SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

February 1, 1924.

President—Mr H. J. BANKS-DAVIS, M.B.

Extensive Bony Growth of the Nasal Septum in a Woman 46 years of age—E. A. PETERS, F.R.C.S.—The patient had noticed increasing nasal obstruction for two years, and, for one year, a hard projection in the region of the nasal process of the left superior maxilla.

A large, smooth enlargement of the septum nasi is seen involving both the cartilaginous and bony constituents of the septum. Under a local anæsthetic an incision, with free bleeding, was made into bone of varying hardness.

There does not appear to be involvement of other bones as in leontiasis.

Suggestions as to treatment are invited.

Mr H. J. BANKS-DAVIS (President) said that the growth was very hard and localised, and he did not think it had any association with leontiasis.

Mr E. D. D. DAVIS asked how Mr Peters proposed to remove the tumour, which he (the speaker) thought was a chondroma of the septal cartilage. Access by lateral rhinotomy would be difficult, and a Rouge operation seemed to be more suitable. He (Mr Davis) asked for opinions as to the operation which would give the best access to the growth. He had seen a recurrence of two enchondromata of the larynx in which the tumour had been scooped out of its capsule. If the capsule was not removed with the growth, a recurrence was probable.

Dr W. HILL asked whether these neoplasms continued to grow. If not, one might bore a hole with a Curtis' nasal trephine, and, having thus given the patient space for breathing, leave the tumour alone. If growth continued, some more radical treatment was indicated.

Dr JOBSON HORNE said that more information about the ætiology would be welcome. Had an operation been performed on the nose of this patient at any time? As the part involved appeared to be entirely the septum, the case was not in the same category as similar cases which had been brought before the Section in which the origin was the outer wall of the nose.

Dr CARRUTHERS said that he had recently seen a similar case. There had not been an X-ray examination previously, but he (the speaker) had attempted removal. The more deeply he had gone, the more bone he had encountered, therefore he had desisted from completing the operation.

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

The patient was a man, aged 53, who had been complaining of nasal obstruction for many years. He (the speaker) had given the patient an air-way through one nostril. On subsequent X-ray examination, it was surprising to find how far the bone had extended. There had been leontiasis involving both orbits, but the eyes were not proptosed.

Dr KELSON said that he had had a somewhat similar case, but in it the growth affected the outer wall of the nasal cavity. He (Dr Kelson) thought the disease was distinct from leontiasis. In his own case the chisel had struck hard bone, and then suddenly went through it into a mass of spongy bone. He understood that a recurrence was frequent, but in his case the growth had not recurred.

Mr PETERS (in reply) said that the Wassermann reaction in this case had been negative, and the skiagram had not shown any involvement of other bones of the face. He was hoping to cut away a piece for microscopical examination. He had made an incision with a scalpel, and the tissue seemed at first like cartilage. Next, he had encountered soft bone, then bone of shell-like hardness. There was nothing to be seen posteriorly. The patient had had suppuration of the lacrymal sac two years ago, and now she had a small fistula there. During the three months in which she had been under observation, there had apparently been no increase in size. He (Mr Peters) hoped to be able to remove the growth and to exhibit the specimen. The nasal obstruction had come on so slowly that the patient had not complained of it.

Specimen of Extreme Metaplasia of Middle Turbinal.—A. J. WRIGHT, F.R.C.S.—The growth consisted of an omentum-like fringe hanging from the left middle turbinal. No other parts were apparently involved, and the only symptom was unilateral nasal obstruction. The growth was removed on 3rd January 1923, and up to the present there is no sign of recurrence. Opinions are invited as to its nature.

Dr W. HILL said the growth seemed to be a villous condition, similar to that seen in connection with ovarian tumour.

