

**Albanus (Hamburg).—The Pathogenesis of Lupus of the Nasal Cavities and its Relation to Neighbouring Parts.** “Archiv f. Laryngol.,” vol. xxvii, Part II.

Statistics showing the frequency of the association of lupus of the nasal mucous membrane with lupus of the skin vary greatly according to the nature of the material investigated. Thus Bender, among 380 cases of cutaneous lupus, found the nasal mucosa involved in one third, while among sixty-five cases examined by Safranek no less than 72·3 per cent. showed the nasal affection. In most cases it is not stated whether the disease was present on the skin of the face or of some other part of the body. The author himself examined 147 cases of lupus of the skin and found the nasal mucous membrane involved in 46 per cent. This was the case in 15 per cent. of those with lupus of the extremities, 56 per cent. of those with lupus of the head, and 87 per cent. of those with lupus of the outer surface of the nose. It is clear, therefore, that in by no means every case of lupus affecting the exterior of the nose has the disease originated in the nasal mucosa.

The author's observations agree with those of Mygind in showing the much greater frequency with which the septum and the inferior turbinal are affected than other areas of the nasal interior. This fact may be regarded as an indication that a considerable proportion of intra-nasal lupus is due to infection reaching the nose by contact or by the air-stream.

All the possible modes of infection and spread of the disease are described and most of them are illustrated by cases from the writer's practice. Recent observations have shown that tubercle bacilli are circulating in the blood of many children in the complete absence of all symptoms, and cases in which numerous discrete foci of lupus appear on the skin and mucous membranes are certainly to be attributed to embolism resulting from this condition of bacillæmia. Acrogenous and contact infections are much favoured by the presence of eczema of the nasal vestibule or rhinitis sicca anterior. This form of the disease appears to begin most commonly in adults on the skin of the ala, in children at the point of junction of skin and mucous membrane in the “nasal pocket.” Spread of the disease by way of the lymphatics may take place either in the direction of the lymph-stream or against it; the author has been struck by the relative frequency of retrograde extension.

In conclusion, the author states his belief that while the importance of the nasal mucosa as the seat of the primary infection in lupus of the skin has certainly been under-estimated by some dermatologists, it has perhaps been exaggerated by some of those who have approached the question from the point of view of the rhinologist.

*Thomas Guthrie.*

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**E.A.R.**

**Goldstein, Max A.—Diseases of the Ear which lead to Brain Abscess.** “Journ. Amer. Med. Assoc.,” September 21, 1913.

Either an acute or chronic suppurative otitis media may give rise to a brain abscess, but the distinction is of no practical value, as the seriousness of the lesion depends upon the virulence of the invading micro-organism.

Until recently brain abscess was regarded as a complication almost exclusively of the chronic forms of suppurative otitis media, but further studies have shown that the acute processes are also agents in the production of brain abscess, and it is in the acute types that the more typical development of brain abscess occurs. The extension of disease from its primal focus in the middle ear to the surrounding intra-cranial areas is greatly favoured by dehiscences in the tegmen tympani or tegmen antri; by the knee of the lateral sinus encroaching markedly on the mastoid antrum; by the floor of the tympanum being incomplete and imperfect, and in close touch with the jugular bulb; by the patency of petro-mastoid, and petro-squamosal sutures; and by the anomalous course of vessels throughout these areas. *Birkett (Rogers).*

**Dercum, F. C.—Diagnosis and Localisation of Brain Abscess.** "Journ. Amer. Med. Assoc.," September 21, 1912.

In the diagnosis of brain abscess the existence of an otitis media, either past or present, is of the utmost significance. The symptoms may only appear years after the aural infection, in fact, a brain abscess, the symptoms of which become manifest in adult life, may have had its inception in an ear disease of childhood. Headache, vomiting and hebitude are the first signs that a brain abscess has become active. Soon after, dizziness, subnormal temperature or moderate fever, optic neuritis, neuro-retinitis and choked disc make their appearance. These symptoms have additional value in the presence of a high leucocytosis, and a negative cerebro-spinal fluid. If in a case of ear disease convulsions supervene, the suspicion of otitic brain disease should at once be aroused. The important differentiation in otitic abscess is between temporal and cerebellar involvement, but unfortunately symptoms pointing to such differentiation may be entirely absent. In the majority of cases symptoms are present, though they are often exceedingly slight.

*Birkett (Rogers).*

**McKernon, James F.—The Operative Treatment of Brain Abscess of Otitic Origin.** "Journ. Amer. Med. Assoc.," September 21, 1912.

McKernon lays down the following rules for the treatment of otitic brain abscess:

In acute and emergency cases operate early, doing the entire operation at one sitting. In subacute cases and those not urgent the modified decompression operation of Ballance with a wait of from twenty-four to forty-eight hours after the dural incision before exploring the brain conserves the best interest of the patient, and minimises the development of secondary meningitis. A large opening in the skull is essential. Dural sutures aid materially as flat retractors, and should the exploration be negative the brain-substance can be covered and protected by tying the sutures. If pus is encountered sutures are removed.

