SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

SUMMER MEETING.

June 2nd and 3rd, 1921.

President—Dr W. JOBSON HORNE.

Is the Mere Enlargement of a Tonsil Good and Sufficient Reason for its Enucleation?—Mr T. MARK HOVELL (*Journal of Laryngology*, p. 457, October 1921).

DISCUSSION.

Mr WM. ROSE advocated complete enucleation. He had records of 12 cases in which a remnant of tonsil had been a constant source of trouble. Tonsillotomy was sometimes the starting-point of attacks of tonsillitis. He agreed with Mr Hovell as to the scarring which might follow enucleation.

Mr FAULDER thought that with mere enlargement without symptoms, removal of the enlarged portion sufficed. In some singers the voice was impaired even after partial removal. He did not know how scarring after tonsillectomy could be avoided. If septic tonsils were left *in situ* they were deleterious.

Sir WM. MILLIGAN considered that an enlarged tonsil was a diseased tonsil. Septic tonsils required enucleation, otherwise the crypts remained, became further infected, and caused trouble. Partial removal often necessitated the performance of a second operation. In cases of hypertrophied tonsils, the nose, mouth, and teeth required attention before operation was undertaken. In many cases dental treatment obviated tonsil operation. An enlarged tonsil might be tuberculous and partial removal would be dangerous. He had not found associated enlargement of the lower turbinals. Like Mr Hovell, he deprecated rapid operations. Haste probably accounted for much of the scarring after operation. In the treatment of hæmorrhage, he did not advocate mere suture of the pillars. The procedure caused cicatricial contraction. Though not often called for, he passed a suture under the bed of the tonsil into the superior constrictor and through the pillars, tying all the tissues together. Cicatricial contraction did not follow.

Dr WRIGHT said that where there had been recurrent attacks of peri-tonsillar inflammation, tonsillectomy was the only effective

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operation. In large movable tonsils enucleation was as easily performed as tonsillotomy.

Mr W. STUART-LOW disagreed with Mr Hovell's views. An enlarged tonsil was diseased and should be removed. Many bad results followed their neglect. He had seen very few cases in which the voice was worse after operation.

Mr DIGGLE found it difficult to distinguish between tonsils which were merely hypertrophied and those which were diseased. In 75 cases examined microscopically and by guinea-pig inoculation, only 5 had been definitely tuberculous. They could not be recognised clinically as such, therefore enucleation was the correct operation.

Mr J. F. O'MALLEY advocated enucleation when operation was decided upon. During the tonsillotomy period hæmorrhage was more frequent and serious than after tonsillectomy. Scarring and contraction were more common in cases of recurrent quinsies and tonsillitis, independently of lesions produced at the operation.

Professor BURGER (Amsterdam) recommended tonsillotomy in children without a general anæsthetic, and tonsillectomy in adults.

Dr DOUGLAS GUTHRIE said that buried tonsils, if unhealthy, should be enucleated. The entirely projecting tonsil seen in some children could be easily removed completely by any method, snare or guillotine.

Mr HERBERT TILLEY had not used a guillotine for five years. He dissected all his tonsil cases whether the organs were diseased or enlarged: 20 per cent. of adults coming to him with chronic septic tonsils had had tonsillotomy done as children. He would like a definition of the border-line between hypertrophy and disease.

Mr HORGAN regarded scarring after tonsillectomy as the result of over-instrumentation. He corroborated Mr Hovell's remark as to the enlargement of the lower turbinals. He was surprised that no reference had been made to the valuable work of Mitchell of Edinburgh on tubercle of the tonsil.

Dr SYME said there was room for better diagnosis of tonsillar conditions. Some tonsils returned to the normal size when left alone. A nasal condition may be responsible for a septic tonsil.

The PRESIDENT understood from the discussion that the surgeon should either perform tonsillectomy or leave the case alone. He considered that size was not an indication for interference. Small, innocent-looking tonsils were often septic; if their removal was not thorough, quinsy might follow. He insisted that removal should not be made a routine matter.

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Mr HOVELL (in reply) said that with septic crypts tonsillectomy was the operation, but he protested against all enlargements being treated in this way. All enlarged tonsils were not diseased, and in many cases the removal of adenoids and of the projecting part of the tonsil was sufficient treatment. He believed that Sir Wm. Milligan's experience as to the rarity of scarring was not the general experience, nor could he agree with Mr O'Malley's statement as to hæmorrhage.

