SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

President—Dr ANDREW WYLIE.

February 4, 1927.

Dental Cyst of the Right Upper Canine—DAN M'KENZIE, M.D.—Woman, aged 28, presented a hard, bony swelling of four months' duration on the ascending process of the right superior maxilla. A small granulation on the labial aspect of the alveolar process in front of the canine socket led by a narrow tract into the heart of the swelling. The canine tooth had been removed. Chloroform was administered and the tract was opened up; a cystic distension of the bone was disclosed. The lining was removed, and the cyst cavity opened into the nasal cavity by removal of its inner bony wall. During the operation a free flushing of the right conjunctival sac with tears was observed, but it ceased with the cessation of manipulations.

Specimen showing Invasion of Endocranium by Carcinoma of Ethmoid — DAN M'KENZIE, M.D., and G. SCOTT WILLIAMSON, M.D.—A male, aged 50, had had two operations for extensive carcinoma of the ethmoid, starting probably near the right orbital wall, as the orbit was invaded by the growth. Death from purulent meningitis followed the second operation. Post-mortem examination showed that the growth had invaded the cranial cavity through the cribriform plate and by way of the perineural lymphatics of the olfactory nerves; that is to say, by the same route as that taken by the bacteria of sepsis in meningitis arising from a nasal focus.

Pathological Report.

The dura mater was punctured or exposed at operation in the right nasal fossa, adjacent to the tumour masses on the right olfactory nerve; there, a rounded mass of granulation tissue, overlain by a thin membrane appears. This mass was not adherent to the pia mater; similar tissue lines the right frontal sinus which is opened. There is no malignant growth in this granulation tissue mass and the dura mater limits the spread of the reaction, but apparently has allowed bacteria to filter through.

The secondary tumour within the skull shows bilateral spread. It is progressing directly through the cribriform plates, in the lymphatics of the olfactory pad, travelling thence into the lymphatics on the superior surface of the olfactory nerves, *i.e.*, in the pial extensions on these nerves. Running back in this tissue the growths reach the surface of the brain,

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just in front of the origin of the nerves, and there the growth presses upon and penetrates (not invades) the brain substance, *i.e.*, the spread is always in the pia; the two pressure necrosis areas in the surface of the olfactory lobes are well shown. On the left side the mass is larger and has become vascularised as the result of the reaction to pressure necrosis.

The instructive features of the preparation are:—(1) The lymphatic pial pathway of the olfactory tract. (2) The specific limitation of this tract, which is clearly marked off from any tracts in the dura mater.

Tuberculosis of Larynx—T. B. LAYTON, D.S.O., M.S.—Male, aged 48, complained on 18th November 1925 of seven months' hoarseness, the whole larynx being infected; both false cords swollen and irregular; interarytenoid space filled up with irregular mass; vocal cords red but not swollen or ulcerated; he appeared to have pain in swallowing. Advised to go into a sanatorium.

On 18th December 1925, admitted to King Edward VII. Sanatorium. Stage II. Right lung + +; left lung +. Epiglottis congested and infiltrated with ulcer on left border and on laryngeal surface. Ulcerating deposit on left aryepiglottic fold and on both false cords, largely concealing vocal cords; no dysphagia; interarytenoid clear. Silence ordered (Sir St Clair Thomson).

20th March 1926.—Vocal cords clear, but anterior quarter concealed by ulcerating deposit on both false cords. Right arytenoid seemed clear, and also the left, except that the latter did not move and expose the left sinus pyriformis; interarytenoid fold is clear.

15th April 1926.—Much ulceration of epiglottis and both false cords: galvano-cautery to epiglottis at five points and to right false cord at two.

15th May 1926.—Healing, good scar in right false cord. Second galvano-cautery to epiglottis at five points, and at two to left false cord.

19th June 1926.—Vocal cords clear. A little thickening over anterior part of the left false cord. Epiglottis very irregular, but healing.

Discharged 28th June 1926.—Lung disease improved, quiescent—sputum negative in twenty-four examinations; weight increased from 9 st. 12 lb. to 10 st. 11 lb.

Seen by exhibitor 17th September 1926.—Irregularity of upper margin of epiglottis. General redness including cords, swelling at anterior end of right false cord, which prevented view of anterior end of vocal cord; no granulations. Advised to continue whispering for a time.

