NOTE ON THE TREATMENT OF EUSTACHIAN DEAFNESS BY AN IMPROVED METHOD OF RHINOSCOPY.

By ERNEST HART, Surgeon in charge of the Aural Department, St. Mary's Hospital.

THE experience of any considerable number of aural cases leaves no doubt on the mind of the clinical observer of the great value of that part of aural therapeutics which consists in the treatment of the internal or Eustachian opening of the auditory apparatus. There are, however, certain practical difficulties experienced in carrying out that treatment. The mouth of the Eustachian tube, hidden from the eye by the veil of the palate, is usually reached by catheterisation through the nostril. Catheterisation of the Eustachian tube is accordingly, in some hands, used almost indiscriminately, where no obvious cause exists, as a means of diagnosis, as well as of treatment.

The investigation of the state of the Eustachian aperture has, in several cases in my practice, been considerably aided by pharyngoscopic inspection. Any one, however, who attempts to carry out the inspection and treatment of the Eustachian tube by the method described by Czernak in his chapter on Rhinoscopy, will find considerable difficulty. The involuntary contraction of the palate, when lifted by the hooked spatula, leaves but little space for the mirror, and renders the manipulations for inspection, and especially for treatment, very embarrassing. It is probably owing to the unsatisfactory experience thus acquired, that the visual inspection of the parts, and their treatment by local applications directed by the eye, have not been more employed. To facilitate this manoeuvre, I have been in the habit of clipping the nostril so as to prevent nasal respiration, and directing the patient (as laryngoscopists do) to sound the *ah* with open mouth. By leaving the tongue in this position, and depressing it with a spatula, the patient continues to breathe the sound without uttering it, the palate is left relaxed, and the proceedings are greatly facilitated.

I find that M. Fournié has been led by some physiological considerations to the same or a very similar method to that which I have for some time adopted in hospital and private practice, and can answer for its practical success. I have at this moment two patients in whom this mode of investigation has been very useful. The one had been treated for some time by external applications, and by catheterisation of the Eustachian tube, for deafness which can by this examination be seen to depend on caries of the posterior nares. The other (a policeman sent to me by Mr. Holmes, the surgeon-in-chief) is suffering total deafness from acute circumscribed inflammation of the Eustachian tubes and the mucous membrane immediately surrounding them, the tubes being almost impermeably strictured. He is improving under the local application of nitrate of silver by a bent *porte-caustique*, and dilatation of the tube by fine gum-elastic bougies.

NOTE ON THE CURE OF ACUTE ORCHITIS IN TWENTY-FOUR HOURS.

By FURNEAUX JORDAN, F.R.C.S., Surgeon to the Queen's Hospital, Professor of Surgery at Queen's College.

It is gratifying to me to know that Mr. Noble Smith has found "most satisfactory" results (BRITISH MEDICAL JOURNAL, Jan. 30th) from the treatment of acute orchitis which I described at Oxford. May I suggest that still better results may be obtained by using a stronger solution of nitrate of silver, and applying it *immediately* the cases present themselves?

In very acute cases, I add a little vesication over the femoral artery of the same side. This is the treatment, as seen in a severe double orchitis treated in my absence, and reported to me by a correct observer, our house-surgeon, Dr. Jolly. A man, aged 30, had intense pain, intolerable tenderness, and great swelling and induration, in both testicles, and could not stand upright. The scrotum was covered with a solution to nitrate of silver (two drachms to an ounce); a stripe of vesication was established over the upper halves of both femoral arteries by means of linimentum iodi; and the testicles supported with cotton-wool. He was well in twenty-four hours.

The treatment of orchitis is of more than ordinary importance, from the discovery by Dr. Marion Sims that closure of the vas deferens from acute orchitis is a common cause of sterility—often where the blame is laid to the wife.

The return of some urethral discharge is best removed, often in a few days, by maintaining, with iodine, a disc of milder counterirritation, the centre of the disc being the genital organs. On this principle I treat all inflammations of the genito-urinary organs, male and female;

adding, in the acute forms, a little vesication on the sheltered position of the femoral arteries.

The above treatment of acute orchitis is simply an illustration of a new system of treating all inflammatory diseases, and which I constantly adopt in all, with a success proportionately as great as in acute orchitis. A brief sketch of the system appears in the February *Practitioner*.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

KING'S COLLEGE HOSPITAL.

FUNGUS HÆMATODES OF THE FOOT: OPERATION.

(Under the care of Sir WILLIAM FERGUSSON.)

T. Y., AGED 56, a rather stout flabby man, was operated upon by Sir William Fergusson on Saturday, January 16th, for fungus hæmatodes of the foot. From the notes of his case, kindly supplied to us by Mr. H. R. Parmiter, dresser, it appears that the patient's family history was of a most suspicious kind. His mother had cancer in her breast; and his only brother died seven years ago from, he had been told, carbuncle, but, from what he has heard, it was like his foot. It was very large, and discharged several pints of very offensive matter daily. Several other tumours of the same kind were found on making a *post mortem* examination of the body. The patient traced his own illness so far back as four years ago, when he had acute pains affecting many of his joints. His right foot and leg continued affected, and at times very painful after the other joints were well. The pain ran up the leg from the foot to the thigh like fits of cramp, causing the whole limb to tremble. He continued in much the same state, the pain coming on at frequent intervals, until two years ago, when his foot became very tender over a spot of the size of a penny-piece in the middle of the sole. There was no swelling, but the spot was very tender, hot, tense, and, the patient states, always bathed in perspiration. The pain in the leg now became less severe. Six months afterwards, he noticed a swelling at the tender part, which he poulticed without relief to the pain, and which had become very severe. This swelling gradually increased in size until last July, when it was as large as half an orange, firm, fluctuating, and very tender. It was opened, and about half a wineglassful of blood escaped. This cut never healed, and from it a dark outgrowth soon appeared, which since that time gradually increased in size, and became more painful. On several occasions it bled profusely. The tumour from which he suffered was a dark coloured cauliflower excrescence as large as a small orange, a little to the inside of the centre of the sole. It was flattened from before backwards, and somewhat contracted at its base, where it appeared to spring from a raised and curved rim of skin. The edges and surface of the tumour were somewhat ragged. At the base of the metatarsal bone of the great toe was a small conical swelling, and the hollow at the inner side of the foot was quite filled up by a tense, fluctuating, very tender swelling, on the surface of which were four or five nodules of the size of small chestnuts, over which the skin was shining, and very tense. The urine was free from albumen.

REMARKS.—Sir William Fergusson said that this case was one of considerable interest. Such a state as the patient's foot presented was now-a-days rarely to be met with; because similar cases were not permitted to arrive at so advanced a stage. The ulcerated tumour, however, was the least serious part of the disease; it was the condition of the bones and soft parts of the foot, involved as it was in the disease, that marked the dangerous character of the malady. The ulcerated state might, he believed, happen where no malignancy existed, by lymph being organised below the aponeurosis, then by its involving the aponeurosis and passing through it, and afterwards pushing its way through the skin and forming a fungous growth. He had advocated the operation some time previously, but the patient would not submit to it, and left. He had now returned for the operation. The man had lost considerable quantities of blood, and he was in rather a weak condition. He determined, therefore, to amputate as low down as possible, believing that the man's chance of recovery would be increased. Sir William then removed the foot at the ankle-joint, but left the posterior portion of the os calcis, and did not interfere with the malleoli. In bringing the edges of the flaps together, however, it was found that the muscles of the calf played upon the os calcis, pulling it, and the posterior flap backwards. Sir William, therefore, cut the tendo Achillis, which had the effect of at once remedying the difficulty.