Mr MUSGRAVE WOODMAN said that macroscopically the striking thing was that Mr Wright had removed the entire turbinal, with its villous terminations. Microscopically, there was an intact, thickened, ciliated mucous membrane over the surface, and, in the centre, projections of solid acini. These were distinctly vacuolated cells, and those cells were the abnormal constituents of the section. Last year, when he (the speaker) had been specially interested in the subject, Professor Shattock had given him much help in the microscopical examination of ethmoidal tumours, pointing out that the chief characteristic of the growths was the presence of vacuolated cells, which he (Professor Shattock) associated with endothelioma, and had named "endothelial sarcoma." He had also pointed out that, clinically and pathologically, they ran a very variable course, some being fairly innocent, others moderately malignant. If removed in the early stage, apparently they did not recur, but in later stages they seemed to break out through the lining mucous membrane and invade bone. He

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

(the speaker) had shown a similar type of specimen in which the growth went through the bone. He suggested that the present case was one of early endothelioma which had not yet broken through the mucous membrane.

Dr P. WATSON-WILLIAMS thought the specimen should go to the Pathological Sub-committee, so that a full investigation might be made of it for future guidance.

Mr WRIGHT said that he had never before seen anything like this specimen, and if anything could be ascertained concerning the pathology he would be glad. The pathologist whom he had consulted had said that the tumour was undoubtedly malignant, probably epithelial. The nose had been filled with it, and he (the speaker) had decided to put the patient under an anæsthetic and make an investigation in order to see what structures were involved. He had found the growth hanging as one mass, and when he had seized it with forceps it had come away, and was found to represent the middle turbinal transformed. He did not know whether to clear out the whole ethmoid ; finally, he did nothing. Now, a year later, there was no sign of recurrence.

It was important to learn, if possible, the nature of the tumour, and to find the appropriate treatment for the different growths of the nose so that the operative measures might be suited to the various degrees of malignancy.

Postscript.—PATHOLOGICAL REPORT BY Dr GEOFFREY HADFIELD : "The growth consists of masses of actively growing squamous epithelium, showing hyperkeratosis, moderate keratinization of the surface layer, and well developed differentiation in the deeper cells. No histological infiltration of deep tissues made out. There is no doubt that if the lesion is not now malignant, it has all the characters of a pre-cancerous condition. From its histology it seems to me to be probably an example of metaplasia following a chronic inflammatory lesion and possessed of high potential malignancy."

Dr G. W. NICHOLSON has also seen this microscopical section and reports as follows : "The section of ethmoidal mucous membrane presents a villous appearance caused by chronic inflammatory changes. The epithelium is squamous with large papillæ extending into the stroma. This change is the result of a process of metaplasia common in the nose and its sinuses. There are no signs of malignancy to be seen."

Specimen, Section and Drawing of a Case of Mycosis Fungoides involving Pharynx and Larynx—A. J. WRIGHT, F.R.C.S.—The patient from whom the specimen was taken was shown by Dr Kenneth Wills before the Section of Dermatology on 18th October 1923. Details of his early history can be found in the "Proceedings."* He was a man, aged 34, and had first shown signs of the disease in September 1920. He first came under my observation on 22nd October 1923, with huskiness of the voice. At that time small tumours were present in the false vocal cords, but the pharynx

* See "Proceedings," 1923, Vol. xvii. (Sect. Derm.), p. 3.

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

was clear. Two weeks later the nasopharynx was entirely blocked, the soft palate being pushed forward, and dyspnœa and stridor were present. Death took place from exhaustion and asphyxia on 13th December 1923. In addition to general enlargement of the lymphatic glands and multiple tumours in the skin, pharynx, and larynx, the mucosa of the bronchi was involved, causing obstruction.

Mr WRIGHT said that tracheotomy had not been performed, though its advisability had been discussed. The palate had been in contact with the back of the tongue, and the patient had been unable to swallow. There had also been signs of respiratory involvement lower down. Extensive deposits had been found in the hilus of the lungs, compressing the bronchi. Tracheotomy would probably not have prolonged the patient's life for more than a day or two.

Foreign Body removed from Right Bronchus—C. F. BEEVOR, M.B.—Child, aged 7 years, playing with a toy trumpet on Christmas Day, 1923, was thought to have swallowed the "squeaker." Parents became alarmed by persistent cough. A skiagram was taken and the foreign body removed by Brünings' tube and forceps. This was done five days after the accident. Air entry to the right lung was very feeble and there were a few rhonchi. The child was perfectly well again in a few days' time.

