SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF OTOLOGY

May 16, 1919.

President—Mr HUGH E. JONES.

ABRIDGED REPORT.

Ossiculectomy in Chronic Adhesive Process, by Dr P. WATSON-WILLIAMS.—Female, aged 26. Deafness for several years. L.M.T. thickened and retracted (malleus immobile). Rinne negative. Gellé positive, therefore stapedio-vestibular joint not ankylosed. Whisper, right 28 inches, left 20 inches; after catheterisation, right 54 inches, left 36 inches. Sphenoidal sinus found infected and opened. Tonsils enucleated. Crucial myringotomy: lower half of the malleus handle removed (left ear). Whisper after operation, 24 feet. Patient shown 17th November 1916, and opinion expressed by some members that the improvement was in part due to suppuration and would not persist. Now, two and a half years after the operation, the beneficial effect on the hearing remains. The ear has remained dry for over a year. Whisper, right $5\frac{1}{2}$ feet, left 25 feet.

DISCUSSION.

THE PRESIDENT, Dr H. J. BANKS-DAVIS, Dr DUNDAS GRANT, Mr CLAYTON FOX, Mr HUNTER TOD, and Dr KELSON took part.

Circumscribed Labyrinthitis, by Mr J. F. O'MALLEY.—Male, aged 35. Partially deaf since four years of age C.O.M.S. bilateral. Admitted 10th August 1910 for severe vertigo. Vomiting. Nystagmus to left. Temperature normal. He was able to get up in ten days. Examination shows granulation tissue in the posterior attic. Whisper not heard close to ear. On cold caloric test nystagmus induced after two and a half minutes. Fistula symptom not elicited.

DISCUSSION.

Mr C. E. WEST, Mr SYDNEY SCOTT, and the PRESIDENT advised that operative treatment should be limited to the middle ear.

Labyrinthectomy, by Mr J. F. O'MALLEY.—Female, aged 27, complained of severe giddiness. Total loss of right membrane and malleus. No pus present. Hearing almost extinct. At radical

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mastoid operation, fistula in the external canal. Later, double vestibulotomy and opening of cochlea. Patient now able to work again.

DISCUSSION.

Mr LAWSON WHALE, Mr C. E. WEST, and Mr SYDNEY SCOTT took part.

Two Cases of Fracture of the Base followed by Otitis Media, Meningitis, and Death.—Mr J. S. FRASER.

CASE I.—Male, aged 44. Two days before admission, as he was going home under the influence of alcohol, he slipped and fell on the pavement, striking the right side of his head. He was not unconscious after the accident, but there was bleeding from the right ear and also from the mouth. After the accident the patient suffered from severe vertical headache. On admission he felt as if he were rotating from left to right about a vertical axis. The right ear has been quite deaf since the accident. He has felt sick but has not vomited. *Examination*—Watery discharge from right ear. R.M.T. red and bulging. Complete deafness. Weber lateralised to good ear. Spontaneous nystagmus to left (sound side) of second degree. Patient tends to fall to right and shows a pointing error to right. No facial paralysis. Temperature 101° F., rose to 103° F. Kernig's sign absent. *Lumbar puncture*—c.s. fluid, blood-stained but not under pressure. Two days later patient very ill. Severe headache and backache. Temperature 105,° pulse only 72. Kernig's sign present. Slight facial paralysis on right side. Second lumbar puncture: fluid under great tension, polymorphs greatly increased. *Post-mortem*—Blood present over vertex in subdural space and also in the right temporal region. At the base purulent leptomeningitis was present over the pons, medulla, and lower surface of cerebellum. Laceration of left temporo-sphenoidal lobe. The right temporal bone showed a stellate fracture involving both petrous and squamous portions.

Microscopic Examination. — External auditory meatus shows fracture of the anterior wall (Fig. 1). R.M.T. is generally thickened and ruptured below and behind the handle of the malleus. The outer wall of the Eustachian tube is fractured. There is a fracture through the roof and floor of the tympanum. There is hæmorrhage in the outer part of the attic, and in the lower part of the tympanum posteriorly; the exudate is purulent. The stapes shows at least two fractures. The malleus and incus are not involved. The fracture goes through the facial canal above the oval window and passes through the upper margin of the window. There is also a fracture of the region of the round window. One can trace the

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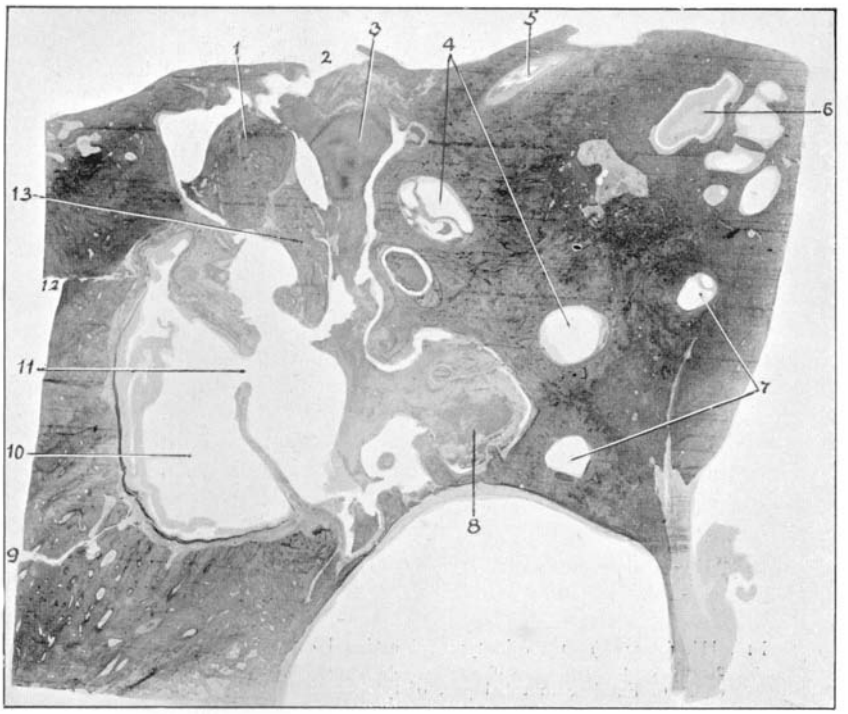


