A CASE OF RHINOLITH.

By MATTHEW D. MORIARTY, M.B., F.R.C.S.I.,
Surgeon-Major, Indian Medical Department.

It would appear that there are not more than forty-five cases of rhinolith on record (BRITISH MEDICAL JOURNAL, pp. 841 and 1164, vol. ii of 1885). I have recently come across a well marked instance. The patient, a Mohammedan female, aged 24, and otherwise in sound health, had suffered from a discharge from the right nostril for six years; the nostril gradually became obstructed, and for two years had been completely blocked. Latterly the discharge had become offensive, with occasional slight bleedings. The right side of her nose, with the adjoining cheek and upper lips, were swollen, slightly reddened, and tender. A thin offensive discharge flowed from the right nostril, the margins of which were red and irritable; the septum nasi was markedly deflected to the left; the mucous membrane of the right nostril was much swollen, congested and thickened, so as to almost completely close the anterior naris. Further examination disclosed two points of what appeared to be dead bone, one in the position of the anterior edge of the inferior turbinated bone, the other in the situation of the nasal spine; they appeared to be firmly fixed. A few days syringing with perchloride of mercury lotion removed the fœtor, and reduced the swelling considerably. With a dressing-forceps, I then seized the end of the supposed sequestrum on the outer side, when, to my surprise, it crumbled away. I tried a second time, with the same result. The portions removed were exactly like bits of a phosphatic vesical calculus after litholapaxy. The nature of the case was now clear; the rhinolith filled the whole nostril, hidden from view, except at two small points, by the swollen mucous membrane.

Taking a strong fenestrated nasal polypus-forceps, I gradually broke down the front of the stone, till finally, getting the forceps well on, I crushed the whole mass, breaking it into three large pieces, which were removed in succession. In the crushing, considerable force was used. The bleeding was slight and easily checked. She complained of a good deal of pain in her upper front teeth, especially when the large pieces were being extracted.

After the last fragment had been removed, she expelled from the nostril a quantity of greyish-white putty-like material, not unlike brain-matter, finishing with a huge plug, which evidently had occupied the posterior nares.

The nose was well syringed with solution of perchloride of mercury, (1 in 1,000). She went home after two days; the external swelling had then almost entirely disappeared. The swelling of the mucous membrane had much subsided. There was no discharge or fœtor; the nostril was free; the deflection of the septum was unaltered.

The stone (dried) weighs exactly two drachms. There is no trace of foreign body. A certain amount of concentric lamination is apparent. A regular analysis has not yet been made. Doubtless the calculus is composed chiefly of phosphates, with perhaps a blood-clot for a starting-point.

SURGICAL MEMORANDA.

THE BEST METHOD OF REMOVING FOREIGN BODIES FROM THE EARS.

I QUOTE the following passage from an interesting pamphlet by Mr. Ernest Maylard. He is speaking of the importance of museum illustrations of the anatomy of the ear, in order that students may know the curves of the external auditory canal, and thus be made competent for the every-day duties of practice. He writes: "How many unfortunate patients have had the membrana tympani ruptured by pushing in a foreign body in the fruitless endeavour to pull it out, from ignorance of the curves and direction of the external auditory canal. I know of one case, which came immediately beneath my notice, where death occurred indirectly from the inflammation set up by a foreign body in the ear. The body was extracted, but not until the evils of previous delay and vain endeavours at removal had rendered the patient's recovery hopeless. But instances too numerous must exist in the knowledge of every surgeon."

My own experience, like Mr. Maylard's, comprises more than one case of this kind; and, whilst I quite agree with him as to the importance of good anatomical knowledge, I am yet induced, by his statements of recent experience, to try to draw attention to a method of treatment which I long ago advocated, and which is so simple and efficient that it almost supersedes the need of knowledge. It is the use of a

silver wire-loop, instead of either forceps or scoop. I have never, since I was a student, used either of the latter instruments; and, for the purpose of extracting hard bodies from the ear, I hold that they are most dangerous. With a flexible silver wire-loop, or, if need be, with two placed at right angles, I have repeatedly succeeded when all other means had failed. Thus, not only is the loop quite devoid of danger, but it is both more easy of use and far more efficient than any other method. It is impossible that it can injure the membrana tympani, or the walls of the canal. The method of procedure is, after having put the patient under an anæsthetic, to introduce the loop gently into the ear, and turn it about until it is believed to have got behind the foreign body. This it will often do at once; but sometimes a little patience is necessary. In one instance, I took out a piece of heavy lead in this way with very little trouble, using two loops at right angles with each other. The simplicity, safety, and efficiency of the method make it desirable that it should be better known.

JONATHAN HUTCHINSON, F.R.S.

CLINICAL MEMORANDA.

AN ANOMALOUS CASE OF RENAL CALCULUS.

CALCULI may exist for long, not only in the pelvis but in the structure of the kidney, without producing any definite manifestation of their presence; and often they are discovered, on *post mortem* examination, in cases in which they were wholly unsuspected during life. Some months ago a young lady, aged 24, consulted me, complaining of aching pain in the right lumbar region, from which she had suffered more or less for six years. During the last two years she had been subject to paroxysmal attacks of severe pain in the same region, shooting across the abdomen towards the left groin, associated with vomiting and occasional rigors. Simultaneously with the recurrence of these attacks of pain, appeared a swelling in the situation of the right kidney. For four or five hours prior to the paroxysm, the patient usually experienced an aching in the front of both thighs, but especially the right. On three separate occasions, I had the opportunity of examining the patient whilst thus suffering. A cystic swelling, about the size of a small cocoa-nut, was distinctly felt in the region of the right kidney, the lower and inner margin of which was always more or less sharply defined. It could be readily palpated by the fingers, employed in the manner usual to elicit any change in the renal organ, but was manifestly tender to the touch. There was marked increase of the area of normal kidney-dulness, whilst, anteriorly, there was a limited though appreciable area of resonance between the liver-dulness and that over the fluctuating tumour. As soon as the paroxysmal pain ceased, which it usually did in twenty-four or thirty-six hours, the swelling gradually disappeared, and the patient was again able to get about as usual. Twelve hours after the cessation of the attack, the right kidney could be felt, apparently normal in size, and no trace of the swelling could be detected. As the tumour disappears, there is no appreciable change in the amount of urine passed. The urine is acid and somewhat thick; it contains a few apparently inflammatory corpuscles, and spindle-celled flat epithelium, with no trace of degeneration; a fact strongly in favour of the supposition of the presence of a calculus, and the removal of the epithelium from the pelvis of the kidney by attrition.

JAMES OLIVER, M.B. Ed., M.R.C.S. Lond.,
Assistant-Physician to the Hospital for Women, London.

THE DIAGNOSIS OF CANCER.

IN A communication to the JOURNAL of March 20th on the diagnosis of cancer of the uterus, Dr. Handford directs attention to the fact 'that negative results of the microscopic examination of scrapings or small fragments by no means disprove the malignant nature of the growth.' In the case recorded by Dr. Handford, the fragment removed for microscopic examination showed mainly the structure of granulation-tissue.

I have witnessed the same occurrence in cases of carcinomatous disease of the larynx, and have recorded one notable example of it in a work recently published by me (*A Practical Treatise on the Sputum*. Edinburgh: W. and A. K. Johnston). In this case, which proved to be of a highly malignant nature, the laryngoscopic appearances during the initial stages closely resembled those of simple chronic laryngitis. Granulation-looking growths appeared from time to time on the surface of the neoplasm without marked ulceration, and were frequently expectorated. Their microscopic examination showed mainly the