5th October 1926.—Sir St Clair Thomson reported larynx quite healed; wasted and irregular epiglottis, stump healed, scars on both false cords; elsewhere normal. Given permission to phonate. The man's courage and implicit obedience were large factors in his recovery.

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Societies' Proceedings

Laryngeal Lesion associated with Apparent Miliary Tuberculosis of the Lung—WALTER HOWARTH, F.R.C.S.—Male, aged 21, had hoarseness for three months. Examination showed a granulomatous patch at the anterior end of the right vocal cord. There was no limitation of movement.

Portion removed for microscopy showed typical tubercle. There were no physical signs of disease in the lung, but the skiagram shows that both lungs are a mass of miliary tubercle. In spite of the absence of symptoms, these cases are invariably rapidly fatal.

Mr F. T. G. HOBDAY said he had seen a cow with a tuberculoma just below the larynx. The animal was killed under the Tuberculosis Order, and was found to have been suffering from the disease in an advanced and generalised state.

Sir ST CLAIR THOMSON asked whether Mr Howarth's case was rightly defined as "miliary" tuberculosis of the larynx. It seemed to be a most chronic and quiescent condition, and there was no invasion of the arytenoid region, nor of the epiglottis. Mr Howarth had informed him (the speaker) that X-ray specialists were now able to tell from the skiagram when a patient had miliary tubercle of the lung. This patient had a quiet pulse, he ate well and maintained his weight, and he did not exhibit a temperature. It would be a great advantage if the expert radiologists could say definitely that such a man would be dead in a few months. Mr Layton's case was quite different; it was chronic, indolent, and almost lupoid from the beginning. A good prognosis had been given, yet the thorough treatment occupied seven months, and if the patient had not been in a sanatorium he would probably have gone down hill. It was doubtful if there had ever been tubercle bacilli in his sputum; they were not found in it while he was in the sanatorium. When he had come under his (the speaker's) observation there was no disease in the interarytenoid or arytenoid regions, but it was extensive in the epiglottis and anterior commissure. When tubercle began in its favourite place, the arytenoid region, and then spread to the epiglottis, the outlook was very serious; but when it began in the epiglottis and the arytenoid was free, the case was, *cæteris paribus*, a favourable one.

Dr JOBSON HORNE said that when the epiglottis was the only part attacked it was as well to exclude other possible conditions. Miliary tuberculosis — in the commonly accepted pathological meaning of the term—did not occur in the larynx. Diffuse, superficial, minute discrete multiple ulcers occurring in the pharynx or larynx in the course of tuberculosis did not constitute miliary tuberculosis.

Tuberculosis of the larynx in animals was very rare if not unknown, the reason being that the animal either was killed or died before the disease in the lungs had had time to infect the larynx. In the specimen of the cow's larynx the tuberculoma was clearly below the larynx and in the trachea.

Sir WILLIAM MILLIGAN said it was difficult to explain away the evidence of the microscope, and yet on the other hand it was difficult to

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decide that this patient had miliary tuberculosis. He (the speaker) had never seen miliary tuberculosis of the larynx, but he had seen more than one case of miliary tuberculosis of the pharynx. Professor Dreschfeld used to teach that the nearer tuberculous disease was to the surface of the body the more rapidly fatal it was. This patient, though he presented evidence of tubercle in his larynx, was in such relatively good general condition that doubts arose as to the existence of miliary tuberculosis.

Mr W. J. IBBOTSON said he had had a case similar to this ; the patient had been in a sanatorium and a very good result had been obtained from the intralaryngeal use of radium combined with ordinary sanatorium treatment. He suggested that radium should be more widely used in the treatment of this disease.

Mr HOBDAY said he agreed with Dr Jobson Horne that it was not common to find tuberculosis in the actual tissue of the larynx of animals, but it was often met with in the glands in the region of the larynx of the cow. It was rare in this region in the horse, the dog, and the sheep.

Mr G. W. DAWSON asked how miliary tubercle could be diagnosed by means of the microscope.