FIG. I. (*Case I.*)—VERTICAL SECTION. (×6 diam.).—1. Malleus. 2. Fracture. 3. Exudate. 4. Lateral canal. 5. Superior canal. 6. Air cell. 7. Posterior canal. 8. Sinus tympani. 9 and 12. Fracture of anterior meatal wall. 10. External meatus. 11. Perforation. 13. Incus.

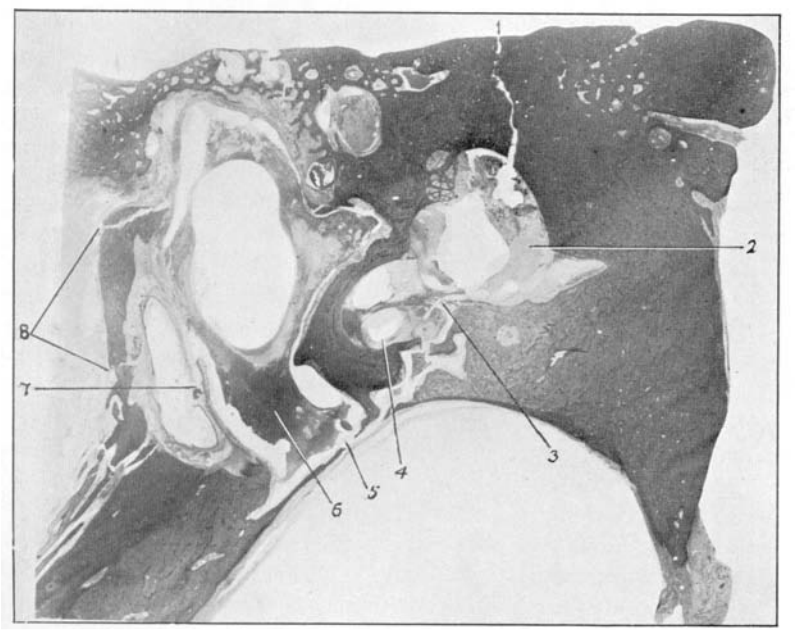


FIG. II. (*Case I.*)—1. Fracture. 2. Exudate in vestibule. 3. Fracture of bony spiral lamina. 4. Scala tympani. 5. Fracture of tympanic floor. 6. Exudate in tympanum. 7. Perforation of drumhead. 8. Fracture of meatal wall.

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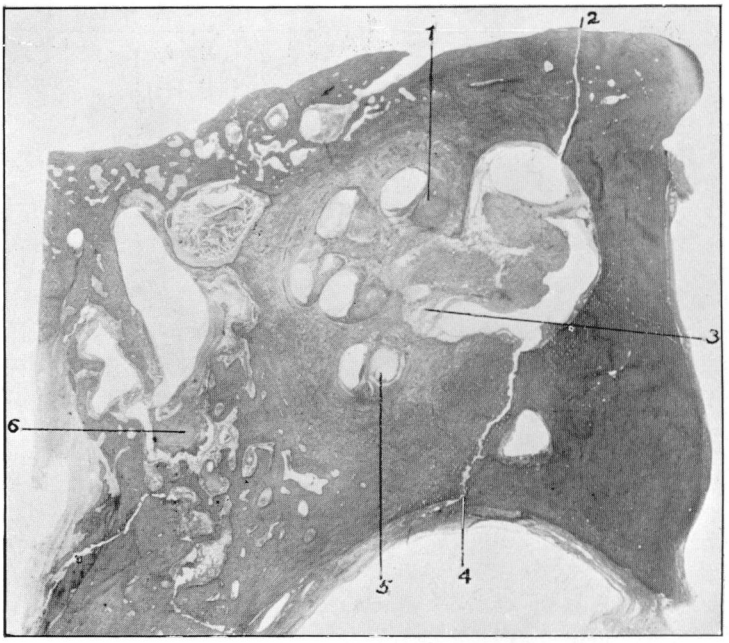


FIG. III. (*Case I.*)—1. Scala tympani of basal coil filled with hæmorrhages. 2. Fracture. 3. Cochlear nerve. 4. Lower end of fractures. 5. Basal coil. 6. Exudate in tubal part of tympanum.

