SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

February 3, 1928.

President—Mr H. S. Barwell, F.R.C.S.

The Patron Saint of Laryngology—Jobson Horne, M.D.—The coincidence of the date of this meeting of the Section of Laryngology with that of the anniversary of the martyrdom of the patron saint of those suffering from diseases of the throat makes the present occasion most appropriate for a contribution on medical hagiology.

On 3rd February, A.D. 316, Saint Blaise, medical practitioner, throat specialist, bishop and martyr, suffered martyrdom.

Blaise started his career in Armenia as a general practitioner, and in a very wide sense of the word. He is regarded as the patron saint not only against diseases of the throat, sore throat, coughs, quinsy, and goitre, but also against whooping-cough and diseases of children generally, wild animals, winds, and storms.

He was the patron also of masons, stonecutters, plasterers, millstone makers, wool-combers, wool-carders, and weavers, spinners, tailors, tanners, shoemakers, and stockingmakers. A truly wide cult, but the inclusion of "shoe and stocking makers" with "sore throats and coughs" to-day is interesting.

Blaise, on account of his saintliness, was made a bishop. In order to escape from the persecutions of Diocletian, he hid in a mountain cave and there became the friend of wild animals, blessing them and curing their ills, while the birds brought to him food. When his hiding-place was discovered, he followed the Roman soldiers sent to arrest him, and on his way performed many miracles, curing the sick and particularly the children.

He saved the life of the only son of a rich widow by removing a fish bone from his throat, for he was invoked especially for what was apparently his *casus mirabilis*, foreign bodies in the throat. When Agricola, the Governor of Cappadocia, saw that Blaise would not renounce his faith, he ordered him to be scourged and thrown into prison. Shortly afterwards he was taken from prison. As he refused to worship the heathen deities, he was tied to a stake and his flesh was torn with nails and iron combs; for that reason wool-combers claimed him as their patron. In one of the engraved portraits he is depicted holding an iron comb. He was imprisoned for a second time. He

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was taken before the Governor for a third time, and as he still refused to worship the idols he was cast into a deep lake, with a large stone tied round his neck. He rose to the surface, however, and walked upon the waters as though they were solid earth, thus converting many to the true faith. This so exasperated Agricola that he ordered Blaise to be beheaded, together with two children to whom he had been teaching Christianity. Tradition states that at the moment when his head was struck off Blaise prayed that he might be allowed to help all those who were suffering from diseases of the throat, and that a Voice said his prayer would be granted. It is on account of this prayer and the miraculous removal of the fish-bone from the child's throat that Blaise is believed to cure all complaints of the throat and neck.

Chronic Hypertrophic Laryngitis treated by Diathermy—HAROLD KISCH, F.R.C.S.—Case shown at meeting, 8th April 1927 (*Journal of Laryngology and Otology*, Vol. xlii., p. 632, 1927). Improvement in voice maintained. The deviation of the septum has been corrected.

"Hyperplastic" Laryngitis (previously shown 7th November 1924) — Sir JAMES DUNDAS-GRANT, K.B.E., M.D.— In this case, when originally seen (*Journal of Laryngology and Otology*, Vol. xl., p. 122, 1925), there was marked inspiratory stridor, for which tracheotomy might have been called for, but the removal of two large flapping masses on the aryepiglottic folds was followed by complete relief to breathing. Since then he has had an attack of pleurisy with effusion, but in spite of a careful search no tubercle bacilli were found.

Chronic Hypertrophic Laryngitis treated by Diathermy—HAROLD KISCH, F.R.C.S.—Female, came to hospital suffering from hoarseness, and attacks of troublesome coughing. There was hypertrophic swelling in the interarytenoid region, and slight changes in the cords. She had simple treatment for six months, but showed no improvement; in fact, the hoarseness was worse, and she could not talk above a whisper. She was kindly transferred by Dr Andrew Wylie to the exhibitor for diathermy treatment. This was carried out on 2nd January 1928. Her voice has greatly improved.