The knife only is to be used for incising brain-tissue; avoid finger manipulation and trauma to surrounding substance. Wipe the cavity gently; no irrigation should be used unless in a chronic abscess cavity with distinct and dense membranous wall. The size of the drainage-tube should be governed by the extent of the cavity; the material used is rubber tubing in the chronic variety and cigarette drain in the acute type.

Rise of temperature or change in mentality of the patient calls for an

immediate inspection of the cavity, with search for obstructed drainage or development of additional foci.

Rapidity in operations is essential to success, and above all frequent manipulation of brain-substance should be avoided.

*Birkett (Rogers).*

**Berlstein and Novicki (Lemberg).—A Case of Tumour of the Eighth Nerve.** "Monats. f. Ohrenheilk.," Year 47, vol. iii.

Emily S—, aged twenty-one, applied for relief of severe headache, from which she had suffered for two years, at the General Hospital in Lemberg, January 11, 1912.

Her history revealed nothing important. The headache was not local, but was almost continuous night and day, causing sleeplessness for the first months after its onset. For the last year she had had attacks of giddiness associated with vomiting and malaise, and her hearing began to be affected, being accompanied by tinnitus, which after some months ceased. During the last three weeks the vision had been worse. No trophic disturbance. She had had one fainting attack, which lasted an hour. Chest and abdomen normal. Wassermann reaction negative. No ataxia. Diadokokinesis normal. Gait uncertain, with tendency to fall to the right. Tendency to fall backwards during Romberg's test. Achilles reflex absent on the left, and only elicited with difficulty on the right. Babinski absent. Otherwise all reflexes, sensation and movements normal.

Examination of the ears: Membrana tympani and middle ear normal both sides. Weber to the left. Rinne, right negative, left positive. Schwabach, right, markedly; left, slightly shortened. C, c<sub>1</sub>, A<sub>1</sub> not heard right, left normal for all forks. With the noise apparatus only loudest conversation heard right. Spontaneous rotatory nystagmus to the left. Vertical nystagmus on looking down. No reaction to either cold or hot caloric test right, nor was the spontaneous nystagmus or the tendency to fall affected. Irrigation of the left ear with cold water induced a horizontal rotatory nystagmus in 25 seconds, which lasted 5 minutes and completely mastered the spontaneous nystagmus, accompanied with a typical tendency to fall to the left in varying positions of the head. Simultaneous cold irrigation of both ears resulted in a coarse nystagmus to the right after 50 seconds. Rotation to the left gave a horizontal nystagmus to the right of 8 seconds' duration; right rotation gave a horizontal nystagmus to the left lasting 35 seconds, which could easily be distinguished from the spontaneous nystagmus. Galvanic reaction, cathode on right ear, anode in left hand, evoked with 5 m.a. some nystagmic movements to the right. Cathode on left ear, anode in right hand, caused an active nystagmus to the left with 2½ m.a. With the divided monopolar electrode, cathodes in the ears, anode on the forehead, resulted in nystagmic movements to the left with 3 m.a. Giddiness occurred from time to time, especially with change of position. Malaise was less frequent than formerly, and was almost always associated with severe attacks of headache. No tinnitus.

No spontaneous deviation, but cold irrigation of the left ear gave a typical deviation to the left: similar test of the right ear did not affect the pointing at all.

The patient was examined three times within a week, and the same reactions essentially resulted; the spontaneous nystagmus, however, varied in intensity and direction. No positive help was obtained from an X-ray picture.

Eyes: Finger counting at 15 cm. left, vision  $\frac{6}{12}$  right, œdema of both discs. No field could be mapped for the left eye; on the right side only the inferior temporal quadrant was preserved. Red was only detected at the centre, whilst for green a relative central scotoma existed.

An operation was performed in two stages. After the first—decompression—the patient was not improved, and fingers could only be counted at 5 cm. At the second operation, seven days later, the patient's condition did not admit of more than removal of a small portion of the tumour in the region of the internal meatus. Thirty days later she died of purulent meningitis.

*Post-mortem.*—An egg-shaped tumour, about 42 mm. by 39 mm., occupied the right cerebello-pontine angle.

Histologically this consisted of a fibro-glioma. The growth, there was good reason to believe, had commenced in that part of the acoustic nerve immediately within the internal meatus, which latter was enlarged. It was most remarkable that neither the facial, the trigeminal nor the sixth nerve were affected during life as they were in such immediate relation with the tumour.

This case and other published records of similar cases are discussed in detail, and the authors are certainly to be congratulated on their most exhaustive account, of which this report forms only a very meagre abstract.