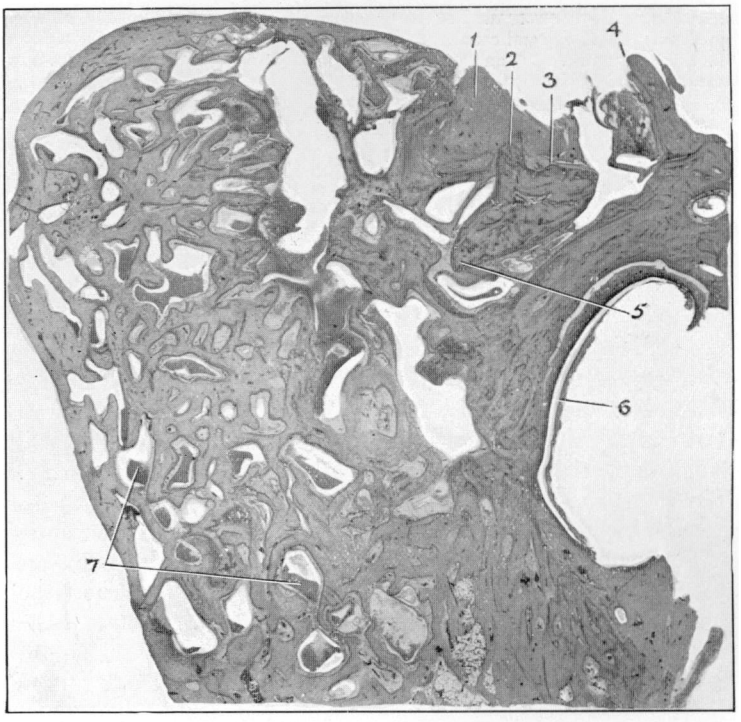


FIG. IV. (*Case II.*)—VERTICAL SECTION. (×6 diam.).—1. Connective tissue in gap left by old fracture. 2. Long process of incus. 3. Articular surface. 4. Edge of fracture. 5. Short process of incus, which has retained its attachment to floor of aditus. 6. External meatus. 7. Air cells with exudate.

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continuity of the exudate in the niche of the round window with that in the scala tympani. *Cochlea*—Only the intra-vestibular portion of the cochlea is fractured. There is hæmorrhage in the spiral ligament. Corti's organ is unrecognisable. All three scalæ contain exudate, but the scala tympani shows much more than the others. *Vestibule*—The fracture runs into the roof of the vestibule and then downwards through the bony spiral lamina and the region of the round window into the tympanic cavity, and finally passes through the roof of the jugular bulb (Fig. 2). The vestibule itself is filled with hæmorrhage. The tip of the promontory is almost chipped off. *Canals*—There is no fracture of the labyrinth capsule in this region, but the lateral canal contains pus and blood. The other canals are more normal. *Internal meatus*—The fracture extends right through from the floor of the middle fossa, through the bony roof and floor of the meatus, to the region of the opening of the aqueduct of the cochlea. Some cellular exudate is present in the fundus of the internal meatus (Fig. 3).

Case II.—Male, aged 6, suffered from fracture of base of skull in August 1913, with bleeding from right ear. He recovered and *remained well for one year*, till 30th August 1914, when, after a severe cold, earache (right) and headache came on. 31st August 1914—Vomiting, unconsciousness, jerkings of right arm, rigidity of neck, Kernig doubtful, temperature 101° F., pulse 110. 1st September 1920—Death. *Post-mortem* (five and a half hours after death)—Flattening of convolutions. Cerebro-spinal fluid increased and turbid: exudate in interpeduncular space. Sphenoid and ethmoid healthy. Left middle ear contained turbid fluid. Old fracture of roof of right mastoid antrum.

Microscopic Examination of Right Ear. — The mastoid cells are full of pus. There is a gap in the roof of the mastoid antrum filled with fibrous tissue (Fig. 4), and there is a piece of bone lying loose in the midst of this fibrous tissue, with pus around it. The piece of bone proves to be the incus, which had become dislocated backwards into the mastoid antrum. From the appearance of the well-formed fibrous tissue surrounding the incus it is evident that this is an old dislocation. What appears to have happened is that the incus became dislocated backwards at the time of the fracture in 1913, retaining its attachment to the floor of the aditus, and at the same time there was a fracture of the roof of the antrum. The patient recovered at the time as no infection occurred, but one year later when he developed an acute suppurative otitis media the infection passed by way of the tympanic cavity, the aditus and antrum, through the old gap to the intracranial structures, and the result was purulent leptomeningitis and death. The lining

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membrane of the Eustachian tube is very vascular and swollen, and the submucosa is infiltrated with pus cells. The tympanic cavity is full of pus. The footplate of the stapes is quite normal. The long process of the incus has been broken. The head of the malleus is ankylosed to the new bone which has been formed in the roof of the middle ear (Fig. 5). *Cochlea*—There are many white cells in the scala tympani in the basal coil, but the pus does not extend as far as the helicotrema. There is some infiltration of pus cells from the internal meatus into the spiral ganglion of the basal coil. Corti's organ is normal. The vestibule and canals are healthy. *Internal meatus*—There are many pus cells in the internal meatus within the arachnoid sheath.