There is catarrh of some of the nasal sinuses which may require treatment later.

Sir ST CLAIR THOMSON said he desired to enlist the interest of Members in cases of this description. They were obstinate to treatment. At one time he used to see a good many, but was never able to get to the bottom of them. A number turned out to be cases secondary to sinus infection; many were syphilitic. But after these had been eliminated there still remained a good number in elderly people which proved to be tuberculous. Even then there still remained a number of cases, mostly,

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though not entirely, in hospital practice, which he could not explain. The patients were chiefly elderly females, and many of them were employed in cleaning offices. Possibly alcohol was a factor in some of the cases. Cases of the kind were obstinate to treatment.

Mr TILLEY said he agreed with Sir St Clair Thomson. Mr Kisch had shown a case at a previous meeting at which he (the speaker) had suggested that the laryngeal condition was only a local manifestation of a general condition of fibrosis; he had then cited the history of a patient whose larynx was in University College Hospital Museum. The specimen showed a large interarytenoid hypertrophy. Death took place by suffocation. The liver of that patient had been cirrhotic. He asked whether, in Mr Kisch's case, there was evidence of fibrosis in any other part of the body, *e.g.* in the kidney.

Mr HARRISON asked what was the technique of the operation in this case.

Mr KISCH (in reply) said that, acting on Mr Tilley's remarks at the former meeting, he had investigated these patients from the point of view of a possible cirrhosis of the liver, or fibrotic changes in any other organs, but he could find nothing of the kind. He had not been able to get any further in regard to the cause. In the first case he had straightened the septum because there had been a gross deflection, but he did not think it made any difference to the other condition.

With regard to the technique: a general anæsthetic was given, a directoscope used, and an ordinary, straight, malleable electrode employed for the diathermy current. The electrode was applied directly to the swelling in the interarytenoid region, and it was burnt off to a depth which was considered safe. There was a risk of causing ankylosis of the crico-arytenoid joint. The after-treatment consisted in resting the voice. In the female patient he showed to-day the voice on the third day afterwards had been good.

Dental Cyst treated by the Blood-clot Method — DAN MCKENZIE, M.D.—A woman, aged 23, had been aware of a swelling in the right upper maxilla for about ten years. Latterly it had begun to grow larger and was causing persistent, nagging pain.

The cyst itself was removed in the usual manner, and as the walls of the bone-cavity were intact, it was allowed to fill with blood-clot and the buccal mucosa was stitched over it.

Mr HAROLD BARWELL (President) said that formerly these dental cysts gave much trouble in treatment. When he was a house surgeon he had seen them treated by opening the gingival fold and packing, the packing being continued until the patient tired of it; there never seemed to be any closure. He had himself opened them in the canine fossa and drained through the antrum into the nose. The incision in the gingival fold healed afterwards and gave no trouble, but in one recent case a fistula had been left in the fold of the gum, through which fluid was apt to find its way into the nose.

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Societies' Proceedings

Hyperplasia of Right Upper Jaw—C. A. S. RIDOUT, M.S.—Male, aged 17½, first noticed enlargement of the right side of the face two and a half years ago; no pain noticed. On examination, the right upper jaw is uniformly enlarged and has progressed in size since he was first seen in October 1926. Nothing abnormal was seen in the nose by anterior or posterior rhinoscopy. Transillumination; right side of face absolutely dense; left clear. Wassermann reaction negative.

Radiograph shows a general and dense enlargement of the right superior maxilla.

Mr MUSGRAVE WOODMAN said the first point in this case was diagnosis. X-ray examination seemed to point to a solid bony tumour; but it was unilateral, and seemed to be bulging through the palate also; on that side the palate was more prominent than on the other. He thought it was a new formation of a low grade of malignancy, possibly an osteo-sarcoma, and should be removed.

