common in these cases. Remedies such as those mentioned should not be accepted upon the experience of a few cases. Many cases recover by themselves.

Mr. SOMERVILLE HASTINGS: In cases of doubt it is wise to open the lateral sinus groove. I have never regretted doing it, but deplored omitting to do it. It is a very important matter, especially in children, because it is often difficult to know whether there are granulations on the lateral sinus. I always open the lateral sinus groove, and freely expose the sinus in doubtful cases. I am surprised to hear of Dr. Dan McKenzie's experience.

Mr. LAKE (in reply): I felt interested in the remark about collosol argentum; I have desired to try it but have never done so. The question of the exposure of the sinus must be left to the individual surgeon. My position is that I would not open a sinus unless I saw a good reason for doing so. The diagnosis of pyæmia and bacteræmia is difficult: I can draw no hard-and-fast line. Sinus pyæmia has been so often discussed that I did not wish to introduce it on this occasion. I do not regard urotropine as a specific, and it must be used with due precautions.

Recurrent Herpes of Auricle.—H. J. Banks-Davis (President).—The patient is a boy, aged nine. Ever since the age of four he has had attacks of herpes regularly once a year: "he feels ill and is feverish," and has an aural eczematous discharge. The attack lasts two weeks and is always unilateral, affecting the right ear alone. He was sent to my department by Dr. Pernet. There was no glandular enlargement.

Mr. H. L. WHALE: Was there dental caries, or any other cause of irritation of the fifth nerve?

Dr. DAN MCKENZIE: Dermatitis herpetiformis must be remembered: it is like herpes, but recurs in the same place. I have seen it return three or four times.

The PRESIDENT (in reply): We could find no cause of irritation. Dr. Pernet sent the case to me. The patient had a discharge from the ear, which was eczematous. Dr. Pernet made the diagnosis given in the title: he had had him under care some time. Vesicles were present on the back of the auricle as well as on the front.

(*To be continued.*)

ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

November 2, 1917.

President: Dr. A. BROWN KELLY.

PRESIDENT'S ADDRESS.

(*Abstract.*)

(The PRESIDENT, having pointed out that it was a fitting time to consider whether the Section was furthering in the best possible manner the progress of laryngology, proceeding to discuss its present and possible future relations to investigation, teaching and publication, said:)

First, with reference to original investigation, I should like to impress

https://doi.org/10.1017/S1755146300019405 Published online by Cambridge University Press

upon the younger members of the Section that for the solution of the more purely scientific questions we are mainly dependent on them. If they are still in touch with the anatomical, physiological or pathological department of their medical schools, they can obtain material and opportunities for research work.

The problems to be solved are innumerable. In the anatomical department the following subjects might be studied: The innervation of the soft palate and the causes and effects of paresis of its individual muscles; the histology of the olfactory region with reference to the changes causing anosmia, including if possible the transitory type, which is a feature of vasomotor rhinitis; a comprehensive description of the anatomical variations met with in the upper air-tract; this last might serve as the basis of a useful chapter in all text-books on diseases of the nose and throat.

In the physiological laboratory work might be done towards the elucidation of the functions of the inferior turbinate, and its variations in bulk and secretory activity. An instrument indicating the amount of air passing through each nasal fossa is still a desideratum. We know that nasal hypersecretion is sometimes checked by calcium salts, but we are still unable to identify the cases in which these drugs are likely to prove useful. Information on such points would help to raise the treatment of the so-called nasal catarrh from the region of empiricism to that of scientific exactitude. The whole subject of vasomotor instability is a mystery, the unravelling of which, however, is unlikely in our present state of knowledge. It is not improbable that vagotonia may account for at least some of the nasal neuroses. Every day we are questioned as to the use of tonsils and adenoids and the cause of their enlargement; and often we have reason to ask ourselves why the removal of a comparatively small mass of adenoids is followed by a physical and mental transformation quite out of proportion to the improvement in the respiratory conditions. Did the adenoids set free a deleterious internal secretion, or inhibit a beneficial one? or, how else are we to explain the great change? All these questions suggest matter for investigation.

We are still in need of *post-mortem* examinations of the central nervous system in neuroses affecting the larynx alone or in association with other regions.

In poor-law hospitals and asylums permission might be obtained whereby laryngological and other cases of special interest could be observed throughout life and the morbid tissues examined subsequently.

Of the relations of diseases of the eye to those of the nose much has been written in recent years, but more information on the subject is required.

Lastly, to any member with opportunities of seeing diseases of the skin, I might mention that we are still in want of an account of the dermatoses as they affect the mucous membranes of the mouth and throat.