Dr W. HILL said that he thought the result was very good, but he considered that the foreign body had been in the right *secondary* bronchus, and that the title of the case should indicate that fact.

Mr NORMAN PATTERSON said that, years ago, he had had a similar case at Golden Square. Bronchoscopy had been performed in the dark room, and the foreign body removed. During the whole procedure the noise from the squeaker had continued. When the foreign body slipped several times, he had attacked it transversely, and had eventually removed it in that way.

Mr BANK-DAVIS (President) (after describing a similar case) said that the presence of unilateral bronchitis or bronchial catarrh in a child should lead one to suspect and examine for a foreign body.

Dr SMURTHWAITE said that he had shown a similar specimen taken from a child's left bronchus. There had been no symptoms until five weeks after the swallowing of the foreign body, when a whistling noise developed on deep breathing. He (the speaker) had removed it with a specially made instrument through a bronchoscopic tube.

Mr E. D. D. DAVIS referred to an identical case in which the X-screen did not reveal the foreign body. He (Mr Davis) had removed it with Brünings' fenestrated bean forceps, which had gripped it very well.

Dr IRWIN MOORE said he agreed with Dr Hill that this foreign body had probably been in the secondary bronchus; it appeared from the radiogram to have been too low down to be in the main bronchus. He congratulated Mr Beevor on the result.

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

Mr A. J. HUTCHISON asked what happened if one failed to remove the foreign body. He (the speaker) had had a case fourteen years ago in which the child had been turned upside down and shaken, etc., and had then suddenly become cyanosed. Tracheotomy had been performed, and a groping effort made to remove the foreign body. By the time his (Mr Hutchison's) aid had been invoked, the body—a metal pencil protector—was in the second division of the right bronchus. He could see it, but could not remove it, therefore he had been obliged to leave it where it was. Last summer, fourteen years after the accident, the foreign body was still in the same place, and seemed to have done no harm.

Mr BANKS-DAVIS (President) said that Chevalier Jackson had stated that there were a number of children who had screws and other foreign bodies in their bronchi, and who did not seem to be harmed by them.

Mr VLASTO reminded the Section of a case which he had shown three years previously, of a child who had swallowed a paper fastener, which he (Mr Vlasto) had failed to extract from the œsophagus.* The opinion of the Section had been divided at the time as to whether the foreign body lay in the mediastinum or in the bronchial tree. He (the speaker) had seen the child two days ago, and the foreign body was still in exactly the same place. The child was perfectly well.

Mr BEEVOR (in reply) said that he had used a Brünings' forceps with a central wire. When he had reached the bifurcation, he could see the foreign body ¾ in. further down. The mucous membrane had been rather swollen. The foreign body might have shifted while the anæsthetic was being administered.

Dilatation of the Lower End of the Œsophagus, Secondary to Hiatal Œsophagismus, cured by the Mercury Bougie—T. B. JOBSON, M.D., and E. W. SHEAF, M.B.—Male, aged 20, agricultural labourer, gave a history of three years' difficulty of swallowing—"food seemed to stick half way down—the next meal pushed some of the previous meal down or was vomited." No particular pain; some loss of flesh but not emaciated; no history of swallowing corrosive fluid. X-rays showed retention of barium meal at lower end of œsophagus. Treatment by diet, bromide and atropine and rectal feeding produced no improvement.

Œsophagoscopy showed a dilatation about the size of an orange, lined with dirty white mucosa at lower end of œsophagus. At the lower end the contracted hiatal opening could be seen and a small bougie passed. Subsequently the hiatus was dilated up to the largest size Jackson bougie. As the amount of dilatation obtainable through the œsophagoscope is necessarily limited, we tried, at Mr Mollison's suggestion, the mercury bougie. This was passed with the aid of the fluorescent screen with the patient in the upright position. It produced an immediate improvement.

* See "Proceedings," 1921-22, xv., "Sect. Laryng.," Supplement, pp. i and ii.