Dr WILLIAM HILL said that as a portion had not been removed for diagnosis, it was difficult to decide whether a partial osteotomy would be sufficient to remove the deformity, or whether the upper jaw and part of the palate should be taken away.

Mr BARWELL (President) said that about eighteen months ago he had shown a case of chronic hyperplasia in a boy, but the deformity was not as great as in this case. He had explored in the canine fossa and found dark-red, spongy bone filling the jaw, and no trace of antral cavity. It healed up well. He had removed enough to diminish the deformity, and during the time he had observed it, the growth was not rapid, therefore he thought it wiser to leave it alone. Dr Douglas Guthrie had collected the records of a number of such cases. In the present case he advised exploration and removal of a piece for microscopy. If it proved to be hyperplasia, it was well to remember the slow growth, and that little trouble ensued, except for the deformity.

Mr H. SMURTHWAITE said he had had a similar case in a boy with an enormous swelling on the side of his face; the antrum was also blocked. Microscopically the growth had appeared to be a fibroma, but, not satisfied with that diagnosis, he had performed Moure's operation, and removed it. The condition had healed within a week. Moure's operation would do no harm in the present case; removal would give room for breathing through the nostril, and if the growth appeared to be malignant a more radical removal could be carried out later.

Mr J. A. GIBB asked whether it was of any use to operate in these cases. He had sent to the Radium Institute the first case of sarcoma treated there. The sarcoma was growing from the scapula, and at operation the growth was found to be so extensive that the wound was sewn up again and radium was inserted. For fifteen years afterwards the patient was absolutely free from recurrence. On the other hand, a friend of his had had a patient, a girl aged 5, with a swelling on the forearm, which the speaker regarded as sarcoma. He (Mr Gibb) had suggested taking the child to the Radium Institute, but, instead, a surgical operation had been

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performed. Three months later the child had died with recurrence in the spleen. Sarcoma was very difficult to eradicate, even when it was in the leg, and amputation was done. He had operated on several of these cases affecting the nose and throat, and the conclusion to which he had come was that surgical measures, with radium, was the best method of dealing with them.

Mr RIDOUT (in reply) said that he had felt diffident about doing anything to the boy at present. If, as it seemed, the diagnosis was doubtful, it was wiser to explore, and have a piece microscopically examined. His own view was that the growth was not malignant.

Carcinoma of the Cheek treated by Diathermy—NORMAN PATTERSON, F.R.C.S.—(1) Male, aged 59, had carcinoma of the left cheek treated by diathermy, 30th June 1926. (Exhibitor's "flap operation," see *Lancet*, 1st October 1927.) Later, involvement of left submaxillary glands occurred. These were removed 29th September 1926. A bony sequestrum came away a year after the cheek operation. In this case no special steps were taken to prevent contraction, and the patient can only open his mouth to a very limited extent. However, he manages quite well with his food, and is at present earning good wages. Professor Turnbull's report on this case is: "Squamous and horny carcinoma of cheek." The report on the specimen removed from the neck is: "Secondary, squamous, horny carcinoma in left cervical lymphatic gland with great central keratinization."

(2) Male, aged 58, had diathermy on 26th January 1927. The disease was rather extensive and involved the periosteum of the alveolus. A "Flap operation performed." Two previous diathermies had been carried out in November by a colleague, and again in December 1926. A bony sequestrum came away eight weeks after the last diathermy. This patient was employed in petroleum works and there were chemical works next door. He says he was subjected to petroleum fumes all the time, and frequently to acid fumes from the chemical works. In this case means were adopted to keep the mouth open. The pathological report on this case is: "Fragments of squamous-celled and horny carcinoma from cheek."

Mr H. BELL TAWSE said that perhaps the pathological malignancy was not very high. He asked whether the growth was adherent to the upper jaw, and whether Mr Patterson set out to destroy the bone with diathermy. Also, was it safe to preserve the skin over the growth? Was there not then a risk of recurrence?

