SOCIETIES' PROCEEDINGS

THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY

THE sixty-ninth meeting of the Society was held in the Western Infirmary, Glasgow, on Saturday November 27th, 1954, with the President, Dr. R. B. Lumsden in the chair.

A paper was given by MR. I. S. D. THOMSON, entitled "*Observations on the Diagnosis and Management of Deafness in Children*".

Deafness is a special handicap to children as it affects their education and development. Hearing tests for the infant are based on the normal infant's behaviour and reflex reactions to noise stimuli. A normal child will look round on test sounds being made behind his back. Location of sounds is present by nine months. From 1½ to 2 years he will, in addition, locate unforced consonants and carry out simple commands. In diagnostic tests, a loudness level meter is valuable, as with it an approximation to an audiometric curve is obtainable. Pitch pipes are also calibrated, and can test the hearing throughout the speech range.

It is important from the educational standpoint to discriminate in early infancy between true congenital deafness and early acquired deafness. Trained health visitors could screen the children at health centres, and travelling clinics for country districts could be incorporated in the scheme.

Pure tone audiometry is a long process and bores the child. Gramophone audiometry involves intellectual and emotional factors. Individual pure tone sweep audiometry can be used at an earlier stage, and a play element introduced. The drawback of the Peepshow is that it tests the combined hearing of the two ears. Turning the head can alter the value by 15 decibels. Diagnosing deafness in early childhood means that education can be commenced at once, in the home. Hence Parent Guidance Clinics are vital. The deaf baby's interest must be kept visual, for then lip-reading will develop as naturally, although more slowly, than speech in the normal child. This start will be valuable when he goes to the nursery deaf school, and later to a school for the deaf (Grade 3).

The Grade 1 child stays in the ordinary school in the second front row. Grade 2 children are divided into *2a* and *2b* on a basis of performance. Pupils graded *2a* carry on in the ordinary school in a favourable position in class, plus the addition of lip-reading classes and a hearing aid if necessary. In the country, an itinerant teacher of the deaf is required, probably on a regional basis. The *2b* children are severely deaf, but have the rudiments of speech, and thus differ from those in Grade 3. They should not be sent to deaf schools, but provision for instruction in lip-reading and speech is essential. The disadvantage of the necessary high amplification of their aids can be overcome by having acoustically treated class rooms.

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Very few profoundly deaf children have no islands of hearing at all, and group hearing aids which can amplify to 120 decibels may be of value. Caution is required in view of the effects of fatigue on an imperfect ear.

The provision of adult continuation classes by the local educational authority merits consideration.

Cases were shown as follows:

DR. GAVIN YOUNG.

1-4. Four cases of *malignant disease involving the antrum, ethmoid and maxilla* were presented. In one instance the tumour was a cylindroma. Treatment was by sub-labial approach, and Moure's lateral rhinotomy, followed by radiation.

DR. COLLINS pointed out the necessity for adequate exposure and drainage in cases treated with radium. He thought that the average survival rate for five years was 30 per cent.

5. *A chemodectoma of the left tympanic cavity* in a woman, aged 30, was removed by radical mastoidectomy. Three years later a recurrence was dealt with endaurally by diathermy.

In reply to a question by DR. VENTERS, DR. MCKINLAY said that a chemodectoma was akin to the glomus tumour of the carotid body.

6. *Carcinoma of the External auditory meatus*, in a case of extensive attic disease. A woman aged 64 had an aural polyp removed on two occasions. When seen, the meatus was full of cholesteatosis and a polyp. The latter proved to be an epidermoid carcinoma. Radical mastoidectomy followed by radiotherapy resulted in a satisfactory cavity, with three years without recurrence.

7. Case of *stenosis of the external auditory meatus* following endaural mastoidectomy, treated by an acrylic meatal tube. This has maintained a satisfactory wide meatus.

8. *Lymphangioma of the tongue* in a female of 31 was treated by diathermy acu-puncture with definite improvement, after vitamin therapy and the radium beam had been used without benefit.

DR. LUMSDEN recalled a similar case in which the condition was further back on the tongue. It responded fairly well to repeated diathermy. DR. YOUNG then mentioned an enormous mixed parotid tumour at the base of the tongue, treated by palliative acu-puncture.

