TREATMENT OF FACIAL PARALYSIS DUE TO DIVISION OF THE FACIAL NERVE IN THE MASTOID OPERATION.

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IN the JOURNAL of May 8th a case of anastomosis of the facial nerve in the aqueduct of Fallopius is described by Dr. F. Sydenham of Walsall. It may interest him and other surgeons to know that a procedure similar in detail has been employed by me in two cases.

CASE I.

Mr. P. H. was operated on in 1900. The facial nerve had been divided by a splinter of bone when "the bridge" was being cut away with a chisel. The division was not noticed at the time, but the paralysis was complete on recovery from anaesthesia. As this persisted, the wound was reopened a fortnight later. The facial nerve was seen to be completely divided, and the proximal end frayed and everted by the gauze packing. At the suggestion of my colleague, Mr. Jordan Lloyd, who was present at both operations, the proximal end was teased into its normal position—coming almost in contact with the distal end; two or three strands of fine chromic gut were placed round the nerve, the ends being inserted into the bony canal, and the parts protected for a short time by gutta-percha tissue in the way described by Dr. Sydenham. Gentle galvanism was subsequently employed; slight return of power commenced in six weeks, and complete recovery resulted.

The case, though not published, has been related to several of my colleagues in the Midlands.

CASE II.

Miss H. F., aged 26. The facial nerve was divided on January 14th, 1908, in clearing a cholesteatomatous mastoid which had been operated upon twice previously, the relation of the parts being much altered by bone absorption. The division was recognized at the time, and the nerve ends were carefully approximated and protected for a few days with gutta-percha tissue. The operation cavity became rapidly covered with epidermis from the meatal flaps, under hydrogen peroxide and spirit treatment. As no sign of regeneration appeared in a month (February 13th) it was decided to reopen the cavity and examine the nerve ends. It was not easy to define these again in the cicatrized tissue and to be certain that no union had taken place, indeed it seemed both to me and to Mr. Seymour Jones who assisted me that there was continuity of a few of the deeper fibres. The ends were readjusted, and a strand of fine chromic gut was with difficulty inserted in each of the aqueduct openings. The post-aural wound was closed, and the cavity rapidly healed without suppuration. Gentle galvanism was continued, but it was not until the end of June—four months later—that signs of power commenced in the mouth muscles; the improvement steadily extended to the other muscles, and the power has now (May 7th) returned to all except the corrugators of the brow.

In this case it is difficult to estimate the value of the second operation; it seems not improbable that if more patience had been exercised the first adjustment would have been all that was necessary.

It, however, showed that the operation is more difficult when the post-aural cavity is completely cicatrized than when it is in a recent post-operative condition.

The cases themselves show:

1. That if division of the facial nerve is recognized at the time of operation, careful adjustment in the manner indicated will probably result in restoration of function.
2. That if division has not been recognized, the wound should be reopened and the nerve ends adjusted at the earliest possible opportunity.
3. That if a careful adjustment has been made a second operation should not be undertaken within three or four months.
4. That this method of adjustment should be tried before anastomosis with the hypoglossal or spinal accessory nerves is attempted, the results of which are not always gratifying.

UNDER the will of the late Mr. Frederick Gorrings, the draper and silk mercer of Buckingham Palace Road, the Clapham and General Provident Dispensary receives a bequest of £1,000. On the death of the testator's wife £5,000 is to be paid to the Bolingbroke Hospital, and the residue of the estate after payment of other bequests divided in equal shares between some eight institutions. Among these are St. George's Hospital and Westminster Hospital; each, it is calculated, will ultimately benefit in this way to the extent of some £50,000.

Memoranda: MEDICAL, SURGICAL, OBSTETRICAL.

DISTRIBUTION OF BILHARZIOSIS ON THE VICTORIA NYANZA.

DURING a visit in January, 1909, to Usukuma on the Southern Shore of the Lake Victoria Nyanza, German East Africa, I was astonished to find at Nassa (a little place some 60 miles east of Mwanza, and on the southern shore of Speke Gulf) a very high proportion of the natives suffering from the symptoms of bilharziosis. I was only able to stay two days in that place, but of 156 patients whom I examined exactly half had the symptoms of bilharziosis of the bladder. Three of these chosen at random were asked to pass urine, and a drop of the urine (not centrifuged) showed in each case enormous numbers of typical ova. One of them was the local king or chief. The briefness of my visit prevented me from investigating the percentage of the general population so affected, nor was I able to investigate the presence or not of ova in the stools. The interest of the observation lies partly in the following facts:

1. The natives obtain their drinking water from the lake, and this lake is the source of the Nile, on the banks of which bilharziosis is endemic. The water is stored, as in my own neighbourhood, in earthenware jars of large size, which are seldom if ever cleaned. The natives likewise (or certain classes of them) do a good deal of wading in the water to fish, though this would not be true of the chief and upper classes.

2. On the northern shore of the lake bilharziosis is comparatively rare. I am told that in Entebbe bilharzia is occasionally found, especially in the stools. But in our hospital at Mengo (with an in-patient attendance of about 1,600 patients per annum, and an out-patient attendance of about 13,000 new cases every year) we have during the past thirteen years seen only two cases of bilharziosis, and they were probably not endemic. Mengo itself is only eight miles from the lake shore.

Mengo, April 6th.

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FATAL HAEMOPTYSIS IN AN INFANT.

THE patient in the following case, an infant aged 3 months, was the child of a puny, young, phthisical mother. It was stated to have kept in good health for four weeks after birth, and then commenced to have fever and cough. For nearly two months the fever never left the child, its cough was very frequent. When I saw it for the first time, a couple of days before its death, the cough was almost incessant. One evening the child was brought to my surgery in great haste, as it was supposed to have vomited blood. It was pulseless, and blood was oozing from its mouth and nose. The coat of the father, who had brought it in his lap, was saturated in front with blood. On inquiry I found that just half an hour before the child was brought to me it had a violent fit of coughing, and blood began to run from its mouth and nose. The haemorrhage proved fatal. That this infant had caught tuberculous infection from its mother and that the violent cough ruptured the pulmonary blood vessels and brought on the fatal issue is clear; but the extreme youth of the patient, which had barely completed the third month of its life, makes the case worth reporting.

A week after the baby's death the mother died also.

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FACIAL PARALYSIS FOLLOWING EMOTIONAL SHOCK.

Mrs. B., aged 38 years, consulted me for complete facial paralysis of the left side. She gave the following history: On Monday morning she was in perfect health. At breakfast she opened the paper and was startled to find news of a terrible shipping disaster, the *Penguin*, a local steamer, had sunk causing a great loss of life. She says that while reading the account of the wreck, she felt a sensation of "clawing" in her left cheek. Two hours later the left side of the face was completely paralysed.

I saw her twenty-four hours later. On examination the whole side of the face was motionless, all the branches of