SOCIETIES' PROCEEDINGS

THE SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY

FIFTEENTH MEETING HELD IN THE ROYAL INFIRMARY, EDINBURGH

June 10th, 1922.

President—DR J. GALBRAITH CONNAL.

Two Cases of Nasal Deformity following Lupus treated by Plastic Operation—Dr DOUGLAS GUTHRIE.

1. In a girl, aged 17, disease had destroyed the bridge, the tip of the nose, and the columella. The parts had been restored by local flaps and the implantation of costal cartilage.

2. The intranasal lupus had been treated successfully by Dr Brown Kelly, but cicatricial contraction had caused depression of the bridge. A graft of costal cartilage had relieved this.

A Method of Rhinoplasty—Mr J. J. M. SHAW (introduced by Dr Martin).

CASE I.—(*a*) Costal cartilage was implanted in nasolabial folds, and vertically in glabellar region. Storage of costal cartilage in abdominal wall. (*b*) Formation of nasal lining by in-turned hinge flaps carrying cartilage implants. Covering skin brought down from forehead by pedicle. (*c*) Restitution to forehead of portion of pedicle.

CASE II.—(*a*) Reconstruction of original wound by complete excision of scar tissue. Suture of skin to mucous membrane round wound. Mould inserted to keep ala depressed to proper position. (*b*) On sound healing of muco-cutaneous junction (three weeks) lining flap of skin turned down and sutured. Covering brought down from forehead by tube pedicle and sutured in raw area.

Scarlet Fever Otitis Media. Report on Two Years' Work at the Edinburgh City Hospital for Infectious Disease—Dr W. T. GARDINER.—(Published *in extenso* in the *Journal of Laryngology*, October 1922, p. 497.)

The PRESIDENT congratulated Dr Gardiner on a splendid piece of work. The excellent results which he had obtained from the removal of adenoids early in the fever were evidence that previous methods should be revised. He congratulated the Society, that as a result of its representation to the Edinburgh Health Committee, an otologist had been appointed to the Fever Hospital, and he suggested that a copy of the Report should

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be sent to the Glasgow Authorities. Dr Gardiner drew attention to the fact that he had not seen sloughing of the tympanic membrane. It was well to remember, however, that there were differences in the type of epidemics, the benign and the malignant. It would be interesting to know the type prevalent in these two years. He (the President) would be inclined to urge the necessity of early and free paracentesis. Wilde's incision had a very limited sphere of usefulness.

Dr C. B. KER (Medical Superintendent, Fever Hospital), considered that Dr Gardiner's appointment had been of the greatest value to the Edinburgh citizens. He (the speaker) was also interested in the question of paracentesis. He thought it was the general opinion among otologists that early paracentesis was going to revolutionise the treatment of ear disease in a hospital such as his was. But the opportunities of doing this were very limited. In young children, half had no pain or any symptom drawing attention to the ear until discharge was seen on the pillow. Further, as Dr Gardiner had pointed out, even if the membrane were bulging, the child could not have an anæsthetic without permission; even in cases where arrangements had been made, the ear had commenced to discharge before operation was possible. Dr T. B. Layton, in London, had had the same difficulty. The new and important step was the removal of tonsils and adenoids. Regarding this at first with suspicion, he had become a complete convert, and many operations had been performed without a single accident. The children were nursed after operation in the ordinary wards of the hospital, and in spite of their open wounds, exposed to virulent infection, no complications had arisen. He believed that Dr Gardiner had already reduced, by about sixteen days, the detention of patients with discharging ears, and this had saved the hospital and the ratepayers considerable expense, more indeed than the salary attached to Dr Gardiner's office. Finally, the speaker had no doubt that the removal of tonsils and adenoids had done much to stop the nasal discharges, and consequently to remove the risk of infection to those at home after the child had left hospital.

Dr LOGAN TURNER had always had the impression that in scarlet fever cases the discharging ear was probably associated with adenoids. But he was interested to find from Dr Gardiner's report that only 47 per cent. of the cases with otorrhœa had adenoids, while 53 per cent. had not. He was interested also in the cure of the ear discharge by means of the incomplete Schwartze operation, when operation was necessary. The older members would recall that about eighteen years ago, considerable discussion had followed upon a paper by Dr Knyvett Gordon, who had found it necessary to do the complete operation in these cases, on account of failure to cure the discharge by the Schwartze method. He (the speaker) wished to know if Dr Gardiner was quite satisfied that his cases were cured.