Mr C. A. S. RIDOUT said the same thing had happened in one or two of his own cases, and there has been quick healing. As to the attachment of growth to the lower jaw, he did not see why the procedure should not be carried out, as the sequestrum would come through the mouth. The operation had opened a new line of treatment of epitheliomata of the cheek.

Mr MUSGRAVE WOODMAN said that in the first of these cases there was evidently a tight band which united the upper jaw to the lower, making it

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difficult for the patient to masticate food. How did Mr Patterson propose to deal with that, and, in future cases, to avoid it? He did not think the suggestion to keep the jaw opening and shutting during healing would help. It might be worth while to line the inner side of the reflected skin with an immediate skin-graft at the time of the operation. For a case with a tight band he would try an epithelial inlay; he would cut the band through, cover it with skin on some dental plastic material, and bury it deep down, so preventing the reunion of fibrous tissue.

Dr DAN MCKENZIE said this operation was particularly applicable to cases in which the growth had extended from the cheek on to the alveolus. One could attack through the buccal orifice and remove by diathermy a growth limited to the cheek, but it was difficult to follow the growth up on to the outer side of the alveolus when it had spread from the cheek. This operation was a considerable improvement on former methods. In one case of epithelioma of the cheek on which he had operated, he had feared that there might be a diathermy hole penetrating the cheek. But the coagulation produced by diathermy was less in the living body than in a piece of dead meat, depth for depth, because in the living body the circulation carried the heat away. Diathermy could be applied to bone, because in the necrosis of bone due to the diathermy the sequestrum separated aseptically several weeks after the application. He had frequently applied diathermy to bone when epithelioma was adherent to it.

Sir ST CLAIR THOMSON said he could add to these cases of Mr Patterson's a third case, seen two years ago, of extensive malignant disease inside the cheek, which he had referred to Mr Patterson, who had not then devised the operation now described. The growth had involved the corner of the mouth, and Mr Patterson had slit the cheek and diathermized the inside of it up to the upper alveolus, to which the growth extended. The only resulting inconvenience was a small opening into the antrum. He had seen the patient recently, and she remained free from recurrence. An interesting pathological point was, why some of the cases were, clinically and microscopically, malignant and with affected glands, while in others, also equally malignant, there was no involvement of glands.

Mr NORMAN PATTERSON (in reply) said he did not think these growths could be classified as highly malignant. In both cases the growth had spread to the upper jaw, and in that position it was destroyed by diathermy. It was easier to get at the affected jaw by the external route than through the mouth.

In answer to Mr Bell Tawse, he would not attempt such an operation if the skin was involved; indeed, when the skin was involved the result of operation was likely to be most unsatisfactory. In reply to Mr Woodman, there was no tight band in the second case; the man could open his mouth quite well, as means had been adopted to keep the mouth stretched open. He did not think an immediate skin-graft would take, but he would like to try it. The parotid duct must be destroyed in these cases; but in neither was there swelling of the parotid gland or inconvenience.

In reply to Sir St Clair Thomson, he thought the question of glands being affected or not was sometimes related to the presence or absence of septic teeth, but it was difficult to give a reason for the late glandular

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involvement in carcinoma of the cheek. He suggested that this method might be used for the insertion of radium, in the same way as that employed by Mr Harmer in laryngeal cases.

Foreign Body in Bronchus—NORMAN PATTERSON, F.R.C.S.—Boy, aged 4, was admitted 4th January 1928. Three days previously he inhaled a portion of a whistle out of a small, wooden, toy trumpet. He had been perfectly well since. Physician's report: slightly diminished air entry in right lower lobe. Skiagram showed opacity in the region of the right bronchus, opposite the level of the seventh and eighth rib. 6th January 1928: under general anæsthesia, the body was located in the right bronchus, about an inch below the eparterial bronchus. It was removed without difficulty through a No. 7 Jackson's bronchoscope. The patient made an uneventful recovery. The interesting point about this case is that during the presence of the foreign body, distinct whistling noises could be heard on respiration at some distance from the patient. The exhibitor has had two other cases where similar foreign bodies were present, and where the same sort of sounds have been heard.