In any of these directions a young medical man with limited clinical material could make valuable contributions to our specialty, and as an incentive to research work the Section might announce that applications for membership accompanied by a thesis would receive special consideration.

An increased production of original papers would allow of the enlargement and improvement of the JOURNAL OF LARYNGOLOGY, RHINOLOGY, AND OTOLOGY.

https://doi.org/10.1017/S1755146300019405 Published online by Cambridge University Press

Having indicated some lines along which investigations may be pursued, let us consider whether the Section gives adequate encouragement to work of this kind.

At present all communications made to this Section must be based upon a patient, specimen or exhibit of some kind, with the result that those living at a distance from London, and therefore almost precluded from showing cases, are unable to contribute to the most interesting part of the proceedings.

According to an unwritten law of the Section notes for the agenda-paper must be as brief as possible. Most of the old members will agree with me in ascribing the success of this Section largely to the practical policy insisted upon in the past. I regret to have to point out, however, that this very conciseness has been seriously detrimental to the study and progress of laryngology in this country. Many of the rare and interesting cases that have been brought before the Section should have formed the basis of extensive investigations, or of analyses of all previously recorded cases of the same nature.

These considerations make it obvious that this Section, although it has attained a high measure of success in relation to practical laryngology, might benefit further by encouraging original investigation, and by gathering to itself some of the work done in the provinces and colonies and abroad. But how are these objects to be accomplished without damaging established and proved usages? Any proposal to have papers read at the meetings would, I am sure, be at once negatived by the majority of the members.

Two ways of settling the difficulty suggest themselves. First, a member desirous of bringing a paper before the Section might submit it to the Council; if approved, it would be printed and sent to the members with the programme of the next meeting; the title only, or, at most, the conclusions, would appear on the agenda paper; at the meeting, the subject, in turn, would come up for discussion, and the paper would afterwards be published in the *Proceedings*.

The second method would be once a year to devote an entire day—say the first Friday in May—to the work of the Section. In the forenoon, papers which had previously been printed and circulated amongst the members would be discussed; in the early afternoon the museum and display of instruments would be inspected; later, the Annual Business Meeting would be held, followed by an ordinary meeting with the exhibition of cases, etc., and in the evening the dinner of the Section would take place. A laryngological gathering such as this would prove an attraction not only to provincial members but also to our foreign *confrères*; it might even serve as an international congress of rhino-laryngology.

If the Otological Section resolved to institute a similar annual reunion the meetings of the two Sections might be held on successive days.

Laryngologists with whom I have spoken on the subject have all expressed the opinion that the teaching of our specialty should now be improved and extended. Consideration of the matter and necessary action lie, of course, with the individual centres or schools. Our young graduates and those of our allies will have no wish to study, as has been the fashion, at the birthplace and early homes of laryngology; their needs, however, can be amply provided for in London. The metropolitan members of the Section whom these matters directly concern might find

https://doi.org/10.1017/S1755146300019405 Published online by Cambridge University Press

it suitable to take their initial steps here. If a great scheme of instruction is elaborated for London, might I suggest that the students be sent occasionally on a provincial tour?

I trust that at an early date the question of granting a diploma in laryngology will be raised. A qualification of this kind would be a stimulus to teachers and to the more exact study of the subject, besides affording a ready means of distinguishing the trained from the self-styled specialist.

The last matter of which I would ask your consideration is the production of a comprehensive and advanced treatise on the diseases of the upper air- and food-passages. Several members of the Section have written on the subject books of which we may be justly proud, for they are unequalled by publications of like aims and scope in any language. The work which I foreshadow is, however, quite beyond the productive power of any one man, and could be evolved only as the result of the experience and industry of many. If, as we trust, our language is to be that of the future, it is incumbent upon English-speaking laryngologists to plan and carry out such a work. In these circumstances would it not be fitting that the Section undertake its supervision and accept the monetary responsibility?

I shall conclude my remarks by emphasising their twofold aim. I have tried to show that this Section of a great Society, in addition to its functions at home, has certain imperial and international obligations, one of the first of which is to open its portals to our overseas and foreign brother specialists and to extend a welcome to their work, also that it can profoundly influence the destinies of laryngology in this country by fostering research, organising teaching, and subsidising approved publications—in short, by becoming the *alma mater* of laryngology.