Dr LEITCH asked whether Dr Gardiner had ever enlarged the perforation when he found the membrane had ruptured, before proceeding to the Schwartze operation.

Dr W. T. GARDINER (in reply) said that the septic cases were, from the surgical point of view, of the nature of ordinary septicæmia. After

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a period of swinging temperature the otitis developed and a mastoid operation became necessary. The temperature then usually settled. At operation an osteomyelitis of the bone was found. After removal of adenoids the discharge ceased, and the perforation, usually an anterior one, healed. The difficulty regarding paracentesis might be overcome by making the second on the resident staff a trained otologist, who would daily examine the cases, while the parents should sign a permission slip, as was done in an ordinary surgical hospital. He was unable to say beforehand in which cases Wilde's incision would suffice. In two or three he might have tried it, but as he had to prove his case he was anxious to avoid second operations. In cases without adenoids he believed the discharge cleared up without mastoid infection, though not always; the rule, however, being that the mastoid cases had adenoids. The Schwartze operation, he thought, was sufficient. He had never enlarged the perforation before doing the mastoid operation, but he had incised the membrane at the end of the operation when he thought it necessary.

Lingual Accessory Thyroid—Dr A. LOGAN TURNER.—Woman, aged 35, admitted with "blood-spitting." No organic disease was detected in chest or abdomen. A smooth, pink, firm sessile mass occupied the base of the tongue. Typical thyroid gland tissue was found in a portion removed for the microscope.

Dr GAVIN YOUNG had failed on palpation to detect the thyroid in the neck. He did not know what steps Dr Turner proposed to take, but in the event of removal of the accessory thyroid, it seemed to him that hypothyroidism should be watched for.

Dr LOGAN TURNER quoted a recent French paper, recording seventy-one cases of lingual thyroid, all, with four exceptions, being in women. As the tumour was giving the patient no trouble he did not propose to interfere.

Small-celled Sarcoma of Naso-pharynx treated by Radium in February 1920—Dr A. LOGAN TURNER.—Female, aged 30. The tumour had occupied the right side of the naso-pharyngeal vault, and radium was inserted for five consecutive days. There was no recurrence.

Sarcoma of Nasal Cavity and Naso-pharynx—Mr J. D. LITHGOW.—Boy, aged 9. In December a fungating mass occupied the left nasal cavity and naso-pharynx. This was removed and the left antrum explored, but found empty. Recurrence of tumour in January 1922. Radium treatment; total dose 3080 milligramme hours; disappearance of tumour.

Dr W. S. SYME thought that there was pus coming from the right sphenoidal sinus in the first case. If that were so, possibly the sarcoma had invaded that cavity.

Dr BROWN KELLY said he had had a case very similar to the first, and about the same age, treated two years ago. He had seen her recently and there was no recurrence.

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Dr EWART MARTIN thought Dr Turner's case had had 1700 radium milligramme hours and Mr Lithgow's about 3080. In the latter case there was complete destruction of the soft palate, which seemed to slough off about five days after the removal of the radium, and he thought that the peculiar character of the voice in Dr Turner's case might be due to slight radium paralysis of the soft palate.

Acute Suppuration in the Left Frontal Sinus: Abscess of Left Frontal Lobe: Operation: Recovery—Dr J. S. FRASER.—Male, aged 29, had influenza on 10th February with development of slight ptosis of left eyelid. Temperature did not rise above 100.5 F.: pulse 75. From 18th to 21st, headache and severe throbbing pain behind left eye. On 22nd February, he had a Jacksonian fit affecting right face, arm, and leg, lasting one and a half hours, preceded by and succeeded by a short period of loss of speech: he was never unconscious. On 27th examined by Dr Edwin Bramwell: headache severe at night, with throbbing pain behind left eye. On 2nd March seen by exhibitor; no pus in nose or turbinal swelling; tenderness over left frontal sinus; the sinuses did not illuminate and X-rays showed blurring of all the sinuses. On 3rd March frequent vomiting; pulse 38, early left optic neuritis: slow speech: absence of contralateral abdominal reflex and presence of Babinski's sign on right side. On the two last points Dr Bramwell based his diagnosis. Operation: pus under pressure in left frontal sinus; cerebral wall removed; granulations found on outer surface of dura mater and a large quantity of odourless pus evacuated from left frontal lobe (pneumococcus); recovery.