9. A case of *mixed salivary tumour of the nasopharynx* in a man of 45 was treated by radiotherapy. The result was good, but a small, smooth nodule was still present on the roof.

DR. GIBSON suggested that a transpalatal approach would give better access and allow removal by surgery.

10. *A pharyngeal diverticulum* in a woman of 62 was cleaned by suction through an œsophagoscope, packed with ribbon gauze, and then dissected out. Abductor paresis followed, but later recovered.

11. A good cosmetic result in a case of *rhinophyma* treated by diathermy was shown. DR. LAND asked if Dr. Gavin Young preferred diathermy to the razor method in these cases. He suggested that the shaving down of the rhinophyma was better controlled by the razor.

12. *Nystagmus of soft palate and vocal cords* caused huskiness and slight difficulty in swallowing in a woman aged 65. Two attacks of cerebral hæmorrhage

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had occurred at 54 and 58 years. DR. LUMSDEN pointed out that there were rhythmic movements of the pharyngeal wall as well.

13 and 14. DR. YOUNG finally showed two cases of *laryngeal carcinoma treated by radiotherapy and laryngectomy*. Both were rather slow in developing œsophageal speech, one being handicapped by a cleft palate.

15 and 16. DR. FULTON CHRISTIE showed two cases of *laryngeal cancer*. The first was a male aged 38, with a growth involving the posterior half of the right cord. Radium beam therapy was completed on *30.8.49*. Seen again on *16.4.53*, when right cord was found to be infiltrated throughout entire length. Biopsy showed a well differentiated squamous epithelioma. Laryngectomy was performed, and patient has good œsophageal speech.

The second case was treated by laryngectomy only. He was found to be suffering also from old standing pulmonary tuberculosis. Some months after laryngectomy, he developed a small granulation at the mouth of the trachea. This was thought to be a recurrence, but proved to be tuberculous. It cleared up as the chest improved. He has good œsophageal speech.

17. DR. MCKINLAY showed a case diagnosed as *chronic hypertrophic laryngitis* in a male aged 57. In *November, 1953*, he gave a history of hoarseness for five years. Both cords appeared thickened and congested, and the interarytenoid region was also thickened, but not ulcerated. Biopsy showed epidermal thickening with underlying chronic, non-specific inflammatory change. Tracheotomy was performed on account of obstruction. Further biopsies gave a similar result, until one taken nine months later, when carcinoma was found and laryngectomy done. The difficulty in diagnosis was caused by the tumour invading the ventricle of the larynx.

MR. HOWIE congratulated Dr. McKinlay on his persistence, and mentioned a similar case in which he and Dr. Brown Kelly had been involved. Several biopsies showed chronic inflammatory change, but the larynx remained so stenosed, even after tracheotomy, that they decided it was a carcinoma. Operation proved that the disease was unapproachable from above. Cases showing lymphatic block were always suspicious.

DR. YOUNG expressed his gratitude to Mr. Howie for his many hints in points of technique in laryngectomy and also for his ever willing help in the Laryngectomy Club. In reply to a question from DR. SEEX, he stated that the best way to get rid of the sticky secretion following laryngectomy was to use a bed-side suction plant.

DR. LAND emphasized the importance of not accepting a diagnosis from only one biopsy, and mentioned a case illustrating this.

18. DR. FULTON CHRISTIE demonstrated a case of *squamous carcinoma of the right antrum and nasopharynx*. The patient, a woman aged 64, underwent a left radical antrum operation in 1938. In *May, 1952*, she had facial pain and epistaxis. The antral ostium was found completely blocked, and an irregularity was present in the right posterior choana. A Caldwell-Luc operation was performed. Biopsy showed a well differentiated carcinoma. Treatment was by deep X-ray therapy followed by a healthy appearance of the nasopharynx until an apparent recurrence in *December, 1952*. Bone erosion in the floor of the right middle fossa followed. The growth appeared in the right ear in *November, 1953*. Palliative

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X-ray treatment has been followed by diminution in the growth, and the ear is almost dry.

