etc.—beloved of our psychological friends; but many are due to a biochemical disturbance, as pointed out by Dr. Hurst at the Cambridge meeting in 1920. It would appear advisable, therefore, to make an investigation of the organs of internal secretion in cases of hysterical deafness, functional aphonia, paraesthesia of the pharynx, etc., and treat the patient according to the findings. I am in the habit of prescribing mammary gland, ovarian extract, and adrenal gland in these cases, in many of them with the happiest results.

As it is in many cases impossible to say which of the endocrines is the *fons et origo mali*, a polyglandular blunderbuss must sometimes be used. This is the more necessary owing to the interactions of the ductless glands, many of which are as yet but imperfectly understood.

Mrs. O., aged 33, was referred to me by Dr. W. C. Rigby, for an opinion as to whether the severe headaches from which she suffered were due to any intranasal condition. She complained of a "thumping" occipital headache, coming on several times a week, worst on awakening, and very severe before the menstrual epoch. Menstruation was of the 28/3 type, scanty, and accompanied by much lumbar pain. She was also deaf, and had been told that both drums were perforated, and nothing could be done. The nose was normal; there was no sign of pus, obstruction, or pressure. The hearing for low tones on the right and for high tones on both sides was diminished. Bone conduction seemed to vary, being sometimes increased and sometimes diminished. Both drums showed a dry anterior perforation, with patent Eustachian tubes. At my suggestion she was given a compound tablet containing ovary, thyroid, and pituitrin. She experienced immediate relief from her headaches, and, what was even more interesting, her hearing improved in a remarkable way. I have not been able to get a detailed examination recently, but whereas at first I had to shout at her, in a few weeks she could hear an ordinary conversation—in fact her husband said she could hear too much sometimes.

Hypothyroidism.

One should always be on the look-out for cretinism in deaf-mutes. Scholz states that 30 per cent. of the endemic cretins seen by him were thus afflicted. Besides such cases of advanced hypothyroidism, we frequently observe ear symptoms, especially tinnitus, in the minor grades. Hertoghe of Antwerp points out¹ the prevalence of chronic benign thyroid insufficiency (myxoedème fruste) and the frequency with which the diagnosis is missed. The symptoms are numerous, and include: infiltration of the skin with waste products; it becomes puffy and ill nourished, dry, rough, and desquamating; perspiration is diminished. Dermatoses are common: eczema among children, acne at puberty, herpes, psoriasis, urticaria, and recurrent erysipelas among adults. The hair is scanty, thin, and ill nourished; bald patches and premature greyness are common. The outer half of the eyebrows often falls out (*signe de sourcil*). The nails are often striated, brittle, and crack easily. The teeth are bad, and decay early in children with deficient thyroid secretion. The basic metabolism rate is diminished, the patients feel cold more than the normal individual, and suffer from dead fingers and chilblains. Constipation, cardiac weakness, and slow pulse are common. Desquamation of the bladder epithelium with consequent enuresis, low urea output, and a tendency to acidosis are frequent. Among other symptoms may be mentioned irregular menstruation, headaches, rheumatism, swelling of the eyelids, and mental sluggishness.

All these symptoms are of course rarely seen in one patient, but when several of them occur in combination with tinnitus a course of thyroid feeding will in a very short time show the correctness or otherwise of the diagnosis. Where there is no apparent local or general cause for tinnitus and any of the above mentioned symptoms are present I find the thyroid extract is often of the greatest value.

I think that I have said enough to show that there is a wide field for investigation along these lines. Many mysteries of hormonal therapy have still to be solved. I am convinced that, while the failures are many, the successes are remarkable, and sufficiently numerous to suggest that it is due, not only to our patients but to the interests of our specialty, that this method of treatment should receive its proper meed of consideration.

REFERENCES.

- ¹ McCarrison: *The Thyroid Gland*. ²Op. cit., p. 4. ³Op. cit., p. 202. ⁴Alvarez: *Arch. Int. Med.*, October, 1920. ⁵*Practitioner*, January, 1915.

CORRECTION OF NASAL DEFORMITIES.

BY

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[Abstract.]

DR. EASTMAN SHEEHAN described his method of operating by the columella route for the correction of depressions of the nasal bridge and columella, and also for the correction of other nasal deformities, whether caused by disease or trauma. He illustrated successive steps of his technique by cinematograph films.

He recommended that before any surgical procedure was attempted a photograph and plaster cast should be made, so that the surgeon was enabled to make a more satisfactory study of the case, and a record was secured which proved of great value for the purpose of comparison during and after reconstruction. Rib cartilage was unrivalled as a means of support for depressions of the nasal bridge; it could be shaped to any desired pattern, it was easily handled, it had the power to combat infection, and was durable and permanent. In prolonged plastic operations a local anaesthetic was preferable, a 1 to 5 per cent. novocain solution having proved, in Dr. Sheehan's experience, the most satisfactory. If a general anaesthetic was employed he had found intratracheal insufflation of ether to be the best.