The PRESIDENT was interested in the fact that, though the pus was under considerable tension in the frontal sinus, there was no pus in the nose and no middle turbinal swelling.

Dr ADAM asked if contralateral absence of abdominal reflex and the presence of Babinski's sign were characteristic of frontal lobe abscess. If he was not mistaken they might occur in a large temporo-sphenoidal abscess, causing pressure on the ascending frontal convolution.

Dr J. S. FRASER (in reply) regretted that Dr Bramwell's absence prevented an answer to the neurological questions. He (the speaker) had operated under instructions, and somewhat unwillingly. He saw no pus in the nose, and the X-rays gave no help, but Dr Bramwell was certain of his diagnosis.

Four Cases of Middle Ear Suppuration with Intracranial Complications.

1. *Female, aged* 55, *with left acute otitis media and anterior central perforation; extra-dural and temporo-sphenoidal abscess*—Dr J. S. FRASER. —On 5th March patient was admitted. She became drowsy, complained of headache, and vomited occasionally. There was no ocular or other

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motor paralysis; discs normal, cerebro-spinal fluid normal; temperature slightly elevated. Operation: mastoid sclerotic, and no pus in an inflamed antrum; dura mater over roof, healthy, but further forwards a large extra-dural abscess and a bone cell in the roof of the aditus contained pus. After operation, vomiting, subnormal temperature and sensory aphasia; evacuation of a large non-fœtid temporo-sphenoidal abscess (22nd March). Recovery.

2. *Boy, aged* 6, *with right chronic middle ear suppuration and a temporo-sphenoidal abscess*—Dr DOUGLAS GUTHRIE.—(Published *Journ. of Laryngology*, August 1922, p. 415.)

3. *Male, aged* 37, *with right chronic middle ear suppuration, anterior perforation, subperiosteal and extra-dural abscess of middle fossa*—Dr EWART MARTIN.—At operation a small hole was found in the squamous temporal above and in front of the meatus at the root of the zygoma, through which pus was oozing; there was also a perforation in the roof of the aditus; a large exposure of dura mater was made with evacuation of the extra-dural abscess; recovery.

4. *Female, aged* 6, *with bilateral chronic middle ear suppuration, left perisinus abscess and septic thrombosis of jugular bulb*—Shown by Dr STEPHEN YOUNG.—On 2nd April cessation of discharge from left ear with pain and vomiting; no rigors, slight neck rigidity, temperature 102 F. Child too restless for detailed examination. First operation by Dr Fraser: cholesteatoma, perisinus abscess with discoloured sinus wall; incision, but immediate free hæmorrhage. Signs suggesting meningitis showed themselves, but throughout illness cerebro-spinal fluid was free from cells and organisms. Second and third operations: ligature of internal jugular, and later, opening of vein and evacuation of pus from the bulb. General septic condition continued; bulb again explored and pus found. Cerebellar hernia developed in consequence of sloughing of dura mater; recovery.

Dr J. S. FRASER said that he had regarded a mucoid middle ear discharge with an anterior perforation as "not dangerous"; intracranial complications were not likely to develop; he had not previously seen a complication. He did not think that there was a cerebellar abscess in the case shown by Dr Young, and he proposed to adopt an expectant attitude.

Dr DOUGLAS GUTHRIE wished to have the experience of members in regard to the presence of healthy dura mater overlying the middle ear cleft. He had traced no track of infection. An interesting feature in the case was the child's sudden return to consciousnesss three weeks after operation.

Dr EWART MARTIN said that in his case the peri-auricular abscess and the anterior perforation caused him to suspect a furuncle rather than a mastoid complication. He thought a discussion on the drainage of brain abscesses would be interesting.

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Dr STEPHEN YOUNG said that the child shown by him had developed, with the cerebellar hernia, rotatory and horizontal nystagmus to the affected side and bilateral choked disc. There was no sickness, vomiting, or headache.