*Alex. R. Tweedie.*

**Vergues, Dr.—The Ear and Typhoid Fever.** “Rev. Hebdom. de Laryngol., d'Otol., et de Rhinol.,” September 28, 1912.

This paper is based on the study of the ear complications which were met with during an epidemic of typhoid fever in 1909 in the naval hospital at Cherbourg. Out of a total of 359 cases of typhoid fever, ear complications arose in 29 cases, *i. e.* 8·07 per cent. In all these 29 cases sero-diagnosis had been positive.

(1) The external ear was affected in two of the cases. Furunculosis is the most common external ear complication. It is usually staphylococcal, and is comparable to the furunculosis which is met with in other parts of the body during typhoid fever. Herpes has also been described. Gangrene of the auricle is rare. Like the gluteal bed-sore, it occurs in very feeble patients, and is due to prolonged pressure and debility.

(2) Otitis media accounted for 26 cases of ear complication, *i. e.* 7·2 per cent. of the total. 2·7 per cent. were acute catarrhal cases. This type of case presents no unusual feature. In 4·4 per cent. the otitis media was suppurative. In the acute suppurative cases there is a rise of temperature, but pain is rarely a marked symptom. The perforation is usually single, of medium size, and almost always antero-inferior. The complication occurs most frequently during the stage of recession of the typhoid fever. Chronic middle-ear suppuration is, in most cases, a sequel of the acute type, but may be chronic from the first. The onset is characterised by a complete absence of reaction, and the condition is often discovered by accident.

The bacteriology was investigated in five of these suppurative cases. In none was Eberth's bacillus demonstrated. *Bacillus coli*, streptococcus, staphylococcus and diplococcus were the organisms found. These otites, then, should apparently be classed as paratyphoid lesions.

The prognosis in the catarrhal cases is excellent. They may, however, become chronic, with adhesion formation, or they may become purulent. In the suppurative cases the outlook is also, generally speaking, favourable. There may, however, be some diminution of the hearing distance.

Further, the suppurative cases tend to run a subacute or almost chronic course. The patient is also exposed to the risk of the ordinary complications of suppurative otitis media. Lermoyez considers that mastoid suppuration is an almost invariable accompaniment of these otorrhœas. The degree of severity of the typhoid fever seems to have no bearing on the occurrence of otitis media, nor on the gravity of the otitis when it does occur.

The usual route of infection is from the naso-pharynx *viâ* the Eustachian tube. Bucco-pharyngeal ulceration, dryness of the mouth interfering with deglutition and diminished resistance of the organism are all factors in the causation. Pre-existing pharyngeal and nasal lesions are predisposing causes.

Treatment is, in the first place, prophylactic—gargles, antiseptic washes, etc. Any pharyngeal lesions which appear should be energetically treated. Once middle-ear suppuration has occurred it should be dealt with on ordinary principles. Any pre-existing nasal or pharyngeal trouble should be attended to as soon as the patient's general condition permits.

(3) Otitis interna is a rare complication. It occurred in only one of the 359 cases. Attacks of slight severity no doubt occur often, but are not recognised owing to the debilitated state of the patient. This complication arises when the fever is at its height, and may be due to hyperæmia, hæmorrhage or serous effusion in the labyrinth.

The only suggestions for prophylactic treatment are the avoiding of quinine and salicylic acid. For the lesion itself, once it has occurred, Hill recommends iodide and mercury with subcutaneous injections of pilocarpine.

*John M. Darling.*

### MISCELLANEOUS.

Feldt, A.—The Treatment of Tuberculosis with Gold. "Deutsch. med. Woch.," No. 12, 1913.

On injection into animals cantharidin causes a local reaction in the shape of a serous infiltration at any existing inflammatory focus, whether tuberculous or otherwise. It was suggested to the author by Prof. Spiess, who had observed this reaction in the human larynx, that cantharidin, although itself without bactericidal power, might be employed to convey substances possessing such power through the blood-stream to the tuberculous focus.

It was necessary in the first place to reduce the marked toxicity of cantharidin, and this was accomplished without diminishing its affinity for tuberculous foci, by forming a new æthylendiamine compound. The latter was then combined with various salts of gold, which are said to be the most powerful destroyers of tubercle bacilli at present known, their virtue being due, as the author was able to prove, to the gold itself and not to the substances with which it unites to form salts.

Animal experiments carried out with the compounds thus obtained gave the following results. Guinea-pigs and rabbits about a month after injection with either human or bovine bacilli showed on subcutaneous or intravenous injection of the gold-cantharidin compound a very marked local reaction of all the affected organs. The author attributes this reaction to destruction of the bacilli in the periphery of the tuberculous foci with liberation of their contained toxins—in fact, a tuberculin reaction resulting from bacterial destruction.

This focal reaction following injection of gold preparations may therefore be termed the "secondary tuberculin reaction."