Adequate treatment is dependent upon the availability of suction and microscope. Meticulous removal of squames from the canal and middle ear is amply rewarding. Although time-consuming, on balance it is time better spent

TABLE

Aural Keratosis. June 1961-62. 13 males, 18 females. Total 31 cases.

	Associated Lesions		
	Under age 15 21 cases	Over age 15 10 cases	Total 31
Established Bronchiectasis ..	4	2	6
Antrum Suppuration	9	2	11
Nasal Polypi	2	3	5
Recurrent or Chronic Bronchitis ..			6
Invaded middle ear (Squames present)			18

than upon tympanoplastic procedures in this class of case, apart from the later humiliation of having to remove skin so painstakingly and mistakenly introduced.

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THE IRISH OTOLARYNGOLOGICAL SOCIETY

The Second Annual Meeting of the Society was held on *Saturday, November 18th, 1961*, at the Institute of Clinical Science, Belfast. The President, Mr. T. G. Wilson, was in the Chair.

Mr. Michael O'Brien read a paper on the "Surgery of Bilateral Midline Laryngeal Paralysis". Mr. H. W. H. Shepperd discussed "Vascular Phenomena in E.N.T.", and Mr. Ronal Harvey presented a paper entitled "Management of Partially Deaf Children in the Early School Age." These papers were discussed by the members of the Society.

In the clinical proceedings cases were shown by Mr. Kennedy Hunter, Mr. D. H. Craig, Mr. G. D. L. Smyth, Dr. Noreen Simpson, and Mr. R. S. McCrea, and of these the following gave rise to discussion:

Case IV. Carcinoma of the Vocal Cord treated by Radium Fenestration

Mr. Woods said that the Finzi Harmer operation was good in suitable cases because it gave a high percentage of 5-year cures, gave a better voice than did

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laryngo-fissure and a shorter convalescence than did treatment with cobalt bomb.

Mr. Wilmot stated that dosage was more accurate using the cobalt bomb.

Mr. Craig doubted if this was true as he had seen more cases of cartilage necrosis following the use of the cobalt bomb.

Mr. Shepperd said that there was more laryngeal œdema following telecobalt therapy.

Mr. Hunter said that he had shown this case because he felt that there was still a place for the Finzi Harmer operation. Time had proved that it gave good results in cases where the growth was limited to the vocal cord and the cord was mobile, but cases where the growth extends back as far as the vocal process were unsuitable for this operation.

Cases VI, VII and IX

These were cases of chronic middle-ear infection with spread of disease to the mastoid process, and were treated by tympanoplasty combined with mastoidectomy but preserving the bony posterior meatal wall so as to avoid leaving a mastoid cavity open to the meatus.

Mr. Craig congratulated Mr. Smyth on his technical ability, and said that he felt sure that this was the correct way to deal with such cases but the technique had not yet become established.

Mr. W. Doyle-Kelly said he was very interested in these cases and asked Mr. Smyth how he separates the mastoid segment from the middle-ear segment.

Mr. Woods asked Mr. Smyth if he could explain how in Case VI a wire strut from the neck of the malleus to the footplate of the stapes brought the audiogram up to the 20 decibel level. There is not much vibration at the neck of the malleus. In Case VII a wire strut from the incus to the footplate did not give any better result. He noted that in one case the deafness was unilateral and doubted if operation was indicated there.

Mr. Smyth in reply said that he closed off the mastoid and tympanum from the external meatus by preserving the posterior bony meatal wall, and by closing the perforation in the tympanic membrane with a vein graft. He did not attempt to shut off the mastoid from the middle ear. In Case VI the improvement in hearing may be due to a columella effect, and perhaps the result would have been better if the strut had been attached to the malleus nearer the umbo.

Cases X–XIII were presented by Mr. Craig to demonstrate the use of periosteal grafts to repair defects in the tympanic membrane, and the formation of funnel-shaped mastoid cavity. In Case XIII cholesteatoma had reformed.