Congenital Specific Deafness showing Hennebert's Sign—Dr J. S. FRASER.—Female, aged 15, with a previous history of bilateral middle ear suppuration, now healed, both membranes showing retracted scars. There was nerve deafness, old interstitial keratitis, but atypical teeth. Wassermann reaction was very weakly positive. Rotation both to right and to left induced no after-nystagmus; cold syringing of right ear induced slight nystagmus in one minute. There was a well-marked fistula symptom especially on aspiration.

Dr A. A. GRAY said this was obviously a case of congenital syphilis, although the teeth were not characteristic. He never considered the absence of Hutchinson teeth as indicating the absence of syphilis; the Wassermann too was frequently negative. He presumed that the keratitis came on before the deafness. He would like to know if the deafness ever preceded the keratitis; it had an important practical bearing, because if salvarsan were used when keratitis was observed it might be possible to prevent the deafness.

Dr J. S. FRASER said that the occasional presence of Hennebert's sign was interesting. Although there was no after-rotation nystagmus and a feeble response to the caloric test, there was a well-marked fistula symptom in the absence of suppuration and of cholesteatoma, and presumably of erosion of the lateral canal. The sign had been attributed to undue laxity of the stapes or to some obscure nervous condition. In reply to Dr Gray, he said that in all the cases of congenital syphilis which he had seen, interstitial keratitis was present.

Paralysis of the Right Vocal Cord following Cancer of the Mamma—Dr J. M. DARLING.—(Published in *Journ. of Laryngology*, October 1922, p. 516.)

Dr LOGAN TURNER agreed with Dr Darling's resumé of the probable route of infection, and it was interesting to find the supraclavicular glands enlarged. They formed an important link in the chain of infection. Whether the cancer had permeated from them to the chain of glands accompanying the recurrent laryngeal nerve, or whether the most internal of the supraclavicular glands pressed directly on the recurrent nerve in the neck, it was difficult to say.

The Radical Mastoid Operation Cavity with Epithelial Inlay—Dr DOUGLAS GUTHRIE.—The method adopted was described by Dr Hamilton White in the *Journ. of Laryngology*, May 1922. A cast of the cavity was taken in dental wax and then replaced, covered with the epithelial graft.

Dr J. S. FRASER asked Dr Guthrie if he found it easy to remove the stent. It would be a great disadvantage if the wound had to be

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left open or reopened for its removal. He was satisfied with the use of iodoform worsted packed on to the graft.

Dr EWART MARTIN had seen Mosher of Boston perform the operation. He left the wound unstitched and closed it about the fifth day; he also plugged with teased-out wool and soft paraffin, the latter keeping fairly soft by the heat of the tissues.

Dr W. T. GARDINER said that the patient had had a good deal of pain after the operation. Did Dr Guthrie remove the stent under general anæsthesia?

Dr GUTHRIE (in reply) said it was not easy to remove the stent through the meatus unless divided before insertion. There was no need to open up the wound. The stent broke of itself into small portions, and after a week it seemed to crumble. He did not think the patient had suffered undue pain, and no opiate was required, nor had he given a general anæsthetic for removal of the stent.

Chronic Hyperplasia of the superior Maxilla—Dr DOUGLAS GUTHRIE.—Female, aged 16, with a smooth, hard, painless swelling of the left upper jaw, of one year's duration. It affected mainly the canine fossa; mouth, palate and nasal cavity are normal and the teeth good. Incision revealed soft spongy bone, and no antral cavity was discovered. The pathologist reported normal bone with the cancellous spaces filled with fibrous tissue. The case conforms to Westmacott's description.

Dr W. S. SYME had seen several cases of thickening of the upper jaw, and suggested that the antrum was a suppurating focus. On the other hand, the case might be a dental cyst.

Dr BROWN KELLY had seen a case of increased bony growth, and had removed soft cancellous bone with a good result. This case did not appear to him to conform to Westmacott's hyperplasia. In these cases there was great broadening of the alveolar edge, and the teeth seemed sunken in the wide plateau. At first sight this case resembled a dental cyst without the parchment crackling and bogginess.

Mr J. J. M. SHAW recounted the case of a man who suffered for nine years from a slowly growing enlargement of the right maxilla. The pathologist reported a diffuse osteoma. The mandible and temporal bone of the same side became enlarged, and were reported on microscopically as identical with the appearances in leontiasis ossea. He suggested the possibility of a similar condition in this case.