Otosclerosis Associated with Otitis Media, by Mr J. S. FRASER.—Male, aged 27, had chronic middle ear suppuration on the left side for ten years. Ten days before admission the wound ceased to discharge, and three days later the patient began to have occipital and frontal headache. For one week there has been facial paralysis on left side. Four days before admission vomiting commenced and has continued. Of late, the patient has complained of giddiness on getting out of bed, and has tended to fall to the left side. *Examination—The right drumhead shows a large retracted scar.* The left external meatus contains fœtid pus and granulations. *Cochlear apparatus*—Schwabach lengthened; Weber lateralised to right (better) ear; Rinne absolutely negative on left side. On the right side Rinne is *said to be positive.* (This test was not carried out by Dr Turner or the writer.) With the noise apparatus in the right ear patient is quite deaf. *Vestibular apparatus*—Patient falls to the left, and the direction of the fall is not altered by changing the position of the head. Slight spontaneous nystagmus to the right, and slow, coarse rotatory nystagmus to the left; pointing error to right in both upper extremities. Cold syringing of left ear produced no change in the spontaneous nystagmus in one and a half minutes. *General condition*—Temperature 98·4° F., pulse 88. Patient lies curled up on the left (diseased) side. Patient is bright mentally. "Finger nose" test more accurately performed on right side than on left side. Dysdiadokokinesia well marked on left side. Grasp of both hands good.

Operation.—Track of pus extending from the mastoid surface to the antrum, which was full of cholesteatoma. Fistula from antrum through posterior wall of meatus. Sinus wall normal. Fistula present in lateral canal. Facial nerve lying uncovered by bone above oval window. Roof of tympanum and antrum healthy. Dense, healthy bone present in triangular area. Posterior canal opened up (Neumann's operation); promontory also removed. Cerebellum

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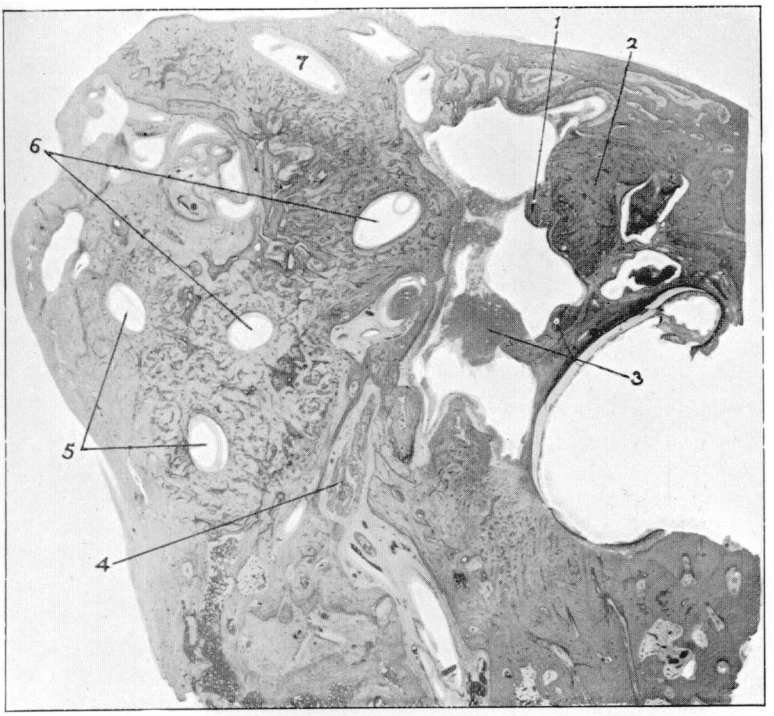


FIG. V. (*Case II.*)—1. Position which should be occupied by body of incus. 2. Malleus. 3. Exudate in tympanum. 4. Stapedius. 5. Posterior canal. 6. Lateral canal. 7. Superior canal.

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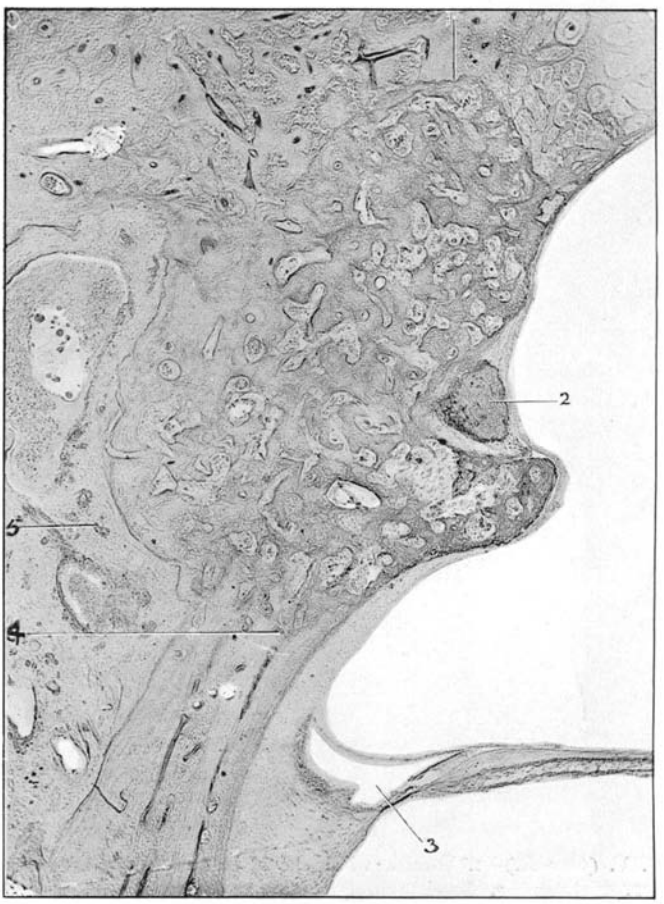


FIG. VI.—OTOSCLEROSIS ASSOCIATED WITH OTITIS MEDIA. VERTICAL SECTION OF RIGHT EAR. (×35 diam.).

