

## Abstracts.

### NOSE.

**Glogau, Otto.**—**Dacryo-systo-rhinostomy.** "Laryngoscope," 1915, p. 28.

Glogau describes a modification of the operation invented by West and Halle. The lateral wall of the nose is cocainised. Through the previously slit canaliculus the sac is first washed out with antiseptic and then cocainised. A lacrymal probe is then introduced. At the anterior attachment of the middle turbinate a portion of the superior maxillary bone, together with its lining of mucous membrane, is removed until a hole of about 3 mm. diameter is formed, and until the chisel strikes the lacrymal probe that is pushed by the assistant towards the nasal cavity. A piece of the inner wall of the sac is then excised, according to West and Halle. A thin probe with an eyelet at its proximal end is now introduced, until it can be seen emerging from the opening of the sac into the nasal cavity. Through the eyelet No. 2 white silk has been threaded. The blunt end of the probe is then caught by means of nasal forceps and the entire probe pulled into the nose. The end of the silk thread thus emerging from the nose is then tied to the other end protruding from the canaliculus. No external dressing is needed, though the silk drain remains in place for several weeks. The patient is not annoyed at all by the thread. By means of a piece of cotton wool a 10 per cent. solution of protargol is applied to the thread, and the latter moved up and down so that the medicament is brought into intimate contact with the new naso-lacrymal duct.

*J. S. Fraser.*

### EAR.

**Kerrison, Philip D.**—**The Psychology of Deafness.** "Laryngoscope," 1915, p. 257.

Kerrison maintains that there is a psychological, as well as a pathological, factor in most cases of advanced deafness. Two individuals in whom careful hearing tests show the same degree of deafness may differ greatly in their power of interpreting conversation. Such differences may be due to the fact that one deaf person is better able to interpret such speech sounds as come to him, because he has a quicker and more synthetic type of mind enabling him to grasp quickly the meaning of a sentence imperfectly heard. We must not, however, forget that the faculty of lip-reading is possessed by all partially deaf people in some degree.

Kerrison holds that the ordinary speech test is far from scientifically accurate in ascertaining a patient's hearing power, for the following reasons: (1) If numbers are used, the patient quickly becomes accustomed to the sounds and is soon able to repeat them correctly. (2) If words are used, the patient soon learns the aurist's test-word vocabulary. (3) When words of more than one syllable are used, certain consonants may be nearly inaudible to the patient, yet the combination and sequence of the vowel sounds and such consonants as he does hear may give him the clue. (4) All partially deaf people hear certain consonants more distinctly than others. Kerrison finds the names of cities convenient.

test words. After calling out several numbers, which the patient has repeated correctly, he suddenly interjects the word Chicago, to which the patient replies "sixty-four" or "seventy-four"—numbers which have a remote resemblance in sound to "Chicago."

Kerrison now uses monosyllables, which, of course, do not contain any sequence of vowel sounds to suggest the word. The patient is not required to close either ear, but is seated within four or five feet of the examiner, and looks away from him to eliminate lip-reading. The patient is instructed to *repeat promptly the words or sounds as they are heard*. Kerrison's test-tables consist of seventeen columns, each column consisting of seven words beginning with the same consonant. Thus, the first column is as follows: bad, band, bed, bend, bard, bold, bond. Beginning with the first word of this column, the examiner calls the words in an average tone of voice from left to right—first the words at the top of each column, *e. g.* bad, cad, dab, fad, gap, hard, jay, lad, mad, nap, pad, rat, sat, tap, vat, wall, zeal; then the second line, and so on. Only the patient's errors are noted on his test card. When the whole table has been gone over one notes the character of the errors, and can thus determine the comparative loss of hearing for the various consonants. Kerrison then makes out a list of practice words containing the consonants which are badly heard, and the patient is instructed to get a friend to call the words over to him several times daily. After several days of practice there is, as a rule, considerable improvement. The order in which the words are spoken is constantly varied. A patient who may be quite uncertain in his recognition of two words spoken singly and separately, may readily distinguish between them when spoken together, *e. g.* bent and tent. This justifies one in saying that if the patient can distinguish the words when spoken in quick succession, he should with practice be able to recognise the "b" and "t" sounds singly.

With regard to the psychic factor in deafness, Kerrison points out that certain deaf individuals gradually and subconsciously surrender their place in the social and working world around them. Such people, realising that they are at a disadvantage, shun society and make no productive effort. They explain all the shortcomings of their lives as the result of their deafness. Thus a vicious circle is set up. To combat these tendencies it is essential that the patient be stimulated to sustained effort in his own behalf. Patients with quick minds catch a word here and there and from these deduce the words which have escaped them. They may even lose whole sentences and yet be able to pick up the line of thought from what follows. This may be compared to the stage at which every linguist arrives in the study of a foreign language when he is able to follow the drift of a conversation, though words, and even sentences, escape him. A deaf patient should seek frequent opportunities for conversation with as many different people as possible, though with only one at a time. He must practice the habit of undivided attention and must not worry if he cannot hear every word which is spoken. He must try to deduce from what he does hear the general trend of the conversation, and resist the inclination to unnecessary interruption. Lastly, he should cultivate the habit of lip-reading, which, according to Pearce, is a universal faculty, *i. e.* a faculty possessed by those of normal hearing as well as by the deaf. Kerrison himself is conscious of some impairment of hearing, but still finds no difficulty in general conversation, and can enjoy a play from most seats in the parquet. He at once took up the

study of lip-reading, and now, by watching the lips of patients, he has no difficulty in determining whether they answer correctly or incorrectly when he calls out his lists of words.