Dr DOUGLAS GUTHRIE (in reply) said that the Wassermann test was not made. He had satisfied himself that there was no antrum. The rounded alveolar border referred to by Dr Kelly was removed by the speaker. He would watch the case in connection with the later development of anything suggesting leontiasis ossea.

Tuberculosis of Tongue, Mouth and Larynx—Mr J. D. LITHGOW.—Girl, aged $9\frac{1}{2}$, showed a diffuse nodular infiltration of the

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dorsum of the tongue, mouth, soft palate and larynx. Sections of the tissue demonstrated abundant lymphoid, epithelioid and well-formed giant cells.

Dr BROWN KELLY asked why the condition had not been labelled lupus. The nasal mucosa was also affected, but the most unusual feature was the implication of the tongue. Tubercle of the tongue was a rare condition characterised by the presence of small ulcers or fissures.

Dr SYME agreed with Dr Kelly's views. He (the speaker) had seen recently a tuberculoma of the tongue in a boy of 15. It formed a pale, firm swelling.

Dr HOWIE suggested the use of acid nitrate of mercury; it did well in these cases.

Mr LITHGOW (in reply) said he saw no special advantage in calling the condition lupus. The patient had tuberculosis of the lungs, and the pathologist reported that it was ordinary tuberculous tissue.

Chronic Middle Ear Suppuration with Extensive Absorption of Bone and Invasion of the Brain with Cholesteatoma—Dr EWART MARTIN.—Male, aged 27, with discharge from left ear following shell explosion in 1917. At the operation in 1922, there was found a fistula in the lateral canal, exposure of the facial nerve, absence of the posterior meatal wall, exposure of the middle and posterior fossa dura mater which was eroded, while the cholesteatoma invaded the convolutions with leakage of cerebro-spinal fluid. The sigmoid sinus was obliterated. The patient had suffered from fits, which had ceased since the operation, but there was still marked irritability of the labyrinth. Suggestions as to further treatment were desired.

Dr J. S. FRASER suggested that Dr Martin should do nothing further in the meantime; the operation had been done quite recently, and it was wiser to leave the granulations alone.

Treatment of Chronic Middle Ear Suppuration by Ionisation—Dr STEPHEN YOUNG.

Dr YOUNG said that all the cases in the series had been previously treated by conservative methods without response. Out of 25 which had been ionised more than one and a half months ago, 11 were completely cured, 4 improved, 8 failed to improve, and 2 did not report. The most suitable case was that in which there was no risk of re-infection from the nose or mastoid antrum. Those with large central perforations did best, not so with the anterior perforation. The zinc solution must come in contact with the whole suppurating surface. The ear was first syringed and cleaned with zinc solution. The patient then lay on a couch, and the speculum with the zinc positive pole attached was inserted into the meatus, the ear being first filled with the zinc solution. The current is raised to 3 milliampères, allowed to remain for eight minutes, and then reduced. Slight giddiness may follow. Only one, or at the most two, séances are required. The ear is afterwards kept dry.

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Dr J. S. FRASER thought that 50 per cent. of chronic cases could be cured by the ordinary "wet" conservative methods, of the remaining 50 per cent. half, *i.e.*, 25 per cent. of the whole appeared curable by ionisation, leaving 25 per cent. not curable by either method.

Carcinoma of the Left Vocal Cord; Laryngo-fissure—Dr W. T. GARDINER.—Male, with small sessile tumour on the middle of the left vocal cord resembling a fibroma, first seen in 1919 and regarded as simple. Patient was again seen in December 1921, when the tumour was removed by the direct method. The pathologist reported epithelioma; laryngo-fissure was performed; no recurrence.

Localised Meningitis of Left Motor Cortex with Contralateral Paralysis secondary to Furunculosis of the Left External Auditory Meatus—Dr D. E. S. WISHART (introduced by Dr Gardiner)—Male, aged 16, with pain in the left ear for one week and swelling above and behind auricle. Development of fever, delirium, and stupor followed by paralysis; ptosis of right eyelid, right internal rectus, right side of face and tongue. No paresis of limbs or trunk. Left temporo-sphenoidal lobe was explored with negative result. The cerebro-spinal fluid was turbid. Post-mortem revealed an acute basal streptococcal meningitis with a definite collection of pus localised over the lower third of the left motor cortex. The interest in the case lay in the character of the initial septic focus and in the localised area of meningitis causing paralysis.