Mr HOWARTH (in reply) said that the case presented some unusual features. The lesion was originally on the anterior end of the right cord. There were no physical signs of disease in the chest, and a piece removed for examination was reported tuberculous. The radiologist said that both lungs were riddled with miliary tubercle and several physicians and radiologists agreed with this diagnosis. This case had followed on two other recent cases, one of which had begun very similarly and had presented almost the same X-ray picture. The other patient had been apparently perfectly well and without abnormal temperature but, later, extensive disease had developed and the patient had died within six months. He (Mr Howarth) did not profess to be an expert either in pathology or radiology, but many people were apparently certain that this was a miliary condition and that the patient would not live long. Time would show. He would report on the case later.

Swelling on Right Vocal Cord: Case for Diagnosis—N. STUART CARRUTHERS, F.R.C.S.—Female, aged 25, was first seen in June 1925, complaining of hoarseness. Onset had been gradual; she noticed that it was worse towards the evening. X-ray report: "No evidence of tuberculosis of lungs." Wassermann reaction negative. Physician reported "No clinical evidence of tuberculosis."

On examination a small isolated nodule was seen on the middle third of the right vocal cord, with minute vessels radiating from it. In spite of rest to the voice the condition has advanced. The greater part of the cord is now involved by an oval swelling, but there is still no clinical or X-ray evidence of pulmonary tuberculosis.

Mr CYRIL HORSFORD said he regarded this as a common condition frequently seen in singers. The patient said she used to sing, and had noticed that after a vocal effort her voice became hoarse. The condition

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might be called fibroma ; he believed it to be a result of vocal strain ; there might have been hæmorrhage in the substance of the cord, and this might have become organised. He (Mr Horsford) had never tried to treat these conditions, as it was difficult to influence them. The only hope for such patients was a change of vocal method, which would probably relieve the laryngeal irritation.

Sir ST CLAIR THOMSON said he thought this was an innocent thickening, fibroma, fibrocystic, or lymphatic. He would like to hear from those who had tried to treat such conditions surgically whether they had not always failed. At one time the galvano-cautery was used for them. It would be an advantage to have a general agreement as to what was desirable in these cases ; whether to leave them alone, dealing only with contributory causes in the mouth, or to treat them by any means other than local surgery.

Dr JOBSON HORNE considered the condition to be vascular in origin and due to strain of voice. He was not in favour of an endoscopic examination, as had been suggested ; in the first place complete rest of voice was indicated.

Sir WILLIAM MILLIGAN said that he disagreed with both the previous speakers, and regarded the swelling as a typical node, with some hyperplasia. It was a great mistake to condemn the use of the cautery in such a case, which, if treated merely by silence, would take ten years to cure. The node could be exterminated by the "direct" cautery, and no risk was attached to that procedure. He (Sir William) had treated many singers, some of them famous, who had suffered from nodes. He had always employed an anæsthetic, and had gently touched the site with the point of the cautery ; the results had been excellent.

Dr ANDREW WYLIE (President) said that at one time he had been enthusiastic about the use of the cautery, but a few years ago two or three very serious complications had occurred and had caused him to change his mind considerably. In one case treated by the cautery, he had been summoned to perform tracheotomy in the middle of the night. A similar event occurred three months later, and since then he had refrained from using the cautery, unless the growth was very small. He thought that vocal rest for fully six months would cure this patient.

Mr CYRIL HORSFORD said he had seen many cases of this kind, and there was neither harm nor danger associated with them. The only real trouble was in the case of a professional singer, in whom absolute perfection of tone was desired. He did not recommend the use of the galvano-cautery in that case. He had seen this condition in professional singers, and it was most difficult to cure. The nodule was not on the edge but in the substance of the cord, therefore one could not interfere with it surgically by any cutting process, and it was not removable by cautery. A nodule on the edge of a cord might be touched lightly by the cautery, but a nodule in the centre so treated would be replaced by a scar, which would distort the cord and spoil its value for singing.

Sir JAMES DUNDAS-GRANT said that the cautery was useful in the case of nodules found at the junction of the anterior and middle thirds

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of the cord. He had a case supporting this view, that of a woman with a large family who had to use her voice a good deal. In the present case there was paresis of internal tensors, and vocal treatment should be given.