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

In a few days the patient learned to pass it himself before each meal. He rapidly gained flesh and had no more vomiting.

Dr W. HILL said he understood, from a conversation with Mr Sheaf, that there had been a stricture at the level of the hiatus, and that at first this had only admitted a 4-mm. bougie, hence it was obviously an organic stricture. Dilatation had ensued from passing other bougies, so that eventually it had admitted the largest size Jackson bougie. This, however, had had to pass through a Jackson tube. The authors had succeeded in dilating an ordinary hypertrophic stricture of the pharyngo-cardiac portion of the gullet, and had then continued the process with a mercury-filled tube. Hiatal œsophagismus suggested spasm, and, if there were spasm, it would be of the fibrous diaphragm. He thought the stricture had been a hypertrophic stenosis which had been cured by dilatation.

Dr BROWN KELLY remarked that the patient stated that he passed a bougie three times daily, and had been doing so for months. He (the speaker) suggested that more forcible dilatation be used, by means of a hydrostatic apparatus, or by an instrument working on the principle of the glove-stretcher. He had treated several similar cases with Gottstein's balloon, which is distended by pumping in water, and, so far, the benefit had been permanent in some, and in others had lasted for months. Recurrence should not constitute a discouragement, as the affection was a functional one. He (Dr Brown Kelly) considered that the title adopted by the exhibitors described the case correctly. When there was doubt as to the presence of œsophagismus, the question could be settled by observing the effect of gently touching the suprahiatal region with the end of the œsophagoscope. If firm closure at the hiatus followed, a heightened tendency to muscular response was indicated.

Dr D. R. PATERSON (Cardiff) said he agreed with Dr Brown Kelly as to the nature of this condition.

Dr JOBSON (in reply) said that at that stage he did not express an opinion as to the pathology. Through the œsophagoscope he could see the hiatal fibres guarding the opening. He had been able to pass a small 4-mm. bougie through the œsophagoscope and this had been gripped. Later he had dilated to 7 mm. Mr Mollison had suggested the use of the mercury bougie, and it had acted very well. After the patient had used it for two days, the vomiting had ceased; the patient had since gained 2 st. in weight, and had resumed his work. After another month he would be advised to discontinue the use of the bougie. If symptoms then recurred, he (Dr Jobson) would employ other mechanical means. The first attempt to pass the mercury bougie had been made with the patient standing in front of the screen, and the bougie had been seen to curl up at the orifice.

Slide showing Section of a Gland removed from a Man with Chronic Laryngitis and an Enlarged Gland in the Neck (previously shown at the November Meeting, 1923)—W. H. KELSON, M.D.—The section shows thickening of the walls of the blood-vessels and general fibrosis (? syphilitic) but no sign of tubercle

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

or new growth. A male, aged 77, came complaining of hoarseness of fourteen months', and a swelling in the neck on the left side, of four months' duration. On examination the left vocal cord was seen to be pink in colour and a little swollen and sluggish in movement. In the anterior triangle of the neck on the left side was a hard but freely movable enlarged gland, about the size of a walnut. No lesion could be found in the nose, pharynx, or post-nasal space.

Mr G. W. DAWSON said that he remembered the case; there had been a hard, somewhat isolated gland, low down on the left side of the neck. Some members had considered that there was evidence of malignancy, but most of those who had seen the case did not think that it was of a malignant nature. It was satisfactory to find that the swelling had only been inflammatory.

Dr JOBSON HORNE said that when the patient had attended the meeting in November 1923, one opinion had been that the enlarged gland was independent of the chronic laryngitis. He (the speaker) inquired about the present condition of the laryngitis.

Dr KELSON (in reply) said that since the date of the report he had not seen the patient, who had been so satisfied to learn that there was no malignancy about the gland, that he had departed at once.

Silver Tracheotomy Tube, shown to illustrate the average life of such an Instrument—Sir ST CLAIR THOMSON, M.D.—The tube had been worn continuously, for three years, in a case of lupus of the larynx. The patient could not be persuaded to submit to a tracheotomy until the stenosis was so extreme that she could hardly walk up one flight of stairs.