Mr. Craig said that he had used periosteum taken from the tibia in 30 cases, and had abandoned its use because he had found it difficult to work with, osteogenesis had occurred in the middle ear, and the patients had complained of a very sore leg. A funnel-shaped cavity was more satisfactory acoustically than the conventional mastoidectomy cavity. His cases did not fit Zollner's classification and he divided them into the following types:

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1. Perforation with an intact, mobile ossicular chain.
2. Deficient ossicular chain.
(*a*) Intact mobile stapes and deficient long process of incus.
(*b*) Mobile stapes footplate only.
3. Stapes footplate immobile.

Mr. Woods said that he considered Case XIII to be the crux of the matter. If a patient had one good ear then an obliterative operation on the other ear may be an unwarranted risk.

Case XVIII. Congenital, bilateral, bony, choanal atresia presenting as cylical asphyxia in the neonatal period.

Mr. Woods asked what operation should be performed in these cases. He had operated through the nose using a wide bore antral trocar and cannula to perforate the atresia, and then enlarging the opening with a burr. This was followed by bouginage two or three times daily for a long period.

Mr. Craig said that he had seen ten cases between 1952 and 1956. Of these, five were bilateral and three had other defects. He had found operation through the nose to be easy and to give satisfactory results. Operation through the palate was a big procedure.

Mr. Curtin had seen one bilateral case who also had no frenum to his tongue. This patient's sister also suffered from absence of the lingual frenum.

Case XXVII. Male aged 53 years, who in *August, 1956*, was found to have a large carcinoma of the left pyriform fossa and a firm, mobile swelling, deep to the anterior border of the left sternomastoid muscle. This was treated by laryngopharyngectomy (two stage), and block dissection of the left side of the neck. About 6 months after operation a swelling was noted in the region of the left sternoclavicular joint, and it was feared that this was due to recurrence of the growth. X-ray of chest was done, and the Radiologist reported that the chest was clear and that there was subluxation of the left sternoclavicular joint. There has been no further increase in the swelling, and it is believed to be due to increased prominence of the inner end of the clavicle.

Mr. McCrea said that he thought subluxation of the sternoclavicular joint was a fairly common complication of block dissection of the neck.

Case XXVIII. Ménière's Disease. This was a male aged 35 years, who was first seen in *April 1957* complaining of left deafness, and tinnitis and attacks of vertigo and vomiting. He was treated with vaso-dilator drugs and repeated blocking of the left stellate ganglion. This gave temporary improvement, but in 1960 the attacks of vertigo became very severe, and in *June, 1960*, the left stellate ganglion was removed. There was marked improvement. The vertigo and tinnitus stopped, his hearing improved, and his head felt clearer. In the past few weeks the tinnitus in the left ear has recurred, and 1 week ago he had an attack of vertigo.

Mr. Wilmot said that one should not forget the importance of the patient's personality, and that sympathectomy was only one incident in the treatment of the case, and should not be expected to give the complete answer. This was

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an intelligent patient who suffered from migraine, and later from Ménière's Disease. Left cervical sympathectomy had helped, but he thought that it should have been undertaken earlier, and that a bilateral operation should always be seriously considered in these cases. The disease is very frequently bilateral, and a bilateral Horner's Syndrome is less noticeable than a unilateral one. He recommended that right sympathectomy should now be performed, and that the patient be given one of the tranquillizing drugs.

Mr. McCrea thanked Mr. Wilmot for his helpful comment.

On *November 17th*, Mr. Terence Cawthorne delivered the first Sir William Wilde Lecture to the members of the Society and their guests. He chose as his subject "Tracheostomy Yesterday and Today".

At the Business Meeting the following were elected Officers of the Society.

President: Mr. F. A. MacLaughlin.
Vice-President: Mr. R. R. Woods.
Treasurer: J. McAuliffe Curtin.
Secretaries: C. D. O'Connell, R. S. McCrea.
Members of Council: T. G. Wilson, H. W. H. Shepperd, D. H. Craig, A. J. Blayney.

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