Mr J. HARPER said that not long ago he had had a similar case in which the only symptom present had been a musical sound heard when the patient exhaled after taking a deep breath. He (the speaker) now showed a "squeaker" which he had removed from a bronchus in the lower lobe of the right lung.

Mr TILLEY said that Chevalier Jackson had frequently emphasised the asthmatoid wheeze as an indication of a foreign body in the windpipe.

Mr G. W. DAWSON said that in this present case, every time the child respired a whistling sound came from the whistle itself.

Mr H. SMURTHWAITE said that several years ago he had seen a boy who could whistle well through his vocal cords while his mouth was wide open. The cords, during the whistling, were seen to be in a position similar to that seen in functional aphonia.

Case for Diagnosis—L. GRAHAM BROWN, M.D.—Male, aged 25, reported at hospital 27th October 1927, with diffuse swelling of the left cheek and lower eyelid. Slight tenderness over the left canine fossa was present. There was no marked œdema and the temperature was normal.

Previous History.—About three months previously "a stinging pain" occurred in the left nostril, which his doctor diagnosed as a furuncle. The whole of the nose swelled enormously for a week; erysipelas supervened and lasted for five weeks. Patient then contracted pneumonia of the right lung. The swelling of the face never really disappeared since its onset, but varied slightly in amount.

Examination.—The nose showed a large septal spur on the left side but no other abnormalities. On transillumination the left antrum

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was darker than the right, and X-ray films confirmed this, but an antral wash out returned clear fluid. There was no peri-apical infection of teeth. On 8th November 1927, a small discharging sinus appeared over the left malar bone. No loose bone could be felt with the probe and the sinus completely healed in three weeks' time. Antral wash out was again clear, and Wassermann reaction found to be negative.

11th January 1928.—Since the condition had remained the same, an operation was decided upon, and an exploratory incision was made under the upper lip and the tissues retracted upwards. No evidence of sequestrum or abscess was found, and the antrum on being opened appeared healthy.

Can the condition be due to lymphatic obstruction following erysipelas?

Chronic Swelling of Cheek—L. GRAHAM BROWN, M.D.—Female, aged 48, has had a diffuse swelling of the right cheek for three years. Swelling varies in amount from time to time. No other symptoms apart from slight tenderness and an aching feeling. The swelling occurred at the same time as a swelling in the region of the occiput (alleged to be glandular).

Nose.—There is present a small fissure in the floor of the right nostril, which is possibly the focus of infection. Patient states that this has been present practically the whole time, and she associates it with a mild nasal catarrh. The case is shown for comparison with the previous case, in which no obvious focus can be found.

Chronic Swelling of Lip—L. GRAHAM BROWN, M.D.—Female, aged 25, for four or five years has had a chronic swelling of the upper lip. It varies slightly from time to time. She has suffered from catarrh, and notices that the swelling of the lip increases after a cold. The case is shown for comparison with the two previous cases.

Mr TILLEY said that similar cases had been described in the *Transactions of the Laryngological Society*. He (the speaker) had shown one, that of a man who after his return from the South African War had a chronic œdema of the forehead, such as one would expect to see shortly after the sting of an insect. The upper eyelids were also chronically œdematous. Investigations had not furnished any satisfactory bacteriological explanation. He believed the condition was due to a chronic form of lymphangitis. No treatment he had tried in his cases did any good. Subcutaneous drainage had been advised, following the technique advised by Mr Sampson Handley, which he (the speaker) thought had been adopted for the œdema of certain types of malignant disease.

