SOCIETIES' PROCEEDINGS

THE SOUTH-WESTERN LARYNGOLOGICAL ASSOCIATION

THE FIFTY-FOURTH MEETING OF THE ASSOCIATION WAS HELD ON SATURDAY, JANUARY 9TH, 1965, IN BRISTOL. THE PRESIDENT, MR. ROY SALKELD, WAS IN THE CHAIR.

On the otological side, four patients with moderately advanced otosclerosis were shown; with solid footplates, there was a preference for pistons either of the stainless steel variety (McGee) or teflon (Shea). In one patient, shown by Mr. Roddie, a high-pitched tinnitus, like machinery, had been more distressing than the deafness; the air-bone gap was closed and the tinnitus was completely relieved. Mr. Bihari remarked that pulsating tinnitus was more likely to be relieved by operation than the high-pitched variety which was usually associated with degenerative changes in the cochlea. Mr. Roddie also showed a patient in whom an intolerable high-pitched tinnitus had been relieved by tympanotomy and division of adhesions and the stapedius tendon in the presence of a mobile stapes and round window membrane; the air-bone gap had been closed with a 30 decibel gain.

Mr. Freeman showed a boy of 16 with cholesteatomatous destruction of the incus and erosion of the lateral semicircular canal. A type III tympanoplasty pre-existed; pressure on the head of the stapes produced a free flow of perilymph from the fistula. Notwithstanding three "fenestrae" good hearing was retained in the ear.

Mr. Malcomson showed a girl of 12 who had had bilateral unerupted cholesteatoma with an average hearing impairment of 40 decibels in both ears; after exenteration of the cholesteatoma which had partly eroded the right incus and completely destroyed the left, a type III tympanoplasty was fashioned. Hearing was restored to normal levels on both sides.

Mr. Roddie showed a patient who had had bilateral hæmotympanum after head injury. There was a severe conductive deafness on both sides. Conventional skull views showed an extensive fracture of the base involving the left temporal bone. Polytomography showed a fracture of the deep meatus and an incudo-stapedial dislocation was suspected. These findings were confirmed on exploration of the left ear; the incus was replaced and splinted with mucosa, the chorda tympani and gelatine sponge but no hearing gain resulted. Subsequently the left ear was re-opened, and a Smythe Clothes-Peg Teflon Prosthesis inserted with an encouraging improvement in hearing. Exploration of the right ear revealed a fixed stapedial footplate and a fracture of the crura. Stapedectomy with a fat-wire replacement was carried out; there was restoration of hearing to normal with closure of the air-bone gap.

Mr. Malcomson showed a man of 57 with giddiness and cochlear insufficiency on the right; this was associated with bilateral stenosis of the vertebral arteries

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at their commencement, more marked on the right side. Vertebral angiographic and aortographic findings simulated those of Subclavian Steal with reversed vertebral artery flow down the right side. Slight improvement in hearing and relief of dysequilibrium resulted from vasodilator therapy (Lipoflavonoid). Mr. Dalton said that he had had similar success with this preparation in cochlear insufficiency, but noted that the preparation was not always tolerated by patients.

Mr. Angell James showed two patients with Ménière's Disease. One was a man of 60 who continued to have attacks of giddiness despite alcohol injection via the oval window in *1942* and ultrasonic irradiation in *1961*; relief was eventually obtained by further ultrasonic irradiation of the vestibule and packing the labyrinth with bone chips. The second was a woman of 35 with dense keratosis obturans and subtotal loss of hearing on the right; after ultrasonic destruction of the membranous canal and vestibule, removal of the utricle and saccule and packing the vestibule with bone chips, her attacks ceased.

Mr. Fairman showed a woman of 51 with unilateral perceptive deafness due to an acoustic neurofibroma. This was subsequently completely excised via the translabyrinthine approach advocated by William House, without post-operative facial paralysis.

Mr. Malcomson demonstrated a man of 55 with Treacher-Collins Syndrome whose hearing deficiency in early life probably led to his classification as mentally defective. Polytomographic studies of the ears showed atresia of the left external auditory canal and absence of ossicles on both sides. The right lateral semicircular canal was short, wide and fused with the vestibule with an associated distortion of the oval window. Both internal auditory meatuses were narrower than normal.

On the oncological side, Mr. Fairman and Mr. Roddie demonstrated five patients in whom carcinoma of the hypopharynx had been treated by excision and bilateral block dissection and colonic replacement. Mr. Roddie's patient was a woman of 42 who developed a postcricoid carcinoma in association with Paterson-Brown Kelly Syndrome. The colon was passed via the anterior mediastinum. There has been no recurrence in over two years.

Mr. Fairman showed four patients all of whom had undergone bilateral block dissection, pharyngo-laryngo-œsophagectomy and colonic replacement of the whole of the œsophagus and hypopharynx via the posterior mediastinum. The first, a man of 42, with a carcinoma of the pyriform fossa, had returned to full duties as a bus conductor with an excellent "colonic" voice. The second, a woman of 35, with a co-existing Paterson-Brown Kelly Syndrome and intermittent dysphagia since childhood, was able to eat her Christmas dinner two and a half weeks after operation. The third, a woman of 65, had had atrophic rhinitis since childhood; because of nasal sepsis she was treated initially with Cobalt 60. Stridor developed and a tracheostomy became necessary; following this nasal crusting completely ceased. A month later she underwent radical excision without any post-operative complications of consequence. The fourth, a woman of 62, with a history of six months had an annular postcricoid growth. The formidable surgical excision was carried out unattended by post-operative disturbances of significance.

During the past three years experience of 25 patients who have undergone this type of surgery in Bristol permits some conclusions to be drawn. The

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procedure allows wide excision which is fundamental in this insidiously infiltrative disease. Hypotension is undesirable as the nutrition of the colon graft might be compromised. Provided speedy hæmostasis is cultivated, blood loss is kept to a minimum and the operative time should not exceed six hours; on one occasion this was just over four hours. Formerly the colon had been brought through the anterior mediastinum but the posterior route is in general more satisfactory; no significant physiological disturbances resulted from this or the bilateral vagotomy which is of necessity entailed when total œsophagectomy is carried out. Finally, the morbidity of the operation is no more prohibitive than surgical strategies confined to the neck with reconstruction using skin; moreover, in a disease which has always had a sinister reputation irrespective of surgical or radiotherapeutic management, colonic replacement offers the best palliative procedure to date.

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