1. Upper edge of otosclerotic area. 2. Footplate of stapes not ankylosed. 3. Intravestibular part of cochlea. 4. Lower margin of diseased area. 5. Thickened periosteum.

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explored with negative result. *Progress*—Vomiting, restlessness, Kernig's sign, meningitic cry. Lumbar puncture fluid showed excess of albumen and many polymorphs. Cerebellum again explored with negative result. Death three days after operation. *Post-mortem*—Basal meningitis. Cerebellar abscess, the size of a walnut, in anterior part of the left lobe further forward than the exploratory opening (although this had been made in front of the sigmoid sinus). The abscess abuts closely on the fourth ventricle, but no communication is visible. The ventricles of the brain contain slightly turbid fluid.

Microscopical Examination of Right Ear (chronic adhesive process and otosclerosis).—There is a large retracted scar in the drumhead adherent to the promontory. Practically no tympanic cavity remains. The attic is filled with delicate, connective tissue. The aditus is obliterated by new connective tissue. The stapes is present, embedded in granulation tissue but is not ankylosed. An area of otosclerosis (osteitis vasculosa) is seen just above the basal coil of the cochlea in the anterior margin of the oval window (Fig. 6). Some giant cells are present in the large vascular spaces of the new bone formation. The focus of spongy bone reaches the endosteum of the vestibule just above the intravestibular part of the cochlea, and new vascular bone bulges into the vestibule (endostosis).

This specimen shows that Lucae was right when he said that it was impossible to distinguish between a chronic adhesive process and otosclerosis, *i.e.*, that the one condition ran into the other.

Microscopical Examination of Left Ear.—Allowing for the fact that double vestibulotomy had been performed on this side, the left ear showed the same changes as those present on the right side (Fig. 7).

Otosclerosis associated with Fragilitas Ossium and Blue Sclerotics, by Mr J. S. FRASER.—Dr Edith Bronson has published an article dealing with the Currie family (*Ed. Med. Journ.*, April 1917). The grandfather, William Currie, was deaf, had had many fractures and his sclerotics were deep blue. He had six children, all girls. Three of these suffer from the same conditions (one examined, Case I.). One other has fragilitas ossium and blue sclerotics, but is not deaf, while the two remaining daughters are normal. The third generation consists of twenty-four children. Two examined (Cases II. and III.), both of whom were daughters of the eldest child of William Currie. Four others show blue sclerotics and fragilitas ossium, though only one is deaf (Fig. 8, Chart I.)

CASE I.—Female, aged 49, has had over forty fractures and has blue sclerotics. Deafness started eight years ago. Tinnitus present. She hears better in a noise. Redness of promontory seen through

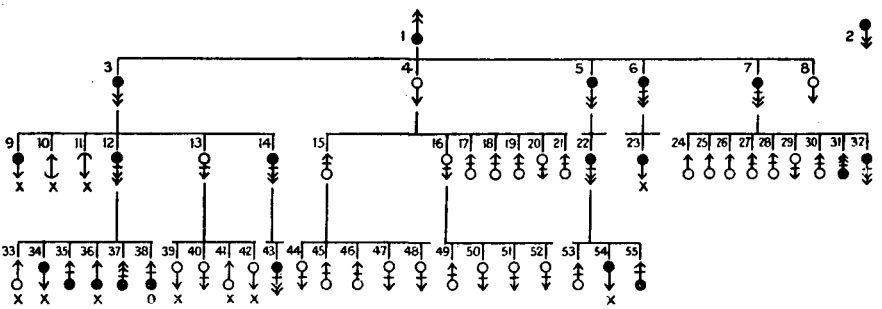
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drumheads. Functional examination shows Bezold's symptom triad and also some nerve deafness. Cases II. and III. similar. Dizziness present in Case III.

All these conditions have been attributed to hereditary inferiority of the mesenchyme, from which the skeleton, including the labyrinth capsule and the sclerotics are formed. The association of otosclerosis with defects of the mesenchymatous structures appears to be of great importance. Just as the fragile bone requires the application of some force before it breaks, so the defective labyrinth capsule

FIG. VIII.

CHART 1.-THE CURRIE FAMILY.



x = Died in early infancy. 0 = Died while family was under observation.

= History of blue sclerotics. = History of fractures and blue sclerotics.

– Cross line indicates case was examined by the writer.

- Colour of sclerotics or presence of fractures not known.

55 individuals in this family. 35 of these examined by the writer. 21 of the 55 have blue sclerotics. Of these 21, 13 had fractures, 6 died in infancy without fractures, 1 is at present an infant, and 1 is a healthy boy of six years with no fractures.

Deafness present in Cases 1, 3, 6, 7, 12, 14, and 22. Only Cases 6, 12, and 14 were examined.