Mr J. F. O'MALLEY said he had seen about eight such cases, usually sent because antral trouble was suspected. They were very difficult to treat. He regarded them as cases of chronic lymphatic obstruction. Sometimes one obtained a history of erysipelas beginning in the region of

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the ala. There was a second type, in which the obstruction arose in the ethmoid region. At present he had a patient with a history of fairly extensive syphilitic disease of the septum and ethmoidal region, and there was much lymphatic obstruction below the left eye, so large that it almost cut off the vision. He intended to try to reduce the size of the swelling, though he might not have much success.

Dr WILLIAM HILL said that the swellings of the lip, which he had seen in his student days, were usually associated in young people with enlarged cervical glands. The teaching then was to look in the nose for some focus infecting the part, but usually there was no ulceration. No pathological explanation appeared to have been advanced to account for these cases. The patients seemed to recover in course of time.

Mr H. BARWELL (President) remarked that in both cases, the first and second, there was, or had been at some time, a small septic focus in the vestibule.

Dr GRAHAM BROWN (in reply) said such cases were not uncommon at his clinic. In the first he had not been able to find a nasal lesion, but in the other two he saw a small fissure, and in the lip case what struck him particularly was the fact that the lip swelled after a cold, forcing the view that there was in such cases a nasal focus of infection. The second case had improved after the fissure in the nose had been treated.

Carcinoma of Larynx—Laryngectomy—CYRIL HORSFORD, F.R.C.S.—Female, aged 70, had since Christmas 1925 noticed gradual increasing weakness of voice, and slight attacks of choking at night, increasing in frequency.

Examination in June last; marked stridor and total loss of voice were noted. A large horny-looking irregular growth sprang from the left vocal cord chiefly, and hid the glottis completely. General condition was good.

All teeth were removed; more than half were carious. Three weeks later I performed total laryngectomy under local anæsthesia. The patient stood the operation extremely well. A week later part of the pharyngeal wound broke down; a few days later it was resutured and the wound gradually closed.

There is no sign of local recurrence. Pathological report by Dr Philip Ellison: "Typical squamous-celled epithelioma, with slight infiltration of muscular portion of cords."

I would emphasise the advantage of local anæsthesia in these cases; it adds, I think, considerably to the safety of the operation. In this case the patient did not object to it, and she showed none of the usual indications of distress. Except for the temporary set-back through the breaking down of the pharyngeal suture, she has done very well.

Extrinsic Carcinoma of Larynx—CYRIL HORSFORD, F.R.C.S.—Male, aged 68, first noticed a hard lump in neck eleven months ago,

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with slowly increasing pain and difficulty in swallowing and increased enlargement of glands.

Examination.—Extensive growth was present in larynx, covering greater part of epiglottis and extending into the right pyriform fossa; vocal cords scarcely visible; chain of hard glands extending to the root of the neck. Voice was only slightly affected. He breathes comfortably at night.

Mr H. BARWELL (President) said he feared this patient was beyond the possibility of any curative treatment; there was a very large mass of swollen glands in the neck.

Mr W. M. MOLLISON said he thought deep X-ray therapy might help the patient; he had seen cases do well with those applications even when there was great glandular involvement.

Mr NORMAN PATTERSON said that from his own experience he could confirm Mr Mollison's recommendation.

Laryngeal Case for Diagnosis—CYRIL HORSFORD, F.R.C.S.—Female, aged 64, has had discomfort and occasional earache on the right side for two years; no pain on swallowing; no alteration of voice.

Laryngoscopic appearances were: large swelling of the size and appearance of a large blackberry with irregular surface, deep purple colour, on the surface of the right arytenoid; it was movable. No impairment of mobility of cords was noticed. She was under observation for six months without apparent change. The growth never bled; it is probably an angeioma. Is any treatment necessary?

Mr H. BARWELL (President) said the growth was apparently angeioma, or fibro-angeioma on the edge of the fold, not very deep. It was almost pedunculated. The question was whether the patient felt sufficient discomfort to justify its removal.

Mr A. R. TWEEDIE said that about a year ago he had removed a similar growth under a local anæsthetic, with Haslinger's "Directoscope."