Mr LAWSON WHALE said he agreed that there was paresis of the internal tensors in this case.

Mr CARRUTHERS (in reply) said that this patient had not been kept absolutely silent, but for seven months she had not spoken above a whisper. In spite of this treatment the local condition had spread and she was very hoarse. Perhaps absolute silence would produce improvement. The patient worked in a dusty atmosphere in a factory where there was machinery and it was necessary for her to strain her voice in order to make herself heard.

Basal-celled Carcinoma of Larynx: Recurrence after Five and a Half Years—WALTER HOWARTH, F.R.C.S.—Female, aged 58, on June 1921, had the whole of the left ventricular band and the left vocal cord along with the anterior third of the right cord removed. The case was fully reported in the *Journal of Laryngology and Otology*, June 1922, vol. xxxvii.

At the present time there is a small recurrence of the growth on the left side anteriorly.

Mr LIONEL COLLEDGE said that before the operation the growth had extended to the opposite side of the larynx, therefore, if this was a genuine recurrence, he thought the whole front of the larynx on both sides—possibly even the entire larynx—would have to be removed. If the patient opposed an extensive operation, radium would be worth a trial, as this form of growth genuinely responded to its use.

Sir JAMES DUNDAS-GRANT said that if the patient were not opposed to operation, a portion of the growth might be removed for microscopical examination. But in view of opposition, it might be better not to take a piece away, as the procedure might conceivably stir up the trouble. Basal-celled carcinoma answered favourably to radium treatment.

Mr HOWARTH (in reply) said that the patient was only opposed to an extensive operation which might involve loss of voice. He proposed to examine her in hospital by the direct method, and to remove a portion of the growth so as to ascertain whether it was a true recurrence or not. He thought more than laryngofissure would be necessary, because of the extent of the primary growth, even though it was a very slow-growing type of cancer, practically a rodent ulcer. If the patient would consent to operation he would expose the tumour and imbed radium in it, or carry out a limited excision.

Two Cases of Chronic Hyperplasia of Superior Maxilla—WALTER HOWARTH, F.R.C.S.—(1) Female, married, has noticed for the past four or five years a gradual swelling of the right upper jaw, quite painless in character.

The diagnosis rests on the long history, the minor character of

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the pain and the resultant deformity, together with the normal condition of the mucous membrane and absence of inflammatory phenomena, especially tenderness on pressure.

Macroscopic and microscopic appearances of a piece of bone removed show the typical structure associated with this condition, which was first described by Mr Westmacott. X-ray examination shows areas of hyperplasia in the basisphenoid and also in the vault of the skull.

(2) Male, aged 19, was operated on three years ago. The macroscopic appearance of the bone was similar to the preceding case, but the microscopic slide shows alternate layers of bone and cartilage, without any fibrous tissue; this appearance is quite different from the usual picture of spongy bone formation with proliferating osteoblasts, together with the destruction of the spongy bone by masses of osteoclasts, a vascular interstitial tissue and the laying down of much fibrous tissue.

The previous operation was not by any means complete, but the clinical appearance has not progressed except in the alveolar border.

Specimen of Hyperplastic Bone from the Frontal Sinus—WALTER HOWARTH, F.R.C.S.—Macroscopic and microscopic appearances of the bone present many features similar to those associated with chronic hyperplasia of the maxilla.

Endothelioma of Antrum apparently Cured by Radium. Recent Local Recurrence after Three Years — WALTER HOWARTH, F.R.C.S.—Patient, a male, had an enormous tumour of right upper jaw and was first seen in a moribund condition. Radium produced an almost magical disappearance of the growth. Recently two small nodules have appeared.

Mr SYME said he had seen numbers of these cases, and did not think that X-ray examination of the sinuses was sufficient to exclude the possibility of sepsis, which was almost always present. These cases ought always to be thoroughly investigated from this point of view.

Mr A. J. M. WRIGHT said that in one such case he had removed a considerable portion of bone and opened the antrum. In that case the lining of the antrum had been healthy.