(*By kind permission of the "Edinburgh Medical Journal."*)

requires some infective agent before otosclerosis develops. There is much too great a tendency to attribute otosclerosis to one single cause alone, *e.g.*, heredity, disorders of the endocrine gland system, toxin absorption, otitis media, or to a weakening of nerve influence. It seems quite likely that several or all of these causes may be combined. No one can deny that heredity plays an extremely important rôle. But, on the other hand, there are undoubtedly many cases in which no family history of deafness can be obtained. Our knowledge of the endocrine glands is at present too vague for us to be able to dogmatise on these subjects. Gray holds that toxæmia plays an important part in the production of otosclerosis. Loss of

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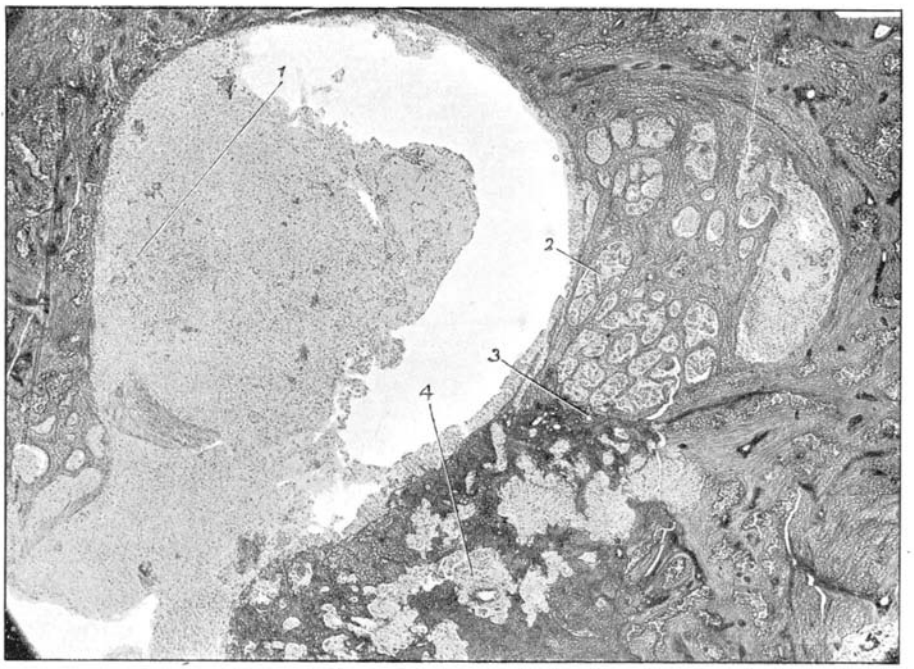


FIG. VII.—OTOSCLEROSIS AND OTITIS MEDIA. VERTICAL SECTION OF LEFT EAR. (× 35 diam.)

1. Purulent exudate in vestibule. 2. Vestibular nerve. 3. Upper end of otosclerotic area. 4. Acute inflammatory infiltration in vascular space.

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nerve influence has been put forward by some as a most important factor in the production of the disease. The female sex is specially affected by such conditions as osteomalacia, fragilitas ossium, and otosclerosis. Pregnancy and the puerperium have a very prejudicial effect on the last of these conditions. The question of the importance of otitis media is much disputed. I hold that an attack of otitis media may be compared to "the match which fires the magazine." The hereditary tendency corresponds to "the powder." The female sex may also come under the heading of "inflammatory material." The loss of nerve influence and disorders of the ductless glands, which preside over the processes of bone formation and repair, may be compared to "a want of water with which to extinguish the flames."

DISCUSSION.

Dr ALBERT GRAY and Mr SYDNEY SCOTT took part.

SECTION OF LARYNGOLOGY

April 4, 1919.

President, Dr JAMES DONELAN.

Radiograms showing Absence of the Right Frontal Sinus, by Dr A. J. HUTCHISON.—The interesting clinical point in this case was the severe pain complained of by the patient in the right frontal region. After removal of polypi and the middle turbinal from the left side of the nose, the pain on the right side disappeared.

Pituitary Tumour removed by the Nasal Route, by Mr H. LAWSON WHALE.—The left nasal cavity was opened through an external incision, the left sphenoidal sinus was opened freely and the tumour, an endothelioma, was curetted. There was very little bleeding and pressure symptoms were relieved.

Patient after removal of Epithelioma of the Left Tonsil by Diathermy, by Mr FRANK ROSE.—Male, aged 67. Two years and nine months had elapsed since the operation and no recurrence was visible, but an ulcer on the right tonsil and a hard gland on the right side of the neck were detected.

Dr Douglas Harmer pointed out that there was not the same rapid recurrence after removal by diathermy as by the knife.

Removal by the Indirect Method of a Jagged Piece of Bone impacted in the Œsophagus, by Dr W. JOBSON HORNE.—The specimen was shown in order to call attention to the growing tendency to substitute the direct methods of operating for the older indirect procedure. There were cases such as this in which the foreign

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body could be easily removed without subjecting the patient to the discomfort and even risk of suspension laryngoscopy and endoscopy.

Case of Naso-pharyngeal Angeio-Fibroma in a boy aged 13½, by Dr G. W. DAWSON.—After preliminary laryngotomy the tumour was removed partly by way of the mouth and partly by the nose. It had recurred. In the discussion reference was made to the value of radium as a method of treatment and to the use of Crile's carotid clamps during the operation of removal.

Four Cases of Atrophic Rhinitis with Ozæna, undergoing treatment by the glycophilic method were shown by Dr C. H. Hayton (see *Journ. Laryngology*, Sept. 1919, p. 365). In all, fœtor had disappeared and crusting had diminished.