Dr JOBSON HORNE considered the growth innocent and advised removal. If a wire snare were used he would prefer one through which an electric current could be passed when tightened, thereby saving injury to adjacent structures.

Mr HORSFORD (in reply) said that the question now was whether to use the simple cautery, the snare, or something in the nature of diathermy, and whether a general or a local anæsthetic should be employed. If a general anæsthetic, should it be intratracheal chloroform?

Chronic Osteomyelitis of Superior Maxilla with Positive Wassermann Reaction—C. HAMBLEN THOMAS, F.R.C.S.—Male, aged 56, eighteen months ago, had a swelling of the left upper jaw in the region of canine fossa: tooth was extracted: he has since had a sinus and nasal discharge—the tooth came out easily and was not in bad condition.

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Patient is healthy looking. The left upper jaw is swollen above the alveolar border. This was firm and tender. Below it, on the alveolar ridge, there is a sinus in the old tooth socket. The nose showed on the left side purulent discharge and a left septal ridge, making approach to the inferior meatus difficult. No other swelling was present, no eye symptoms. X-rays showed antral opacity, otherwise indefinite. As the condition did not improve with antrum wash-outs, the antrum was opened above the alveolar margin. The tissues bled freely and the scalpel entered the antrum without encountering bone. Thick, cheesy pus, in small quantities, was washed out of antrum. On exploring the antrum with the finger the bony inner wall was found to be deficient. A free opening into the nose was made. The alveolar condition was improved. Later a thickening of the soft tissues of the septum occurred.

The Wassermann reaction was positive.

The patient was put on antisyphilitic treatment, but there seems to be an extension of the purulent infection of his sinuses.

Mr TILLEY said that there was a profuse secretion of pus in the ethmoidal region, and he suggested that in order to gain easy access to it a submucous resection should be done. The ethmoidal suppuration should be treated before anything else was done. It might be that this focus of sepsis was the cause of the swelling.

Mr HAMBLEN THOMAS (in reply) said the chief feature was the positive Wassermann reaction. He had feared to operate because of the risk of the osteitis spreading, but he would now do so.

Mass of Adenoids resembling Choanal Polypus—R. SCOTT STEVENSON, M.D.—The specimen exhibited a polyp-like mass of lymphoid tissue, arising from adenoids, removed from a child aged 10. It is shown because of the difficulty in diagnosing it from a choanal polypus arising from the maxillary antrum. On examination of the patient, a reddish, polypoid mass was seen just below the soft palate, and examination with a postnasal mirror and a probe confirmed one's belief that this was a choanal polypus. On proceeding to remove this, under a general anæsthetic, the polyp-like mass was found to come from the adenoids, which were then removed in the usual way with a curette.

Mr A. J. WRIGHT asked whether there was a history of any previous operation. He said that in his experience a pedunculated mass of adenoids usually indicated a previous attempt at removal.

Mr H. S. BARWELL (President) agreed that this mass looked like a large tag of adenoid pulled down at a previous operation.

Mr SCOTT STEVENSON (in reply) said that there had been no previous operation, and it was true that the child had not the obvious adenoid facies. He showed the case because he had seen one or two which turned out to

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be choanal polypi when they had been supposed to be adenoid cases, and he thought it might be worth while to show the other side.

Laryngeal Case for Diagnosis—W. M. MOLLISON, M.Ch.—Male, aged 63, a farmer, complains of increasing hoarseness for six months. He was a heavy smoker, but gave it up two months ago. He has a good deal of expectoration but enjoys good health. The soft palate and pharynx and tongue are reddened and show flakes of dry mucus. The deep pharyngeal wall is covered with a dense adherent felted membrane; this "membrane" covers the aryepiglottic folds and extends on to the epiglottis.

In the larynx the same "membrane" occupies the posterior commissure, forming thick masses as in pachydermia laryngis; the cords also are partly involved, but they move normally. There are no enlarged glands in the neck. The Wassermann reaction is negative. The sputum contains no tubercle bacilli. Culture from the pharynx grew a yeast, Gram-positive bacillus and streptococcus longus.

