only in a few cases has no improvement been obtained. The instrument used was Gottstein's dilator, the bag of which is distended by pumping in water. Other dilators are on the market—*e.g.* Brünings' and Plummer's.

Dr. JOBSON HORNE: We have got somewhat off the line in attaching so much importance to the oïdium and so little to the stricture. Does Mr. Shattock consider the oïdium a causative factor, or is it merely a coincidence?

Prof. SHATTOCK: I entirely agree with the President that the growth of the oïdium or *Blastomyces albicans* is a pure epiphenomenon: that it is not causally connected with the dilatation of the œsophagus. It occurs, probably, from some accidental infection having taken place in a passively dilated tube. As to the depth to which growth penetrates, I must protest against assuming that in this case it penetrates into the muscular wall of the œsophagus. I believe the growth is confined to the mucosa, and dilatation of the cardiac orifice would probably cure the infection. The fungi of proper blastomycotic granulomata belong to a different species from that of common thrush.

Sir STCLAIR THOMSON (in reply): I agree the case might form the basis for a much larger discussion. I do not know what to dilate, because although the cardiac end of the œsophagus will not let food through, yet there is no obstruction. You have seen how the patient can herself pass a feeding-tube. We cannot get forward with the treatment until we are agreed as to the pathology. Is this a spasm of the cardiac end, or atony of the œsophageal muscles. Am I to dilate the cardiac orifice, or stimulate the constrictor peristaltic muscles? I will try to do both, and report.

(*To be continued.*)

ROYAL SOCIETY OF MEDICINE: SECTION OF LARYNGOLOGY.

SUMMER CONGRESS, FRIDAY, MAY 2, 1919.

THIS meeting, which is the first Summer Congress of the Section, will take place at the House of the Royal Society of Medicine, 1, Wimpole Street, London, W.1. The following programme has been arranged.:

The mornings of Friday, May 2, from 10 a.m. till 1 p.m., and of Saturday, May 3, from 10 a.m., will be devoted to the reading of papers and to their discussion. The following papers have been accepted.

P. WATSON-WILLIAMS.—"Latent Sinusitis in relation to Systemic Infections."

C. H. HAYTON.—"A Contribution to the Treatment of Atrophic Rhinitis with Ozæna, based on an Altation in Reaction of the Substrate in which the Bacterial Ferments are Acting."

A. BROWN-KELLY.—"Spasm at the Entrance to the Œsophagus."

DAN MCKENZIE.—"An Operation for the Complete Removal of the Soft Palate (Staphylectomy)."

D. R. PATERSON.—"A Clinical Form of Dysphagia."

J. F. O'MALLEY.—"Gunshot Wounds of the Nasal Accessory Sinuses."

IRWIN MOORE.—"The Treatment of Enlarged Tonsils in Cases where Operation is Contra-indicated."

W. H KELSON.—"Pharyngeal Diverticula, with Notes of Two Cases,

https://doi.org/10.1017/S1755146300019417 Published online by Cambridge University Press

in one of which the Pouch was removed under Local, in the other under General Anæsthesia."

W. S. Syme.—"A Series of Cases of Maxillary Antral Disease. Some points of interest."

Readers of papers are requested to send in abstracts of their papers without delay to the Hon. Secretaries for publication in the *Proceedings* of the Section. It is hoped to publish the papers *in extenso* in the Journal of Laryngology.

On Friday afternoon, from 2.30 p.m. till 4 p.m. a series of demonstrations will be given, including one by Dr. W. Hill on "Radium in Œsophageal Disease," and one on "Rhinoplasty," by Messrs. Gillies and Hett.

A museum of interesting specimens, etc., is being organised.

The ordinary Clinical Meeting of the Section will follow the demonstrations, commencing at 4 p.m.

In the evening at 7.45 p.m. the Section Dinner will be held at the Café Royal, and as this will be the first social gathering since the outbreak of the War a large assembly of members and friends is expected.

All communications regarding the Congress and the Dinner should be made to the Hon. Secretaries of the Section: Mr. F. A. Rose, 68, Wimpole Street, London, W. 1., or Dr. Irwin Moore, 30A, Wimpole Street, London, W. 1.

Abstracts.

PHARYNX.

The Lingual Tonsil: General Consideration and its Neglect.—Herman B. Cohen. "The Laryngoscope," September, 1917, p. 691.

The number of nodules in the lingual tonsil averages sixty-six. The size varies from one-half to six millimetres. They rest on a basement-membrane of fibrous tissue analogous to the capsule of the faucial tonsils. The lymphatic drainage empties into the suprahyoid glands and the submaxillary and deep cervical glands. The two portions of the tongue (anterior and posterior) have different origins, the sulcus terminalis being taken as the division between the oroglossus and the pharyngo-glossus. The part behind the pharyngo-glossus contains the lingual tonsil. The anterior portion differs completely from the posterior portion anatomically, physiologically and pathologically. The lingual tonsil is the last to undergo atrophy.

The diseases of the lingual tonsil are similar to those of the faucial tonsil, but are usually milder.

Superficial varices only make their appearance when the deep varices have acquired a certain development. The trunk of the lingual nerve, the seat of glossodynia, is accompanied by a satellite vein. All neuroses in this situation may be attributed to superficial and deep varices. A constitutional or acquired debility of the vasomotor system is the chief cause. Some cases occur at the menopause. Other ætiological factors are constipation, hepatic cirrhosis, and chronic intestinal disturbance. The symptoms are cough, "foreign-body" sensation, paræsthæsia, voice-changes, hæmorrhage and respiratory distress, constant pain at the root of the tongue, pain on swallowing referred to the base of the tongue and

https://doi.org/10.1017/S1755146300019417 Published online by Cambridge University Press