SECTIONS OF OPHTHALMOLOGY AND LARYNGOLOGY

April 2, 1919.

President—Mr W. T. HOLMES SPICER.

Discussion on Injuries and Inflammatory Diseases affecting the Orbit and Accessory Sinuses.

After some introductory remarks by the President, Mr L. V. CARGILL, F.R.C.S., opened the discussion. After referring to the anatomical relations which existed between the accessory sinuses and the orbit, he pointed out that ophthalmic complications of sinus inflammation might present themselves as functional disturbances, toxic effects, or orbital inflammations the result of direct extension. Ocular complications were numerous: contraction of visual field, central scotoma, enlargement of the blind spot, retrobulbar neuritis, papillœdema and papillitis; more rarely, uveitis and episcleritis, subretinal effusion, retinal hæmorrhage and detachment. The orbital complications consisted in subperiosteal inflammation and abscess, usually with necrosis and perforation of the bony walls, and to a lesser extent, retrobulbar inflammation due to trauma, metastasis, or septicæmia.

Orbital inflammations at the Royal Eye Hospital constituted .5 per cent. of the total admissions, and the age of the patients varied from 11 months to 68 years: the males were as three to two of the females. The ethmoidal cells were the most frequent cause, then the frontal and maxillary sinuses.

Treatment should be by free incision and separation of the periosteum and the establishment of good drainage from the affected sinus.

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He dealt next, at some length, with the subject of injuries to the orbits and accessory sinuses, illustrating his remarks by experience gained during the war.

Mr G. Seccombe Hett dealt with war injuries, insisting upon the principle of free drainage together with the retention of any loose skin flap or portions of conjunctival mucous membrane and the removal of foreign bodies, sequestra, damaged turbinals, and septum. Subsequent plastic operations and the grafting of cartilage helped to restore the face.

Mr Arthur W. Ormond's remarks dealt mainly with the war injuries affecting the sinuses.

Mr E. D. D. Davis summarised twenty-two cases sent to him by ophthalmic surgeons for nasal examination. In all of them there was loss of sight as a result of retro-bulbar or optic neuritis. Three were due to suppuration of the ethmoid and sphenoid of long duration: in fourteen the nose was absolutely normal and the cause was not determined, while four were syphilitic and one of doubtful origin. The charts of the field of vision, though insufficient in number to be conclusive, suggested that the outer fibres of the optic nerve were affected in cases of nasal origin, and that all the fibres of the nerve were involved in idiopathic retro-bulbar neuritis cases.

Mr H. D. Gillies was of the opinion that in war injuries of the sinuses, the external route for drainage was to be preferred.

Mr D. Leighton Davies referred specially to the possibility of a latent chronic sinus infection when there was irido-cyclitis and choroiditis. Disturbances in vision were rarely very severe in sinus affections. Disturbances of accommodation in young adults, when there was no error of refraction, demanded a careful examination of the sinuses.

Mr W. M. Mollison pointed out that cases of orbital cellulitis almost invariably were due to sinus suppuration, but there were exceptions.

Mr J. F. O'Malley dealt with war injuries of the sinuses and lachrymal apparatus.

Mr G. H. Pooley (Sheffield), referring to defective vision due to nasal conditions, considered it to be caused either by pressure on the optic nerve or to toxic influences on the retinal cells. When a toxin had been the cause, he had seen marked improvement after an operation on the nose.

Mr E. H. E. Stack (Bristol) spoke upon the treatment of injuries.

Mr W. Stuart-Low referred to the relief obtained in acute inflammatory conditions of the frontal sinus associated with œdema of

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the upper eyelid, by packing round the swollen middle turbinal with cocaine and adrenalin. On removal of the plugs there was escape of pus and relief. The suction method of evacuating the sinus was also useful.

Mr HERBERT TILLEY emphasised the necessity of keeping in mind the fact that orbital cellulitis may arise in children secondary to sinus suppuration. Well-developed ethmoidal and sphenoidal sinuses may be present at the age of three years.

Mr H. LAWSON WHALE quoted some cases of injury.

SECTION OF LARYNGOLOGY

Summer Congress, May 2-3, 1919.

The President, Dr JAMES DONELAN, read a paper on **Some Suggested Alternatives to Operation for Adenoids and Enlarged Tonsils in Young Children** (*Journal of Laryngology*, July 1919, p. 229).

Dr WATSON WILLIAMS remarked that many of those cases suffer from infection of the nasal sinuses.

Sir WILLIAM MILLIGAN had made careful trial of thyroid extract, without effect. He deplored the fact that removal of adenoids was so often regarded as a simple operation.

Other members spoke, and were agreed that too much time should not be wasted in breathing exercises and paints. The snuff treatment must be condemned. Dental sepsis should receive attention.

Dr WATSON WILLIAMS contributed a paper on **Latent Sinusitis in Relation to Systemic Infections** (*Journal of Laryngology*, July 1919, p. 233).

Mr O'MALLEY quoted a case of rheumatoid arthritis, in which the pain disappeared after ethmoidal suppuration had been treated.

Colonel SHARP had a similar case cured by drainage of the sphenoidal sinus.

Dr BATTY SHAW stated that rheumatoid arthritis was an infective disease, and one must examine carefully for every possible source of infection.