Mr HOWARTH (in reply) said that he had hoped to obtain suggestions as to treatment. Mr Westmacott, in 1913, had suggested chiselling away all the redundant bone until healthy bone was arrived at. That had been done in the case of the boy (Rouge's operation); the woman had been treated with radium. He thought this might produce a good result, because it was difficult when doing a Rouge's operation to be certain where pathological bone ended and normal bone began, as one shaded off into the other. The deformity in these cases was sometimes very distressing. The boy was not cured, but was much improved. He (Mr Howarth) understood that these conditions did not originate in or

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invade the nasal cavity, and the remaining portion of the antrum was found to be healthy. The origin of the condition was, he believed, in the teeth, the sepsis there causing a chronic osteomyelitis. Pathologists were not agreed as to the exact nature of the condition.

The specimen of frontal bone looked like the other under the microscope. He showed the endothelioma in order to demonstrate what could be done with radium in an inoperable growth. The tumour dropped out after radium treatment. There were two small recurrences, which he intended to deal with in two days' time by excision, as radium used for recurrences was in his opinion often unsatisfactory.

Osteoma of Frontal Sinus—D. F. A. NEILSON, F.R.C.S.—Male, aged 43, was first seen in 1925. He then consulted his doctor on account of pain and inflammatory swelling over the left eye. This lasted for two weeks, subsided, and has not recurred. For some years previously he had noticed a swelling in the middle of the forehead.

No history of headaches or frontal pain except during the attack mentioned. Nasal fossæ appeared normal.

Since 1925, his sight, which before that date was perfect, has deteriorated rapidly. The fundi have been examined several times and reported as normal, the defective vision being due to marked astigmatism and myopia. Stereoscopic X-ray films demonstrate an osteoma with well-defined margin and surrounded in places by the expanded walls of the frontal sinus. The cranial fossa is invaded to quite an appreciable extent, and in this locality the roof of the sinus is well away from the margin of the osteoma. Presumably a mucocele is developing.

The patient has refused treatment, but the rate of increase in size of the growth is being observed.

During the first year no increase was detected.

Sir JAMES DUNDAS-GRANT asked how the defect of vision and the development of polypi in the right nasal cavity could be explained in this case. It seemed as if there had been some invasion of the posterior ethmoidal cells, involving the oculo-motor nerves.

Two Specimens of Exotosis arising in the Floor of the Frontal Sinus—WALTER HOWARTH, F.R.C.S.—Both these tumours produced a mucocele of the frontal sinus. They are shown as a corollary to the previous case.

Tumour of the Nose — G. W. DAWSON, F.R.C.S.I. — Male, aged 24, had a tumour on the right side of the nose, extending from the eyebrow to the ala. It is soft and ill-defined and has been present for sixteen years.

Sir JAMES DUNDAS-GRANT said he thought the growth was a lymphatic nævus.

Dr W. HILL said he would treat it with the ionization needle.

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Mr A. J. M. WRIGHT said electrolysis might be worth trying here.

Mr M. VLASTO said that as the condition was obviously benign and as, apart from the disfigurement, the swelling did not incommode the patient, he would not advise operation. As an alternative diagnosis, he suggested that of a soft lipoma.

Miss ELEANOR LOWRY said that a few weeks ago she had had a patient with a soft swelling over the mastoid, which it was said varied in size. There was a chronic discharge from the ear, and, on operation, the swelling was found to be a lipoma. Possibly the present case might be of the same nature.

Dr IRWIN MOORE said he, too, thought the swelling was a lipoma, and would advise leaving it alone.

Two Cases of Laryngectomy: Specimens Shown — W. J. HARRISON, M.B.—(1) Male, aged 54, complained of weakness of the voice and huskiness of about three months' duration. On examination the right cord was found to be motionless and the posterior third had a "mouse-nibbled" appearance. The right arytenoid was immobile and there was a good deal of swelling in this region, extending into the interarytenoid space. Wassermann reaction weakly positive. Pathologist's report on specimen: "A typical squamous-celled carcinoma." The patient is edentulous. Operation 20th July 1926. Laryngectomy without a preliminary tracheotomy. Larynx removed from below upwards. Uneventful recovery. Primary union of the wound. Highest temperature 99.6. Fastest pulse rate 112. Greatest number of respirations per minute 24. Now speaks in a whisper which is becoming louder and more distinct. Has put on weight since the operation (he says 16 to 17 lb.). Specimen opened from the front.