Tracheotomy was performed—under local anæsthesia—as low as was possible. As a result the lupus in the larynx completely healed, a good voice returned, but the stenosis, from cicatrization, prevented the patient from abandoning the tube which she has now worn for three years. During that time she has married and has had a healthy child. She indulges in dancing, skating, tennis, and other sports. The tracheotomy tube, which is shown, has only been removed four times a year for cleansing purposes. It will be noticed that, at the end of three years, the silver is worn so thin that it is beginning to crack. In my experience this is about the average life of a silver tracheotomy tube.

Mr C. PARKER said that the effective life of a tracheotomy tube varied enormously. In some instances they had to be renewed in considerably less than three years, whilst on the other hand he (the speaker) had known them last for even longer periods. Much seemed to depend on the nature of the secretions bathing them in each particular case.

Case of Extensive Thickening beginning in the Ventricular Bands, and covering both Cords—A. L. M'LEOD, M.B.—Male,

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

aged 52, shown to the Section, February 1923, with extensive thickening beginning in the ventricular bands and covering both cords. Opinions were divided as to presence of tubercle, syphilis, or simple inflammatory thickening. Wassermann negative.

Seen on 4th June with right cord fixed and more extensive thickening.

Seen again 30th November with marked dyspnœa; larynx almost filled; right cord fixed; tracheotomy performed next day and piece of ventricular band removed for examination.

Mr TILLEY said he regarded the condition as epithelioma. He did not think malignant disease could be excluded because ulceration had existed a year. He remembered a case which had been watched by Sir Henry Butlin, Sir Felix Semon and Sir Charters Symonds for six years, after which the patient had come to him (the speaker). He had operated and found malignant disease of the vocal cord. If the case now shown was not one of malignant disease, his (the speaker's) alternative view was that the condition was syphilitic perichondritis.

Dr JOBSON HORNE said he could not see sufficient clinical evidence of malignant disease. The case, he thought, turned on the disputed question whether a primary perichondritis could occur in the arytenoid region. He hoped a further report would be forthcoming.

Dr SYME said that his first impression of the case was that it was syphilitic. He had seen it a year previously and had then thought it was lymphangioma; he still held that opinion. He had seen such conditions involving the arytenoid region and the ventricular bands.

Angiomata of Palate—F. COURTENAY MASON, M.S.—Female, married, aged 49, with swelling of palate which existed in childhood untreated. When aged 28, she sought advice at the Throat Hospital, Golden Square, but no treatment was given. The swelling has caused no trouble until recently, when the tumour of the soft palate produced dysphagia and that of the hard palate displacement of an artificial denture.

There is a cavernous angioma, the size of a cherry, involving the uvula and adjacent soft palate. A second growth, of similar nature but larger, is situated on the left side of the hard palate and alveolus, replacing the bone and the floor of the antrum. The patient has reached the climacteric.

Mr COURTENAY MASON said that he had brought the case because he hoped that some diathermy experts would express an opinion as to the value of that procedure. He had not as yet employed it in a case of angioma, and he wondered as to the risk of hæmorrhage. The anterior growth had caused considerable bony erosion and might have gone up into the antrum, and if so, it would involve more radical treatment than would a superficial growth. As the patient was a woman of fifty and the growths had only caused distress in recent years, the case was an interest-

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

ing corollary to that of a child shown by Dr Lowry some months ago. He (the speaker) had proposed to use the galvano-cautery, but he was not certain that it would be suitable for the deeper growth in the hard palate.

Mr BANKS-DAVIS (President) suggested that electrolysis would be the safest treatment; he did not think it would cause hæmorrhage.

Dr IRWIN MOORE suggested that the case should be treated with radium by means of a special applicator placed in the mouth. Successful cases had been recorded by Rogers * in Toronto; also by New and Clark † (Rochester, Minnesota).

Dr ELEANOR LOWRY said she had sent her patient, a child, away for six months to the country for treatment of his anæmia. She might possibly apply the galvano-cautery to the edges of the nævus before operating upon the tonsils.