A paper on **A Method of treating Atrophic Rhinitis, with Ozœna** (*Journal of Laryngology*, Sept. 1919, p. 365) was read by Drs T. H. C. BENAIRS and C. H. HAYTON.

Mr H. A. WORTHINGTON said that further investigation of the normal bacterial flora of the nose seemed desirable.

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Dr WILLIAM HILL had explored the nasal sinuses in some cases of ozœna, but never found infection or crusting. The immunity of the sinuses from disease which affected the contiguous nasal cavities was remarkable.

Mr TILLEY supposed that the infection of the mucous membrane in ozœna was a superficial one. The most satisfactory treatment is packing the nose several times a week with a strip of gauze soaked in glycerine.

Sir WILLIAM MILLIGAN had used glycerine treatment for years, but had not been able to explain why it was effective. The paper just read offered the explanation.

Dr SYME made a practice of operating upon the antrum in early cases of atrophic rhinitis, as the disease was, at its commencement, hypertrophic.

Dr WATSON WILLIAMS said that the terms Ozœna and Atrophic Rhinitis were not interchangeable.

Papers were also read by Dr A. BROWN KELLY on **Spasm at the Entrance to the Œsophagus** (*Journal of Laryngology*, Aug. 1919, p. 285) and by Dr D. R. PATERSON on **A Clinical Type of Dysphagia** (*Journal of Laryngology*, Aug. 1919, p. 289).

Dr DE HAVILLAND HALL referred to two men who were addicted to morphia and who, on giving up the drug, suffered from dysphagia.

Sir WILLIAM MILLIGAN said that in all middle-aged people who suffer from dysphagia a direct examination of the œsophagus should be made. The symptom may be a passing phase or it may be the commencement of organic disease. How many of those cases of spasmodic dysphagia eventually develop malignancy?

Dr WILLIAM HILL would not admit the possibility of primary spasm of the lower pharynx, but thought that there was a condition, not of spasm, but of paresis in those cases of functional dysphagia. The patient made no effort to swallow and the forward and upward movement of the larynx did not take place. We should separate those cases of slight narrowing due to inflammatory and other organic causes from the smaller group which are of functional origin and are paretic rather than spasmodic neuroses.

Mr R. A. WORTHINGTON made it a rule never to pass a bougie until an endoscopic examination had been carried out.

Dr DAN MACKENZIE, in a short paper, described **An Operation for the Complete Removal of the Soft Palate** by means of the diathermy knife and cold wire snare.

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Societies' Proceedings

A paper on **Gunshot Wounds of the Nasal Accessory Sinuses** (*Journal of Laryngology*, Sept. 1917, p. 333) was read by Mr J. F. O'Malley.

Mr Howarth said that free drainage was important in such cases, and the frontal sinus was the most difficult to treat.

Dr Paterson mentioned the question of hæmorrhage, and described a case of gunshot wound of upper jaw in which ligature of the external carotid was required.

Mr O'Malley (in reply) was opposed to irrigation of the antra in gunshot wounds, as the natural protective mechanism was thereby destroyed.

Dr Irwin Moore read a paper on **The Treatment of Enlarged or Diseased Tonsils in Cases where Surgical Procedures were contra-indicated** (*Journal of Laryngology*, Oct. 1919, p. 387).

Dr Donelan preferred the electrocautery to caustic paste.

Dr Dundas Grant was of opinion that the ideal operation was to remove all the interior of the tonsil by punch forceps, leaving the capsule intact.

Dr Wm. Hill regarded partial tonsillectomy as sufficient in singers.

Mr Rose had no experience of caustic paste but had found the electrocautery unsatisfactory.

Dr Kelson thought that the subject of tonsil enucleation required revision.

Dr Moore (replying) said that he had treated fifty cases with caustic paste, and, in all, results were satisfactory.

Notes of Two Cases of Pharyngeal Diverticula were communicated by Dr W. H. Kelson (*Journal of Laryngology*, Nov. 1919, p. 444).

In one case the pouch was removed under local anæsthesia.

Sphenoidal Sinus Empyema and Cerebro-spinal Meningitis was the title of a paper by Drs D. Embleton and E. A. Peters (*Journal of Laryngology*, Jan. 1920, p. 11).

Dr Watson Williams urged the importance of routine examination of the sphenoidal and other sinuses, with culture investigations, in all cases of cerebro-spinal meningitis.

Sir St Clair Thomson did not regard the exploration of the sphenoidal sinuses as an easy procedure.

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Royal Society of Medicine

Mr WALTER HOWARTH read a paper on **Sellar Decompression for Pituitary Tumours** (*Journal of Laryngology*, Feb. 1920, p. 49). In reply to questions Mr Howarth stated that in no case had there been severe hæmorrhage. The operation was not for the removal of large growths but was intended to relieve pressure.

Dr W. S. SYME contributed a paper on **A Series of Cases of Maxillary Antral Disease.**

The following demonstrations were also given during the course of the Congress:—

Microscopic Specimens, by Dr WYATT WINGRAVE.

Casts and Models illustrating Rhinoplasty, by Mr H. D. GILLIES and Mr G. SECCOMBE HETT.

Application of Radium in Malignant Disease of Œsophagus, by Dr WM. HILL.

Treatment of Ozœna by Ionic Medication, by Mr A. J. HUTCHISON.

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