Operations on the Frontal Sinus—Mr WALTER HOWARTH (*Journal of Laryngology*, p. 417, September 1921).

Mr HERBERT TILLEY had not performed the Killian operation for six or seven years. He agreed with Mr Howarth that the cause of failure in many frontal sinus operations was due to outlying suppurating orbito-ethmoidal cells being overlooked. If these were more generally recognised, surgeons would have more successes. Could all the anatomical difficulties be overcome by operating from the orbital roof? He wished to know if Mr Howarth divided the supra-orbital nerve in his operation. Patients suffered for a long period as a result of its division.

Sir ST CLAIR THOMSON had not operated externally since before the war; he had adopted the intra-nasal method. When doubt and trouble arose over the ethmoidal cells, then he had been dissatisfied with intra-nasal methods. The problem of the orbito-ethmoidal cells seemed at present insoluble. Statistics were fallacious. In Killian's first eighty-six cases there were no deaths, but before he had operated upon one hundred, three deaths occurred.

Dr W. S. SYME said that ethmoidal cell suppuration, in association with frontal sinus disease, could not be dealt with save by external operation. In the main, he did the intra-nasal frontal operation, but when a case demanded more, he performed the Killian operation. All dead spaces must be opened up if cure was to be expected.

Mr O'MALLEY thought that the majority of cases of frontal sinus disease were due to backward pressure sepsis from the ethmoidal cells. The results obtained in the more recent traumatic cases were better than those in the old standing chronic inflammatory sinuses, and his own experience of Mr Howarth's method when dealing with the former type of case was satisfactory.

Mr KISCH considered that the removal of the ethmoidal cells was the essential point in dealing with the frontal sinus, and that the so-called intra-nasal operation was really an ethmoidal operation.

Mr T. B. LAYTON thought that the most important point emphasised by Mr Howarth was the statement that the mucous membrane should be disturbed as little as possible, and possibly the success which that

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operator had obtained was due to his treatment of the lining mucosa of the sinus.

Sir WM. MILLIGAN considered that the acute or subacute cases and the chronic cases should be looked at from two entirely different points of view. In the former there was good reason for an intra-nasal operation, but in the latter such a procedure was unlikely to effect a cure owing to the disorganised state of the mucosa. He advocated the Killian operation in certain circumstances, but he removed the bridge because, if left, there was more probability of unhealthy granulation tissue forming, necessitating another operation. Preservation of the mucous membrane was desirable if there was not much disorganisation. The whole problem resolved itself into thoroughly exposing the entire septic tract and to providing proper drainage.

Sir J. DUNDAS-GRANT considered the intra-nasal operation the best in the cases where it was called for. Mr Howarth had pointed out the success of his non-disfiguring operation, which was a simpler one than the Killian.

Dr NEIL MACLAY wished to sound a note of warning in regard to the intra-nasal operation. He had had two cases of diffuse osteomyelitis following it. He was now cautious in the use of the method, and he welcomed Mr Howarth's fresh proposals for an external operation.

Mr HOWARTH (in reply) said that by his method he could remove practically the whole of the sinus, displacing the eyeball very considerably in order to do so. He did not consider the operation applicable to every case, but he obtained a pretty good view. He admitted that the galleries in the temporal region involved difficulty. He left the mucosa because it was not so disorganised as it appeared to be. He formed the impression when working in Killian's clinic, that the latter's operation was not a satisfactory one. He believed that the operation now described did expose the whole of the septic tract.

The Usual Site of Origin of Intrinsic Cancer of the Larynx as demonstrated at fifty Laryngo-Fissures—Sir ST CLAIR THOMSON (*Journal of Laryngology*, p. 462, October 1921).

Mr HORGAN, from an experience of four cases of laryngo-fissure, corroborated Sir St Clair Thomson's remarks. In one case, when the growth was situated on the anterior two-thirds of the vocal cord and extended into the subglottic region, he had found operation troublesome, and he had failed to remove the tumour completely.