Fusiform Dilatation of the Œsophagus, coated with *Oïdium albicans*, in a Girl, aged fifteen, and apparently Idiopathic.—Sir StClair Thomson.—W. R——, aged fifteen, was admitted to Lister Ward, King's College Hospital, on April 21, 1917, with a suspicion of an œsophageal pouch. Symptoms started one year previously with violent fits of coughing and regurgitation of food. She had no difficulty in swallowing and ate anything, but shortly after each meal food was regurgitated into her mouth. Condition varied: for fourteen days she might have little or no difficulty in retaining everything, and then for days she might be unable to get any food down, as regurgitation followed fast on every effort to swallow. It was rare for food to be regurgitated which had been swallowed on the previous day. No blood. Discomfort referred to middle of sternum. No loss of weight or strength, and patient is particularly vigorous, well grown and intelligent. Patient has had every single tooth in her upper jaw removed, as it was thought that her trouble was due to pyorrhœa.

Present condition: On ordinary examination there is nothing to be detected. Examination on the screen shows that a bismuth feed passes freely to the middle of the œsophagus, where it is held up for a short time. Plate examination shows a definite obstruction at cardiac end of œsophagus, with considerable dilatation above the obstruction, and some irregularity of the shadow about the middle of the œsophagus. Œsophagoscopy is particularly easy, and shows an evenly and widely dilated, fusiform gullet, irregularly coated with extremely adherent plaques of dirty white material, like curdled milk. On removal, this

https://doi.org/10.1017/S1755146300019405 Published online by Cambridge University Press

material was reported to consist of a mass of *Oïdium albicans* with other bacteria. No pus, blood, or fragment of growth.

A series of lavages, including peroxide and eusol, were carried out in May, and the patient was relieved. She has again come under treatment, and remains much *in statu quo*.

The PRESIDENT: As Sir StClair Thomson has put this case down as fusiform dilatation, and has not used the terms "achalasia, "cardiospasm," or "atony of walls," we should, in the discussion, keep to the clinical side. I hope that in the course of the Session cases of this class will be specially considered some afternoon, when members will have an opportunity of expressing opinions as to the ætiology.

Prof. SHATTOCK: The whole interest of this case lies in the fact that the interior of the œsophagus is coated with oïdium. The subject of œsophagectasis was so fully discussed last year, in the Medical Section, that I hardly think it can be necessary to go into the matter again now.

Sir STCLAIR THOMSON: I shall be glad to leave out what might complicate the discussion as to why the œsophagus is dilated, whether it is the consequence or the cause of the *Oïdium albicans*. But the comfort of the patient is a consideration, and this patient has come up twice from Southampton to be cured, and I have failed! Therefore I shall welcome any suggestions. A physician suggested that the oïdium occurs in the mouth when there is an excess of alkalinity. Therefore we washed out this case with dilute hydrochloric acid, and we have used boric acid, peroxide, and painted it with nitrate of silver. She has had the condition since April.

Dr. DAN MCKENZIE: I should be inclined to see what would be the effect of a piecemeal removal of the accessible part of the fungus, followed by a rubbing in of some such substance as tincture of iodine. I have seen such a condition in the pharynx of adults not infrequently, but usually in persons who were dying. In them one noticed that it produced a peculiar interference with swallowing. It was obvious that the growth had made its way amongst the muscular fibres in the neighbourhood, producing, no doubt, an interference with muscular movement. The dysphagia in this case may be of that nature.

Mr. MARK HOVELL: I have never seen a case similar to this one. I think a remedy of a penetrating nature is required. For that reason I would try collosol iodine, or collosol silver, or collosol copper, locally. Collosol iodine and collosol argentum is made up in suppositories, and these could be passed down to and lodged in the œsophagus, and being non-toxic are quite harmless; 2 to 4 drm. by the mouth is a dose. If that did not succeed, I should try a germicide solution, such as cyllin.

Mr. HERBERT TILLEY: Before trying ionisation, I should advise the free application of a weak solution of sulphurous acid: it seems very effective in the destruction of various forms of "mould."

The PRESIDENT: Do members think the two conditions here are related—that is, is not the oïdium accidental? I have met with the oïdium in the gullet on several occasions, but not always associated with fusiform dilatation. I would be inclined to treat the fusiform dilatation first and see whether the oïdium did not afterwards disappear. The treatment I have employed for the underlying affection, the so-called cardiospasm, has been dilatation of the cardiac end of the gullet. This has occasionally effected striking benefit, patients who were practically invalids having been restored to perfect health, and others having been improved for six months, or a year, when the dilatation had to be repeated;

https://doi.org/10.1017/S1755146300019405 Published online by Cambridge University Press

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/S1755146300019405 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/S1755146300019405 Published online by Cambridge University Press