(2) Female, aged 37, had noticed an alteration in her voice for six months, but she had taken little notice of it. Had had attacks of weakness of her voice for the past two years.

On examination a fungating growth was found in the upper part of the larynx, on the right side, and a gland on that side of the neck was enlarged. Wassermann reaction negative. Pathologist's report on specimen: "A squamous-celled carcinoma." Patient wears complete dentures. Operation 4th January 1927. Laryngectomy without preliminary tracheotomy. Epiglottis removed owing to situation of growth. The division of the muscles was made some distance from their insertion, as the gland over the cricothyroid membrane was enlarged. The gland in the neck and the gland-bearing tissue in this region were removed.

Considerable difficulty was experienced in closing the pharyngeal wound owing to the free removal of the larynx.

Some sutures in the skin have given way, but healthy granulations are springing up and the wound is closing rapidly (20th January 1927).

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General condition very satisfactory. Temperature once reached 100° F. (on the sixth day after operation). Highest pulse-rate 114, for a short time. Respirations 24 per minute for the first twenty-four hours, since then 22 per minute.

Mr HARRISON said that the method he had adopted in dressing these cases was to wrap the tracheotomy tube with gauze so that it completely filled the lumen of the trachea. Ribbon gauze was packed from below upwards into the wound and a piece of gauze was packed in below this immediately above the trachea. These packs had to be changed frequently at first at about twenty-minute intervals. He wished to learn what other methods members used. He got these patients up in three days, sitting in an armchair. He would welcome suggestions as to how long the nasal feeding tube should be kept in in cases which were doing well. He had seen it stated that these patients generally died within three years of the operation from lung complications. What was the experience of others in regard to lung complications?

Sir ST CLAIR THOMSON said that these interesting specimens were very instructive. In similar cases, in early days, he (the speaker) had attempted laryngofissure, and usually there had been a recurrence. The kind of case from which these specimens were shown was unsuitable for laryngofissure, but was usually admirably suitable for laryngectomy. In the case of the male, it was remarked that the cord was motionless, and his (the speaker's) statistics showed that recurrence, after laryngofissure, was much more frequent in cases in which the cord was fixed than in those in which it was mobile. Mr Harrison had told him that what was remaining of the cord in the second case had been quite concealed. Mr Harrison had acted rightly in performing laryngectomy instead of splitting the larynx or doing laryngofissure, but if Mr Howarth had to operate further on his patient, he (Sir St Clair) suggested that it would be worth trying to save part of the larynx, however small, even if a tracheotomy tube had to be worn for the remainder of life. He (himself) had had one case in which he had performed secondary laryngofissure. That was three years ago, and the patient was going about in society; the tracheotomy tube in her neck was concealed, and her voice was certainly better than none at all.

With regard to these patients continuing to breathe through the neck; there was no particular danger in that. In his (the speaker's) book were references to individuals who, having undergone tracheotomy at the age of 30, had died aged 80, and had worn the tube during the intervening time. Despite the *a priori* physiological arguments as to the importance of warming inspired air in the nasal passages, he knew of people who while wearing their tracheotomy tube played tennis, begat children, and did all the other things the ordinary citizen accomplished, except swim! Moreover, they did not seem more subject to bronchitis than were other people. The malignancy in Mr Howarth's case was of a low form, and he (the speaker) thought that an operation might be performed, in which as regarded severity, would lie somewhere between laryngofissure and complete laryngectomy.

Mr C. A. SCOTT RIDOUT said that he had shown at a previous meeting a patient with a similar condition. This patient had progressed well and

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was quite cheerful, having had no trouble at all, though since the operation he had had an acute attack of appendicitis. He had never had a cold in the head since the throat operation.

Mr LIONEL COLLEDGE said that in the first of these specimens the epiglottis had been left; in the second it had been removed with the larynx. On close examination the growth was seen to approach closely the cut edge of the epiglottis. It was better, when removing the whole larynx, to take away the epiglottis at the same time. In some of his own cases, on examining the patient with the mirror, the epiglottis had appeared to be free, but afterwards, in the specimen, it was seen to be deeply infiltrated. With regard to drainage, he had not found gauze drains efficient. He used rubber tubes instead, and as soon as there was much discharge he syringed the tubes through with eusol; a simple rubber tube having lateral holes was the best form of drain.

