rapidly become reorganized and converted into a small active thyroid gland. Further details are promised in a later paper.

*Arthur J. Hutchison.*