Differential Diagnosis between Chronic Rhinitis and Ozena.

In the advanced stages ozena is easily differentiated from all other chronic rhinitis, but at the onset of the affection this differentiation may be very difficult. (Della Vedora, in *Rev. Hebd. de Laryng., etc.*, No. 19, 1897.) The author believes that this diagnosis can be made at any period by bacteriologic examination and sero-therapy. He believes the discovery of the pseudo-diphtheritic bacillus indispensable for the diagnosis of rhinitis chronica atrophicans fœtida. Under sero-therapy the pseudo-bacillus is enfeebled in all its vital manifestations.

Thus, ozena may be differentiated from, first, rhinitis with crust formation, without odor; second, rhinitis with abundant catarrhal secretion, with odor; third, rhinitis sicca with more or less pronounced atrophy of the nasal mucosa; fourth, rhinitis with crust formation and fetid odor; fifth, rhinitis with crust formation, without odor, and with more or less pronounced atrophy of the nasal mucosa; sixth, rhinitis with scanty secretion, without odor, and with atrophy of turbinates.—*Jour. E. E. and T. Dis.*, July, 1897.

Naso-Pharyngeal Catarrh in Children.

In adult patients chronic disease of the nose and throat is very apt to be referred to specialists for treatment. In early childhood, however, this course is not so often convenient, and the cases remain under the care of the family doctor. Upon the general subject we observe an article by J. Comby in *La Medicine Moderne*. When brought into contact with a severe cough it is necessary, in the first place, to exclude bronchitis, whooping-cough, and disease of the mediastinal glands. The next step consists in the examination of the throat and nose. In the former we may find hypertrophy of the tonsils, pharyngeal granulations, or muco-purulent catarrh of the back of the nose and posterior wall of the pharynx.

The symptoms of naso-pharyngeal catarrh are a sense of dryness in the throat, some difficulty in swallowing, a dry, frequent and spasmodic cough, nocturnal rather than diurnal. Such a cough may even be followed by vomiting. It is of reflex origin, and caused by the secretion present in the pharynx threatening the entrance into the larynx. Such cases should be examined not solely by means of the tongue-depressor, but by anterior and posterior rhinoscopy. If we restrict ourselves merely to cauterizing the tonsils or pharyngeal granulations, we fail to attain our object. It is necessary, according to our author, to act upon the coryza and pharyngeal catarrh through