Dr LOGAN TURNER said he believed he had seen a similar condition in the pharynx, and on the base of the tongue and the epiglottis. In Mr Mollison's case as in his own he thought the appearance was due to yeast fungus. In his (the speaker's) case fungus was present upon an underlying epithelial growth on the posterior pharyngeal wall, which for a long time was obscured by the thick, tenacious coating. He hoped Mr Mollison would investigate his case from that standpoint.

Mr BARWELL (President) said the condition covered the back wall of the larynx and extended below. The centre of it appeared to be in the pharynx. One would have thought the cause of such a solid membrane would have been a streptothrix; he would not expect the yeast fungus to form such a thick mass.

Dr W. JOBSON HORNE thought the disease was pharyngeal in origin. The appearance in the larynx did not in any way suggest to him either pachydermia laryngis or malignant disease.

Mr GIBB said that he thought the condition was malignant, the cancerous part of it being in the lateral wall of the pharynx, where he saw ulceration. There appeared to be no interference with the functional part of the larynx.

Mr MOLLISON (in reply) said that a yeast had been cultivated from the surface, but the pathologist had found streptococci and a Gram-negative bacillus, which had nothing distinctive about them. The membrane on the surface of the pharynx was not removable; it all seemed part of the epithelial covering. Before he (the speaker) had seen the patient, Mr Gibb had suggested that the condition was inoperable epithelioma, but he (Mr Mollison) felt sure that this could be excluded, because the function of the larynx was so good, and the cord movement did not seem to be restricted, despite the great thickening of the interarytenoid region and the aryteno-epiglottidean fold. He had wondered whether it might not be an aphthous condition. He had not seen a similar one and he brought

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the case up for diagnosis. What Dr Logan Turner said was very suggestive, namely, that there was a condition due to yeast superimposed on an underlying epithelioma, and that it had not yet affected the underlying muscles of the vocal cords. The Wassermann reaction was negative, as also was the complement-fixation test for tuberculosis. So far no treatment had been carried out. He thought it was justifiable to take away a piece from the posterior pharyngeal wall, and if the growth was diffuse epithelioma, deep X-ray therapy might give some help. He proposed to try it.

Dr JOBSON HORNE suggested that before this was done Mr Mollison should try firm applications of absolute alcohol daily, rubbing it well in under an anæsthetic.

Epithelioma of Vocal Cords—W. H. JEWELL, M.D.—Male, aged 49, was previously shown in January and March, 1927 (*Journ. of Laryngol. and Otol.*, Vol. xlii., pp. 621-637, 1927). At the first meeting the consensus of opinion was in favour of tuberculosis, and at the second malignant disease. Excision of the larynx had been advised. The left vocal cord was fixed and deeply excavated and the subglottic region involved. The right cord was active and covered with macerated, thickened epithelium. Operation April, 1927. Excision of left cord, and about the anterior fourth of right cord; the cricoid was divided. Growth on each was reported to be epithelioma. The right cord is still active, but appears to be infiltrated.

Mr H. S. BARWELL (President) said that the question now was whether the patient was free from disease in his larynx or not. The other cord did not look altogether normal, and he thought the case would have to be carefully watched for some months to see whether any further growth arose. If it did, probably laryngectomy would be the only possible operative treatment.

SOCIÉTÉ DE LARYNGOLOGIE DES HÔPITAUX DE PARIS.

MARCH 1927.

(*From the Archives Internationales de Laryngologie*, 1927-1928.)

Abstracted by M. E. VLASTO, F.R.C.S.

Retropharyngeal Abscess Consecutive to Caries of the Cervical Spine—A. BLOCH and LEMOINE.—The case was that of a child of six years; the abscess was opened through the mouth and not through the neck as it is classically taught should be the selected route of approach.

In the discussion that followed, the majority of the speakers were

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