Mr NORMAN PATTERSON said that the galvano-cautery was dangerous in these cases.

Mr COURTENAY MASON (in reply) said that he would investigate the possibilities of radium as suggested by Dr Irwin Moore, and would inform the Section of the result.

Ulceration of Left Vocal Cord (?) Epithelioma—W. H. JEWELL, M.D.—Male, aged 60, has been hoarse for nine weeks after having a cold. The anterior two-thirds of the left vocal cord are ulcerated—the movements of the cord are active but it lags on phonation. Wassermann negative.

Mr O'MALLEY, Mr WRIGHT, and Dr SYME said they considered that the growth was epithelioma.

Dr CARRUTHERS also thought that the growth was epithelioma and that it was subglottic, a position which would account for the recent history.

Mr ARMOUR BROWN said that one point against the diagnosis of epithelioma was the short history of hoarseness—only nine weeks. In the case of such an extensive lesion, if malignant, one would expect a longer history.

Mr JEWELL, in reply, said that he considered the growth was an epithelioma and extended to the subglottic area, and he intended to perform thyrotomy.

Postscript: (February 12, 1924). Thyrotomy has now been carried out and the vocal cord, ventricular band, and adjoining mucous membrane and perichondrium removed, *en masse*, as far back as the arytenoid.

Patient was able to swallow liquids on the evening of the day of operation and semisolids on the following day. Highest temperature 99°. Progress has been continuous and he is now convalescent.

---

* *Journ. Canadian Med. Assoc.*, Toronto, 1912, o.s., xli., n.s. ii., p. 111.

† *Ann., Otol., Rhino., and Laryngol.*, 1919, xxviii., pp. 1025-1037.

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press

Abstracts

Case of Ulcer of Nasal Septum—PHILIP FRANKLIN, F.R.C.S. —Male, aged 50, with extensive ulceration of left septal mucosa with the edge raised and œdematous; history of occasional epistaxis during nine months. Wassermann negative.

MR WRIGHT suggested that a piece should first be taken from the thickened edge for microscopical examination.

Dr SYME said he thought that the diagnosis lay between chronic tubercle and malignant disease; on the whole, he thought the ulcer was malignant.

Subsequent data: *Microscopic Report.*—No evidence of tubercle or new growth. The ulcer and underlying cartilage and bone were removed by a sub-mucous resection. On examination one month later the area of removal was seen to be entirely healed.

ABSTRACTS

THE EAR.

Protective and Magnifying Glasses attached to the Binocular Reflector of Clar, V. NASIELL; *Spectacle Magnifier of Gullstrand*, J. W. NORDENSON; *An Otomicroscope*, C. O. NYLÉN; *A Binocular Magnifier*, J. MOLINIÉ; *My Binocular Apparatus for Throat, Nose, and Ear Surgeons*, C. VON EICKEN; *A Stereoscope for Diminishing Inter-pupillary Distance in accordance with Physiological Principles*, E. WESSELY; *The Binocular of Zeiss with Improved Fixation and Lighting*, W. TRENDELENBURG. (*Acta Oto-Laryngologica*, Vol. v., fasc. 4, November 1923.)

Two distinct objects have been aimed at in the construction of the various forms of apparatus described in these papers. The first three, that is, those described by Nasiell, Nordenson, and Nylén are intended to give increased magnification, while serving also the purpose of protecting the eyes of the user against injury by blood, pus or expectorated material. The apparatus, referred to in the other four articles, have the additional and still more important function of rendering possible binocular and stereoscopic vision in the narrow passages with which the throat and ear surgeon has to deal.

Among the apparatus whose chief object is simply increased magnification, the instrument of Nasiell consists merely of a Clar's forehead lamp (with an improved headband) to the hinder surface of whose reflector are attached a series of Zeiss focal lenses of various strengths, supported on revolving carriers so that the power of magnification can be altered as required. The magnification is of

https://doi.org/10.1017/S0022215100026098 Published online by Cambridge University Press