Sir J. DUNDAS-GRANT commented on the tendency to subglottic extension when the disease was close to the anterior commissure. He

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was impressed, when recently reading a French authority, by the statement that a growth at the anterior commissure was an indication for laryngectomy.

Prof. BURGER (Amsterdam) had always thought that the posterior part of the cord was the area chiefly affected. Was impaired mobility or fixation a contra-indication to laryngo-fissure?

The PRESIDENT said it was important that the laryngologist should make a careful study of the normal histology of the larynx. He should know exactly where squamous epithelium ended and columnar commenced; then one could draw valuable conclusions. One knew where epithelioma would occur, and one could state that if in a certain part of the larynx, then prognosis was favourable.

Sir ST CLAIR THOMSON (in reply) said that there were degrees in malignancy of which, at present, we knew little. He had published all his cases, and had had two deaths. Laryngo-fissure was safe if proper precautions were taken. Otherwise death occurred from hæmorrhage or pneumonia. Impaired mobility or fixation of the cord was not necessarily a contra-indication to laryngo-fissure. Some cases with fixation had survived for many years after operation.

Diathermy in Inoperable Pharyngeal and Epilaryngeal Malignancy—Sir WM. MILLIGAN (*Journal of Laryngology*, p. 369, August 1921).

Mr MUSGRAVE WOODMAN had experienced trouble with hæmorrhage, and advised preliminary ligation of the neighbouring large vessel or vessels so as to avoid it. He had found it easier to deal with columnar-celled and spheroidal-celled carcinomata than with squamous-celled growths. The latter formed a tough resistant residue. It was difficult to know the exact point at which to stop when one was coagulating tissues.

Mr WRIGHT asked for information as to the treatment of the skin incisions when dealing with secondary deposits; was immediate suture recommended? Had Sir Wm. Milligan seen necrosis of the laryngeal cartilages?

Dr DIGGLE wished to know if adhesion of the growth to bone was to be regarded as a contra-indication to diathermy.

Sir ST CLAIR THOMSON had found that tumours of the palate and pharyngeal wall were more favourable cases; in disease of the base of the tongue and epiglottis the procedure was either dangerous or difficult.

Mr RIDOUT had treated and greatly relieved an epithelioma of the right upper maxilla in a patient with high blood pressure; also a case

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of epithelioma of the epiglottis and laryngeal pharynx after preliminary tracheotomy, and there was steady improvement.

Mr WORTHINGTON thought that diathermy should not be reserved for cases deemed inoperable by ordinary surgery, but that it should be regarded as preferable to the knife. He had treated a case in which a surgeon wished to remove the tongue: the patient was unwilling to lose his tongue. He (the speaker), after ligating the internal carotid and removing the glands, was able to complete the treatment by removing the tumour only by diathermy.

Mr WALTER HOWARTH had had considerable experience of diathermy, and he suggested "diathermy cauterisation" as a better term. In operations on the tongue or floor of the mouth, when extensive bleeding might be expected, he preferred ligation of the lingual as well as of the external carotid artery.

Mr NORMAN PATTERSON illustrated upon the epidiascope the results obtained in several cases of malignant disease of the throat treated by this method. He agreed with Mr Worthington that diathermy should not be confined to so-called inoperable cases: all cases of malignant disease in the mouth and larynx could be treated better by diathermy than by cutting methods. He was adverse to operation in stages, and preferred to ligate vessels, remove glands and the primary tumour at one sitting. Diathermy was much more than a palliative operation.

Sir WM. MILLIGAN (in reply) suggested the term "Endothermy." He thought there was a great field for the method in cases adjudged as operable in the ordinary manner. He had not had an equal success with tumours in the laryngeal pharynx. He could give no indication as to the point at which to terminate the operation: the effect of diathermy extended into the contiguous tissues. In laryngeal cases there was a danger of necrosis of cartilage. His best results were on the palate and fauces. Unlike Mr Patterson, he preferred to operate in stages. As to cure, he asked the question, when was a case of cancer cured? At any rate, patients were enabled to live comfortably, often for years.

Paralysis of the Vocal Cords Secondary to Malignant Tumour of the Mamma—A. LOGAN TURNER, M.D. (*Journal of Laryngology*, p. 373, August 1921).