Operation.

After the skin had been prepared, the airway on each side was packed with dry gauze; a vertical incision was made with a small, sharp plastic scalpel through the centre of the columella, extending through the under surface of the tip of the nose down to the philtrum. The incision was then deepened throughout its full length, until the vertical edge of the septal cartilage was reached. The septum on both sides was then excised for a short distance, and the cartilage, if deflected and blocking the airway, could be removed in part or in whole. The cartilage of the columella, if present, was next removed, and the loose tissue of the nose was then separated on each side of the nasal bridge up to the infraglabellar region, and a bed made for the reception of the graft. The exact length of the cartilage required was determined by accurate measurements, and a triangular piece of cartilage was excised at the proximal end of the graft for the purpose of bending it to a right angle after the graft was shaped to the desired pattern. The perichondrium was removed except at the angulation, its purpose there being to hold the long and short limbs of the graft together; the perichondrium was also left at the far end of the short limb, where it was allowed to flare out to either side in order to hold the end firmly in place by suturing it to the deep tissue of the upper part of the philtrum, thus preventing tension upon the sutured part of the columella. Two mattress sutures of fine silkworm gut closed the columella, and the raw surfaces were carefully and accurately brought together with a lock-stitch of horse hair.

As a rule, no bandaging was necessary, and the sutures were removed on the fourth day. In hump deformities and deflected noses the same incision in the columella was made, but it was not necessary to extend the incision to the deep tissue of the philtrum, nor to separate the septal membrane.

In the plastic repair of nasal deformities due to syphilis, one of the most important advances was the general recognition that the lining was as essential as the external covering. The lining could be obtained by means of a skin graft of the Thiersch variety, wrapped round a model of "stent," and either sewn or held in place by a dental splint or similar appliance. If the loss of mucous membrane was extensive, better results would be obtained by transferring a pedicled flap of forehead skin, thus ensuring against contractions. In replacing the loss of mucous membrane with a Thiersch graft a small balloon was inserted in the nose, which, when inflated, exerted even and firm pressure on the transplant. After four days the balloon was deflated and removed, and the nose was kept clean for a further period of four days and then irrigated.

Mr. V. E. NEGUS (London) read a paper entitled, "A newly described function of the vocal cords." He said that the larynx, apart from sound production, performed other functions, notably those connected with respiration and deglutition. He adduced evidence, derived from a study of comparative anatomy, indicating that pronounced modifications had been evolved in the larynx for the purpose of fixing the thorax for forearm work. These changes occurred more especially in arboreal types of animals. As a practical application of his theory Mr. Negus suggested

that when complete rest of the larynx was required the patient should be instructed not only to keep silence, but also to refrain from forearm efforts. This paper, which is intended as a preliminary communication, as further researches are being continued by Mr. Negus upon the subject, will appear in the *Journal of Laryngology and Otology*.

Dr. J. A. GIBB (Maidstone) read a paper, derived from his own experiences, on the referred pain of nasal sinus disease. He said that the site to which pain was referred was often disregarded. The position and severity of the pain did not appear to depend in all cases on the severity of the disease of the sinus. He detailed the areas for the various sinuses, and quoted cases illustrative of his thesis. This paper also will appear in the *Journal of Laryngology and Otology*.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

PAN-SINUSITIS AND SEPTIC THYROIDITIS.

THE following case presents some features of interest, as the condition is comparatively rare; a somewhat similar case was recently reported by Sir StClair Thomson.¹

A woman, aged 44, presented herself at the out-patient department of the Rochdale Infirmary on March 17th, 1923, complaining of severe occipital headache and marked tenderness of the thyroid gland. She stated that a year ago she became very susceptible to "colds," and shortly afterwards noticed some fullness of the lower part of the neck, in front. A week before attending at the infirmary she began to suffer from severe occipital headache and general malaise; the pain and tenderness of the thyroid gland began later in the same day. She had always been constipated. She looked acutely ill; the tongue was coated, temperature 100°, pulse rate 118. The thyroid gland was enlarged, firm, and very tender. There was no complaint of nasal discharge and the nose was not examined. She was admitted that day. Treatment by local application of heat to the neck was adopted, but the symptoms did not abate.

On March 21st Dr. E. H. Cox exposed the thyroid gland by a vertical incision, but apart from slight oedema of the overlying tissues nothing abnormal was seen. The gland itself was explored with a hypodermic needle and from each puncture a small quantity of serous fluid was withdrawn. A small drainage tube was left in position and the wound sutured. The symptoms greatly improved. Three days later the discharge from the tube became purulent. Seven days after operation the temperature, which had fallen to 98°, rose to 102°, the severe occipital headache returned and was accompanied by tenderness of the thyroid gland despite the abundant purulent discharge. These symptoms gradually abated and on April 11th she was free from symptoms except for a slight serous discharge from the sinus in the neck. On April 16th the severe occipital headache returned and her temperature rose to 102.2°. After a brisk purge she was free from symptoms and the remainder of her convalescence was uneventful. On May 19th she was transferred to the out-patient department, as there was still slight discharge from the sinus in the neck.