ROYAL SOCIETY OF MEDICINE—SECTION OF OTOLOGY

May 19th, 1922.

President—Dr A. LOGAN TURNER.

(The Discussion on Mr George Wilkinson's paper on "The Analysis of Sound by Resonance," appeared on page 480, *Journal of Laryngology*, September 1922.)

Specimen of Left Internal Auditory Meatus dilated and occupied by New Growth, involving the Auditory Nerve—Sir JAMES DUNDAS-GRANT, K.B.E., M.D.—The case of cerebello-pontine tumour from which this specimen was taken presented many features of left-sided cerebellar disease. The ear tests were as follows: —Hearing: right ear, normal; left ear, complete deafness. Tuning fork on vertex was referred to the right ear. Vestibular nerve: a fine spontaneous nystagmus to the right and a coarse nystagmus to the left. Cold air testing; right ear, lateral canal, induced nystagmus after 30″ (normal); vertical canal, induced nystagmus after 90″

https://doi.org/10.1017/S0022215100023847 Published online by Cambridge University Press

(delayed). Left ear, no induced nystagmus from lateral and vertical canals after 60″. Intense optic neuritis was present and there was paralysis of the 5th C.N.

The involvement of the fibres from the opposite (right) vertical canals in accordance with the current views suggests a cerebello-pontine tumour in the pons; these fibres are believed to run near the middle line, and, therefore, to be liable to compression by a tumour pressing on the parts. The corresponding track for the horizontal canal lies in the medulla and further from the middle line.

Dr A. A. GRAY said that tumours of the cerebello-pontine angle would have more attention in the future. Everyone must have missed cases in the past from ignorance of the symptoms. More light was now being thrown upon them. One of the difficulties in diagnosis was due to the long duration of the symptoms.

Malignant Disease of the Temporal Bone with Involvement of Cranial Nerves—Dr J. S. COLLIER and LIONEL COLLEDGE, F.R.C.S.—Male, aged 40, was seen on 21st February 1922, with headache and pain in the frontal region and with right facial paralysis. Deafness in right ear absolute. A red mass filled the deep part of the external meatus. The man was rather drowsy, with sluggish but equal pupils; no optic neuritis. The mastoid process and middle ear were full of growth, and the facial nerve exposed for about $\frac{1}{4}$ in. There was a fistula in the lateral canal, and the canals were filled with growth. The dura mater of the middle fossa was covered with it over an area of 1 in. × $\frac{1}{2}$ in. Further, the tumour extended between the inner and outer tables of the skull in every direction. The operation was therefore abandoned. Three weeks later, a boss the size of a crown piece appeared on the right frontal bone, and another just above the right ear. Difficulty in swallowing, and paralysis of the right half of the palate and both sides of the tongue, supervened. The right vocal cord was paralysed and weakness of the sterno-mastoid and trapezius appeared. The right cranial nerves, from 7th to 12th, are involved. Some stiffness of the neck suggests extension to the occipito-atlantal joint. The pathologist was unable to give a diagnostic opinion.

Right Facio-Hypoglossal Anastomosis—Mr LIONEL COLLEDGE, F.R.C.S.—Girl, aged 16, was operated upon a year ago for mastoid disease and staphylococcal meningitis secondary to suppuration in the labyrinth of the right ear. The cochlea was opened and found full of pus. The facial nerve was not seen, but a complete facial palsy resulted. As this showed no improvement after six months and the reaction of degeneration was present, the hypoglossal nerve was divided and the central end anastomosed to the peripheral end of the facial. The peripheral end of the hypoglossal was anastomosed

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to a slip from the spinal accessory. Some wasting of the right half of the tongue followed, but this is now very slight. Patient complained temporarily of discomfort in the shoulder, but the sterno-mastoid was more affected than the trapezius. Six months later, tone has returned to the facial muscles at rest, and movements of the tongue are associated with movements of the right half of the face, but there is dissociated voluntary control of the side of the face.