Sir WM. MILLIGAN thought that paralysis due to this cause must be rare. He had only seen two cases—one homolateral, one contralateral. The paralysis in the latter occurred four and a half years after removal of the breast. He believed that there had been no enlargement of the supraclavicular glands.

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Mr WALTER HOWARTH had recently seen a case with right vocal cord paralysis and a mass of glands above the inner end of the right clavicle. The right breast had been removed for scirrhus.

Sir J. DUNDAS-GRANT did not think that every case of vocal cord paralysis following mammary cancer was necessarily dependent on that cancer. In one of two cases of alcoholic neuritis causing recurrent paralysis, one breast had been removed for carcinoma. Under suitable treatment the woman recovered her voice.

Mr PYKE referred to the case of a man who developed right recurrent paralysis after removal of the rectum for malignant disease. No explanation of this had been forthcoming.

Dr A. LOGAN TURNER (in reply) said that in the large general hospitals the question of subsequent paralysis after breast operations should be investigated and probably more cases would be recorded.

Observations on the Results of over 2000 Cases of Vocal Cord Paralysis in Horses treated by the Stripping of Morgagni's Ventricle—Professor F. HOBDAY (*Journal of Laryngology*, p. 422, September 1921).

Mr HERBERT TILLEY pointed out that the occasion for the ventricle stripping operation in man arose in cases of bilateral abductor paralysis, and not in the ordinary case of unilateral paralysis. In the former there was bilateral adduction, probably due to fixation of the crico-arytenoid joints. It meant, further, that the human subject had a grave intra-thoracic or a central lesion, which must be taken into account. In a small residue of cases of fixation he might consider Mr Hobday's operation.

Mr MICHAEL VLASTO had made dissections of the larynx in man and the horse. In man he had found the ventricle fixed down by the thyro-arytenoideus and the structures forming the false cord: the entrance to it was very small. He doubted whether the operation, if feasible, would be successful. In the horse moderately large raw surfaces became opposed to each other; in man, one could raw the surface of the ventricle but could only oppose it to a raw point on the true vocal cord.

Mr WORTHINGTON asked for the percentage of successes in Mr Hobday's last 500 cases. He suggested experiments on animals whose larynges more nearly approximated to the human type.

Mr J. F. O'MALLEY did not think that the effect of the operation on the voice was a contra-indication, because if Mr Hobday merely stripped the lining membrane of the ventricle, the approximation of the cords in phonation was not particularly interfered with.

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The PRESIDENT expressed his interest in the pathogenesis of the condition in horses. He had examined the larynges of these animals thus affected and had found mainly an atrophy of the nerve. It was a neuropathic condition: it might be produced by the tugging movements of the aorta upon the nerve when the horse exerted itself. The condition occurred more often in thoroughbreds, and more often in stallions than in mares, and it seemed to be transmitted from parent to offspring.

Professor HOBDAY (in reply) said the condition was a paralysis of the left vocal cord, and it occurred in animals who were subjected to much exertion. The continual tapping of the aorta upon the nerve caused atrophy. Another theory was that the atrophy was induced by the enlargement and pressure of the glands upon the nerve in the disease called "strangles." Seventy per cent. of owners said that the horse was all right until it developed "strangles."

Bronchoscopy in the Treatment of Asthma—Dr W. S. SYME (*Journal of Laryngology*, p. 427, September 1921).

Mr A. J. HUTCHISON wished to know if Dr Syme had limited his treatment to the passing of the instrument or had also used medicaments, as cures had been reported after the combination treatment.

Dr HORGAN had used 10 per cent. cocaine and adrenalin combined in two cases, but in neither was there any noticeable improvement in the asthma.

Mr HERBERT TILLEY asked for an explanation of the mode of action of the treatment, seeing that these cases were anaphylactic in origin.

Dr SYME (in reply) said he had not used the bronchoscope alone. The application of adrenalin to the mucous membrane had been advocated. In his method of treatment the silver nitrate was converted into oxide of silver in the tissues, and it remained for a long time as a coating on the bronchial mucosa. Cocaine dulled the reflexes. The cases of asthma thus dealt with were so severe that he wished to bring forward his experience.

Eversion of the Sacculus Laryngis: the so-called Prolapse of the Ventricle—Paper read by Dr IRWIN MOORE (to be published later in the *Journal of Laryngology*).

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