*J. S. Fraser.*

### MISCELLANEOUS.

#### Otto J. Stein.—Hypophyseal Growth Operated on through the Nose and Sphenoid. "Laryngoscope," 1915, p. 159.

Stein's patient was a female aged thirty-five. Menstruation began at thirteen and ceased at twenty-three. Three years ago the vision of the left eye became reduced, and for the last year this has been much worse. Examination of the nervous system showed no focal symptoms of paralysis, but the consensual Wernicke pupil reaction was present. The right eye showed choked disc, but the vision equalled  $\frac{2}{3}\%$ . The left disc was pale and flat, the nerve head atrophic, and vision reduced to light perception. The patient complained of violent bi-temporal headaches and dizziness. The patient was a very large woman and weighed 230 lbs., but she was not of the acromegalic type, and the obesity was of the infantile type seen in hypopituitarism. She was sexually impotent. Knee-jerks reduced, four or five attacks of vertigo daily. X ray showed conspicuous involvement of the sella. *Operation:* Hypodermic of scopolamin, grs.  $\frac{1}{150}$ , and morphia  $\frac{1}{6}$  were given and repeated in one hour. One c.c. of pituitrin was also injected. The nasal septum and right middle turbinal were then carefully anaesthetised with a cotton applicator, moistened in adrenalin solution and coated with cocaine. A rapid submucous resection of the septum was now performed back to the rostrum of the sphenoid. The right middle turbinal was then entirely removed. These two procedures gave amply sufficient room. Now, by means of Killian's extra long bi-valve nasal speculum, the septal flaps were held thoroughly apart to allow of painstaking elevation of the thin periosteum covering the rostrum and anterior wall of the sphenoid. The membranes were then retracted with an extra long and wide retractor, while, with a sharp spoon or sphenoid punch forceps, the wall of the sphenoidal sinus was rapidly removed along with the septum between the two sinuses. On entering the sphenoid cavity a slight amount of bloody serous fluid was met with, and the probe made out that the floor of the sella was defective in places as a soft mass was occasionally felt. Touching the dura mater caused the patient great pain. Stein states that the probe by accident entered the brain on the left side, causing immediate collapse of the patient, with slow pulse and respiration and dilated pupils. The operation was hastily completed, an iodoform gauze drain being placed between the septal flaps. The patient soon recovered, and the slight paresis of the right side disappeared within a few days. There was no disturbance of speech. Seven days later considerable improvement in vision was noted, and the headache had entirely disappeared. The patient can now read and sew and has got rid of her vertigo. The visual fields have increased in size, though the discs are still choked. With the left eye the patient can count fingers at eight feet.

Stein states that the early operations on the hypophysis by the nasal route entailed clearing out most of the nasal structures, and hence left objectionable after-effects. Stein does not follow Cushing's method of

making the original incision through the mucous membrane at the junction of the gum and upper lip, but adopts the procedure first reported by Oscar Hirsch, which has just been described. Cushing holds that the mere feat of removing a tumour is not the only thing to be borne in mind, for this is a sorry accomplishment if the patient is left blind, palsied, aphasic, epileptic, or continues to be intellectually or physically crippled in any way. Hirsch's method has several advantages: (1) Local anæsthesia; (2) little destruction of tissue; (3) most aseptic; (4) little danger of infection; (5) no bad after-effects in nose or throat. In addition to the ordinary instruments for submucous resection, Stein uses the Killian extra long bi-valve speculum, an extra long and wide hand retractor that will pull aside one entire flap from the incision to the base of the sphenoid; long-handled mastoid chisels; mastoid sharp spoons with long handles; a small strong hook on a long handle, for removal of the floor of the sella. The following points are of importance: (1) maintenance of an unbroken muco-periosteal flap in order to thoroughly protect your line of retreat and avoid after-infection. (2) Elevation of the periosteum from the face of the sphenoid. In some cases the tumour may be encountered immediately on entering the sphenoid, as the tegmen of the sinus may have been absorbed. If not, a long narrow-handled chisel should be used to chip away the tegmen. Further progress may be made by the use of the sphenoid punch, the smooth mushroom head of which pushes away the dura and so avoids damage to the gland or tumour. A careful study of a good X-ray picture is an absolute necessity. One must not go too high for fear of entering the anterior fossa and injuring the chiasma, or too low, for then one may get into the middle fossa or the thick bone of the basishenoid. On the other hand, if one goes too far to the side, there is the danger of injuring the cavernous sinus, the carotid artery, and the optic nerve.

J. S. Fraser.

## REVIEW.

*Pye's Surgical Handicraft: A Manual of Surgical Manipulations, Minor Surgery, and other Matters connected with the work of House-Surgeons and Surgical Dressers.* Edited and largely rewritten by W. H. CLAYTON-GREENE, B.A., M.B., B.C.(Camb.), F.R.C.S. (Eng.). Seventh edition, fully revised with some additional matter and illustrations. Pp. 614. Price 15s. net, 1916. Bristol: John Wright and Sons, Ltd.; London: Simpkin, Marshall, Hamilton, Kent and Co., Ltd.; Toronto: The Macmillan Company of Canada, Ltd.

*Pye's Surgical Handicraft*, when it first appeared, was at once popular, on account of its intrinsic value, and also of a further peculiar attractiveness derived from its genial author, Walter Pye. It has been edited and largely re-written by Mr. Clayton-Greene with the happiest result. A further edition, the seventh, has been called for within a comparatively short number of years. Considerable pains have been expended by the editor and his collaborators to bring this latest edition well up to date. Mr. Carson has had charge of the sections on the surgery of the throat, nose, and ear, and he has crammed into the space at his disposal an