Dr DAN M'KENZIE said that dissociated movements were undoubtedly present in this case. One corner of the girl's mouth moved without any movement of tongue or shoulder. The operation failed in obtaining for the face the movement due to an emotion apart from the patient's direct volition. The most striking change after anastomosis was the improvement in the tonus of the face. The orbicularis palpebrarum in this case might yet improve. When should the operation be done? By delay the muscles atrophied unless nutrition was maintained by massage and electricity; after two or three years the operation failed, because the muscles had lost their function. If one operated early, the result was not very good; and most of the cases which were not operated upon at all regained considerable movement of the face after a period of time.

Dr A. A. Gray said that the absence of emotional expression took much from the charm of the face, and from the charm of the operation also. He agreed it was extraordinary how these cases recovered function without operation even many months after the paralysis occurred.

Cerebellar Hernia—Dr DAN M'KENZIE.—Girl, aged 15, had operation three months ago for symptoms of pronounced meningitis. Fœtid pus in the mastoid cells was traced into a large cerebellar abscess cavity. This was drained. Patient was not under exhibitor's observation during convalescence. About a month ago hernia developed.

In these cases Sir Charles Ballance advised enlargement of the opening in the dura mater; subsidence followed and the skin could be united over the gap.

Mr CLEMINSON said he had seen a case in which a decompression operation was done with good effect on the opposite side of the head.

Otogenic Meningitis spreading from the Roof of the Antro-Tympanum—Dr DAN M'KENZIE.—Female, aged 28, admitted with double mastoiditis. She died of meningitis five days later. The case is reported, as some doubt has been expressed as to whether meningitis ever does start from the roof of the antro-tympanum.

Post-Mortem Report.—Pia mater; on the surface of the right temporo-sphenoidal lobe the pia mater applied to the surface of the dura mater over the tympanum held in its meshes a thick lymph; its surface was rough and taggy, an infiltrate extending out over an area of 1 inch or more; granular yellow lymph extended along the

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sinuses and had accumulated at the vertex on that side. Dura mater; after stripping this, swelling and loss of lustre was observed at the site of attachment to the roof of the tympanum. The pia was adherent to this area of the dura by very recent tags of fibrinous exudate. The sinuses were free from ante-mortem clotting. Section of the post-mortem clot showed no abnormality. The dura mater over the sinus had retained its lustre and healthy appearance. Bone: the roof of the tympanum was the seat of a circular opening $\frac{3}{4}$ in. diameter. The bone was spongy, where normally dense and eburnated, and its edge was uneven at the internal quadrant. The area showed an ischæmia, and the substance a sandy, crumbling consistence of necrotic bone.

Notes.—There can be no doubt of the primary osteomyelitis extending beyond the area of operation. This had set up by organisation a path of distribution through the dura to the pia mater. The bone of the roof was crumbly, spongy and cancellous, unlike the more common egg-shell bone. The sinuses were thoroughly searched and contained no tittle of evidence of septic thrombosis. The base was peculiarly free from all infiltration of lymph and the cisterna contained clear fluid.

ABSTRACTS

NOSE

The Treatment of Paroxysmal Rhinorrhœa (Vaso-motor Rhinitis) by Alcohol Injections into the Spheno-Palatine Ganglion. FEIN (*Vienna*) (*Verhandl. d. Gesellsch. Deutsch. Hals-, Nasen-, und Ohrenärtze*, p. 146, May 1921.) Leipzig: Kurt Kabitsch.

The spheno-palatine ganglion lies in the spheno-palatine foramen behind the posterior end of the middle turbinal, and sends the greater part of the nasal branches anteriorly and inferiorly along the lateral wall of the nose as well as into the posterior regions.

To reach the ganglion with the needle a portion of the inferior or of the middle turbinal must be sacrificed. (The details of the operation are not given.)

Only two cases had been treated, one with very great benefit.

Discussing this paper Bönninghaus cogently pointed out that the symptoms of the condition indicate an irritation of the area supplied, not by the branches of the spheno-palatine ganglion, but by those of the ethmoidal branches of the first division of the fifth cranial nerve. (This was the rationale of the treatment of vaso-motor rhinitis carried out some years ago by Yonge of Liverpool, D.M.)

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