Sir JAMES DUNDAS-GRANT said that in a case in which he had seen Mr Lionel Colledge operate, the existing tracheotomy wound was adherent to the surface of the neck, and Mr Colledge had cut through the trachea above it, bringing the skin together behind the cut surface of the trachea, so that he was then able to plug it until union was established and so to protect the lungs from infection—the patient breathing through the tracheotomy tube. Might not this safeguard be more frequently adopted?

Mr LIONEL COLLEDGE (in reply to Sir James Dundas-Grant) said that a preliminary tracheotomy allowed the cut end of the trachea to be packed so that the trachea was completely shut off. But in three cases in which there had been preliminary tracheotomies there had been recurrence in the tracheotomy wound, and he wondered whether making an additional wound there before doing the main operation did not expose the patient to an additional risk of recurrence.

Dysphagia for Three Months due to Foreign Body in the Œsophagus—C. GILL-CAREY, F.R.C.S.E.—Patient, a woman of 32, complained of inability to swallow solid food for three months. Could not remember having swallowed a foreign body. Had lost 2 stone in weight.

No abnormality in larynx; no excess of mucus in the pyriform fossæ.

X-ray examination made by Dr Graham Hodgson, who reported an abnormal opacity in the œsophagus between the sixth and seventh cervical vertebræ.

By œsophagoscopy a piece of glass was removed from the œsophagus 25 cm. from incisor teeth. No ulceration of the œsophagus was present.

Complete recovery after removal of the foreign body.

Dr ANDREW WYLIE (President) said that he had seen the patient in this case, and she had complained very little. Mr Gill-Carey had removed the foreign body in a very skilful manner. It was uncertain at the time of the operation whether a foreign body was present.

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Royal Society of Medicine

Lymphosarcoma of the Tonsil and Tongue with Glandular Involvement—NORMAN PATTERSON, F.R.C.S.—Female, aged 64, had eight years ago noticed swellings on the left side of the neck. Later on she was treated by X-rays, and the enlargement of glands disappeared after six months. About two years ago the swelling re-appeared, but the condition improved under treatment. The glands began to enlarge again last summer.

On examination a large, smooth, firm mass is found in the region of the left tonsil and there is a similar swelling involving the lingual tonsil. There are enlarged glands on both sides of the neck, and the pre-auricular gland on the left side is distinctly swollen. There is also enlargement of a small gland in the right axilla.

Lymphogranuloma (so-called large-celled lymphosarcoma) was diagnosed microscopically.

The patient has, of late, been under medical treatment.

Further Report on Cases Previously Shown.

Sarcoma in Cricoid Region—GEORGE W. DAWSON, F.R.C.S.I. —Female, aged 58, married (shown at meeting held December, 1926, see *Journ. of Laryngology and Otology*, April 1927, pp. 257 and 258), had tightness of throat since previous Christmas; later, difficulty in breathing and laryngeal stridor; has been treated for asthma. Wassermann reaction negative. There is a smooth, round tumour covered by normal coloured, mucous membrane, situated below the right vocal cord. Both vocal cords and arytenoids move well. Voice normal.

December, 1926—Urgent tracheotomy. Owing to slight bronchial trouble operation postponed to 4th January 1927. Laryngofissure. Round-celled sarcoma in cricoid region. Secondary hæmorrhage eight days later. Patient died 15th January 1927.

Mr DAWSON said the general view when his case was shown had been that the growth was an enchondroma. It was a soft growth in the region of the cricoid. He had split the larynx, and it did not appear white, as it had done on laryngoscopic examination. He excised a piece, and the report was that the growth was round-celled sarcoma. The patient went on very well for eight days, then secondary hæmorrhage occurred, and was repeated, and on the following day she died.

Perforation of Hard Palate—A. L. MACLEOD, M.B.—The patient, aged 69, has worn a tooth-plate for years. For five years liquids and soft foods get into the right nostril. There is a perforation of the hard palate which the exhibitor suggests is due to pressure atrophy. There is no sign of a neoplasm, but in view of the possibility of malignant trouble, he was to report himself every month.

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