The fever and headache were treated on general principles, but throughout the illness great difficulty was experienced in keeping the bowels open. At no time during her illness did she complain of nasal discharge. The pus from the thyroid gland was not examined bacteriologically.

I had considered her infection to be of intestinal origin until I read Sir StClair Thomson's article. I then immediately requested Dr. P. A. Harry, ophthalmologist and laryngologist to Rochdale Infirmary, to examine her. He reported that there was pus in both middle meatuses, muco-pus in the left maxillary sinus, but none in the right, and that the anterior end of the left middle turbinate was enlarged and cystic. On June 28th he removed the anterior ends of both middle turbinates and the anterior end of the left inferior turbinate. The anterior end of the left middle turbinate was definitely cystic and showed evidence of chronic inflammatory changes. He also curetted the ethmoidal cells and pus was present in the scrapings from both nostrils. The patient is at present under treatment by Dr. Harry; she informs me that apart from slight discharge from the sinus in the neck she feels perfectly well.

I submitted the facts of the case to Dr. Harry, and he considers the occipital headache and the thyroiditis to be due to an acute exacerbation of the chronic nasal sinusitis. The fact that the patient noticed the thyroid enlargement simultaneously with her susceptibility to "colds" is of interest, as this may explain the origin of some of the rare cases of so-called "idiopathic" chronic inflammation of the thyroid gland.

¹ Acute Pan-sinusitis. BRITISH MEDICAL JOURNAL, June 2nd, 1923, p. 924.

My thanks are due to Dr. Harry for his observations on the condition of the nose, and to Dr. Cox for permission to publish this case.

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FACIAL PARALYSIS FOLLOWING HERPES FACIALIS.

THE case of herpes with paralysis reported by Dr. Tomb (BRITISH MEDICAL JOURNAL, November 10th, 1923, p. 878) leads me to send the following notes of a similar case under my care.

On October 17th, 1923, I saw a Mrs. K., aged 50, who thought she had been bitten or stung by a small insect in the ear. She complained of intense pain on the right side of the face and forehead. I noticed some swelling of the external auditory meatus and surrounding tissues. The next day there was a very definite eruption of herpes involving the edges of the meatus and the concha, with complete facial paralysis of the affected side. The constitutional symptoms were severe: nausea, persistent vomiting, with severe headache and vertigo, and a temperature of 100.5° F. This went on for more than three days, and was accompanied by pain, sleeplessness, anorexia, and partial deafness (which, I venture to suggest, is due to paralysis of the stapedius muscle). No other lesion could be found to account for these symptoms.

This is clearly a case of herpes facialis with facial paralysis, and the paralysis is still total at the end of nearly four weeks. One point is, I think, of interest in view of recent controversies on the subject—namely, the incidence of some cases of varicella in the village at the same time. During the last two years I have observed four cases of herpes zoster in the same village, which were also coincident with an epidemic of varicella; one, a case of exceptional severity, actually occurred in the father of a child suffering from varicella at the time.

MONTAGU LAWRENCE,
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Reports of Societies.

PULMONARY LESIONS OF INFLUENZA.

AT a meeting of the Newcastle-upon-Tyne and Northern Counties Medical Society, held in the Royal Victoria Infirmary, Newcastle, on November 1st, with the President, Dr. R. ESMOND MOYES, in the chair, Dr. A. F. BERNARD SHAW made a communication on "The pathology of the respiratory system in influenza," illustrated by a series of lantern slides showing the histological appearances of the lesions.

Dr. Bernard Shaw first referred to certain data regarding the disease which had emerged from historical study and observations made in the last pandemic. Certain of these data bore more or less directly on the remarkable series of changes found in the respiratory tract, and could be adduced as evidence of the possibility that influenza did not fall within the category of a bacterial disease. It had been shown that epidemics and pandemics of influenza had affected man since the fifteenth century and probably earlier. It had frequently been described as a "new disease." Its manifestations were extraordinarily protean. The phenomenal rapidity of spread was unlike a bacterial disease and, in spite of the enormous amount of work done recently, there was no definite proof of its bacterial origin. No one had succeeded in inoculating healthy men with the disease. Probably no other acute disease so greatly lowered the resistance of the body to infection by bacteria as influenza. In the fulminating cases there was an intense tracheo-bronchitis with an aplastic exudate diffused throughout both lungs and necrosis of the epithelium at all levels of the bronchial tree. Later, localization of the process occurred together with a leucocytic reaction. At this stage there might occur as complications—acute bronchiectasis, abscess and gangrene of the lung. In those cases which survived a few weeks there was found extensive organization of the exudate leading to obliterative bronchiolitis, obliteration of alveoli,