19. DR. BROWN KELLY showed a case of *congenital abnormality of the ears* in a girl aged 7 years. Deafness had been present since birth, but was not complete, and she could speak well. The auricles were well developed, but each external canal ended in a cul-de-sac at a short distance from the entrance. X-rays showed middle-ear cavities and semicircular canals, but no sign of ossicles. Her mother and sister had normal canals and drumheads. Advice was sought as to treatment, with special regard to advisability of attempting a fenestration, as a flap would be difficult to form. Audiograms were shown.

DR. SIMSON HALL stated that in this type of case when the hearing is good (loss of 20 decibels) a drum membrane is often found. In Dr. Brown Kelly's case there was a loss of 40 decibels, and the drumhead may be replaced by a mass of fibrous tissue or by bone. He advised an early fenestration, providing a pedicle graft from the outer part of the roof.

DR. MITCHELL said that he had seen a similar case, but the hearing was so good that operation was out of the question. He suggested a submentovertical X-ray to show up the ossicles.

20. DR. MCKINLAY presented a woman aged 43 with *atresia of both external meatuses*. She had had a febrile illness at the age of 2, and had to attend a clinic for her ears thereafter. A blue stained membrane extended across the deep right external meatus. The left was a blind ending featureless cavity. X-rays showed non-cellular mastoids. Hearing tests revealed conduction deafness. The possibility of injury had to be considered.

MR. HOWIE thought that on the right side there was a false membrane. The left side looked like a destructive otitis.

21. DR. MCKINLAY also showed a male aged 62 with *periostitis of the left tympanic plate*. Removal of a hard crust adherent to the postero-inferior surface of the left external canal revealed a small ulcer with granulations and bare bone. There was slight deafness, but both drumheads appeared normal. Previous X-ray treatment for rodent ulcer behind the ear was not considered responsible. Biopsy showed thickening of epithelium with hyperkeratosis.

DR. LUMSDEN had a similar case which produced small sequestra. There was extensive spread, and a large part of bone had to be excised. He advised repeated X-ray examinations.

22. *Sudden unilateral deafness with recovery* in a woman aged 26. Seen by Dr. McKinlay in *May, 1954*, with deafness and tinnitus in the left ear of sudden onset ten days previously. Drumhead normal, apart from slight retraction. Eustachian tube patent. Deafness of perceptive type. Intravenous Priscol produced rapid improvement in hearing and diminution of tinnitus. Several relapses occurred, but on each occasion Priscol reversed the symptoms. Hearing continues to improve.

MR. HOWIE pointed out that she had vertigo and walking to one side when tinnitus was present. There was nystagmus to the left.

In reply to a question by DR. GIBSON, DR. MCKINLAY explained that Priscol was a vasodilator. He had heard of a case of aphasia due to disease of intracranial vessels which cleared up temporarily with Priscol.

DR. GIBB thought the case might be one of Ménière's syndrome.

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DR. BROWN KELLY recalled the treatment of otosclerosis by intra-tympanic injections of thyroxin which acted as a vasodilator. This method was introduced by the late Albert Gray.

23. DR. MCKINLAY finally showed a case of *myoblastoma of the larynx* in a male aged 44, with a history of huskiness for three weeks. A small nodule was noted overlying the left vocal process. It came between the cords on phonation. Removed by direct laryngoscopy. Histological report showed granular myoblastoma. There is now a slight fulness of the left vocal process which has not altered in three years. The cords are mobile and the voice clear.

EXHIBITS

DR. SEEX showed X-ray plates and microscope slides illustrating a case of *laryngeal carcinoma treated by laryngo-fissure*. A preliminary tracheotomy was followed by surgical emphysema of chest and face, a right sided parotitis, and bronchopneumonia. The laryngo-fissure, however, proceeded smoothly apart from severe bleeding, and he now has a good voice and a false cord.

DR. GAVIN YOUNG and DR. FULTON CHRISTIE showed photographs illustrating *ulceration of the anterior nares*, classified as granuloma malignum. Treatment with X-ray therapy was successful. The case had been shown to the Society 18 months ago. It was not, as some members had suggested, a Leishmaniasis.

DR. FULTON CHRISTIE showed audiograms and X-rays from a case shown to the Society 18 months ago. The patient, aged 55, had a navy blue coloured drumhead and a mild conduction deafness on the left side. Large cavities in the bone of the left mastoid were unlike typical mastoid cells. Hearing has now returned to normal.

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