SOCIETIES' PROCEEDINGS

THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY

THE sixty-eighth meeting of the Society was held in the Ear, Nose and Throat Department of the Royal Infirmary, Edinburgh, on Saturday, June 5th, 1954.

The President, Dr. R. B. Lumsden, occupied the chair.

The cases shown were grouped into comparable cases for the purpose of discussion, as under:

Two patients illustrating the *Wilson transpalatal approach* were shown by DR. I. SIMSON HALL and Dr. G. D. MCDOWALL. DR. HALL'S case was one of left-sided *choanal atresia* in a girl aged 15. Dr. Hall was of the opinion that the Wilson approach did not offer sufficient access for this condition. He thought that the incision should be placed further forward than Wilson recommends, and stated that he preferred to remove part of the hard palate. The approach was, however, of use in the placement of an acrylic tube to maintain patency.

DR. MCDOWALL'S patient, aged 53, had a *reticulum-celled sarcoma* involving the left side of the nasopharynx, with no cervical adenitis. Preliminary pathological report suggested that the tumour was simple, and it was excised by diathermy using the Wilson approach. Dr. McDowall found access to be adequate for this type of case. Further pathological investigation showed that the tumour was a reticulum-celled sarcoma with chronic inflammatory accompaniments.

DR. HALL showed a boy of 6 with a narrow right external meatus and a *congenital deformity of the left ear* with a non-existent meatus. Exploration of the left mastoid revealed a horizontal canal and the upper part of the middle ear could be identified. No drum could be found, and no middle ear cavity or Eustachian tube could be located. Three months later a fenestration operation was carried out with slight improvement in hearing. In reply to a question, Dr. Hall said he thought the operation would have been unnecessary had the opposite ear been normal.

DR. HALL and DR. MCDOWALL commented upon a series of five cases illustrating the *per-meatal section of the chorda tympani nerve in Ménière's Disease*, one of whom was shown. Two of these had been successful, two unsuccessful and the case shown had only been operated upon a few days previously. DR. MCDOWALL discussed Rosen's publications and stated that he found in actual practice that an incision placed higher on the posterior meatal wall than Rosen suggested afforded a better view of the nerve. The operation was not technically difficult. DR. HALL said that for some time past he had been dividing the chorda tympani nerve in every fenestration, and his impression had been that these patients had suffered less vertigo. THE PRESIDENT mentioned that he had recently had the opportunity of seeing a case of Ménière's Disease treated by ultrasonic waves, and had been extremely impressed with its possibilities.

https://doi.org/10.1017/S0022215100050350 Published online by Cambridge University Press

The Scottish Otolaryngological Society

DR. A. BROWNLIE SMITH showed two cases of *carcinoma of the upper jaw*. The first, a female aged 42, gave a month's history of pain in the left side of the face. X-ray showed a slight opacity of both antra, but there was no suggestion of a tumour in the Radiologist's report. Proof puncture of the left antrum produced a few flakes of curdy pus. This was sent to the Pathologist who reported that the cells seen in the material washed from the antrum suggested that they were derived from a squamous carcinoma. Treatment was radium to the antrum followed by deep X-ray therapy.

The second case, a male aged 63, had a recurrent swelling below the right eye. The antrum was opened, and, although there was widespread invasion of the anterior wall of the antrum, the cavity was not involved. Treatment was local radium and deep X-ray therapy. Since treatment there has been severe pain in the upper jaw and such fibrosis that he could not open his mouth. To help this, the masseter and pterygoid muscles were detached from the mandible with slight improvement in the ability to open his mouth. The question of leucotomy for the relief of pain has been considered by Professor Dott. DR. SEEX considered that more radical initial surgery in these cases gave better results.

DR. SMITH showed two cases of *sudden nerve deafness* which were thought to be of vascular origin. DR. COLEMAN (by invitation) described the investigation in these patients. DR. VENTERS felt that the first case (a male, aged 22) had had mumps, while DR. LAND wondered if there were anything to suggest hysteria in this case.

THE PRESIDENT showed a case of *glomus jugulare tumour* in a female aged 56 on whom a modified radical mastoid operation had been performed in 1949. A slowly progressive facial paralysis developed in 1953, when a purple swelling was seen on the meatal floor. Biopsy of this was reported as glomus jugulare tumour which was treated by deep X-ray therapy. Dr. LUMSDEN discussing his case said he had been agreeably surprised to find the tumour so much smaller. He had been advised never to operate on such cases. DR. OTTY said his experience had been quite contrary. He found that the tumour could be removed at an early stage with a minimum of bleeding. DR. MCKINLAY quoted two such cases on whom he had operated with success.

Four laryngeal cases were next discussed, two cases of *keratosis of the larynx* being shown by the PRESIDENT and one case of keratosis and one of *leukoplakia of the larynx* by DR. I. M. FARQUHARSON. DR. LUMSDEN said that his patients, a man aged 46 and another man aged 57, were both causing some anxiety. The former had been examined in 1950 and the right cord was stripped. His hoarseness had become worse, and in 1951 a laryngofissure was performed using Jackson's subperichondrial technique. Both cords were removed in one piece, and biopsy then showed a well differentiated squamous epithelioma. Regular examinations since have shown small patches of keratosis, mainly on the right cord.

Dr. Lumsden's second case was previously shown to the Society in November 1950, and was treated by laryngofissure at which the right true and false cords and the anterior one-third of the left cord were removed. No subsequent change until 1953 when he became more hoarse. Recent examination revealed a rough keratotic area at the base of the epiglottis, biopsy from which showed no

https://doi.org/10.1017/S0022215100050350 Published online by Cambridge University Press

evidence of tumour. DR. OTTY suggested that the laryngofissure be repeated and the epiglottis amputated.

DR. FARQUHARSON'S case of keratosis had also been under observation since 1950 with a history of hoarseness for many years. Repeated examinations and biopsies have failed to show any evidence of tumour formation. The appearances vary from time to time, and whenever he has a cold the granular appearance of the cords becomes more marked. He is now on a course of Ro-A-Vit.

The case of leukoplakia of the larynx occurred in a woman aged 63, who had a five years' history of hoarseness. She has been treated with large doses of Ro-A-Vit and a slow improvement has been noted.

DR. J. F. BIRRELL showed a case of *subglottic angioma* in a baby aged 17 months, who had been seen at the age of three weeks on account of marked dyspnœa. Laryngoscopy revealed a subglottic swelling obstructing three-quarters of the airway. Tracheotomy was performed and, as there was no local improvement in two months, laryngofissure was carried out and the tumour removed. Pathological report—capillary haemangioma. There has been no local recurrence. DR. MUNRO quoted a similar case who also had angioma of the face and lip. His patient was treated by radiotherapy with recovery.

A case of *congenital glioma of the nasal cavity* in a baby was also shown by DR. BIRRELL. A fleshy mass completely occluded the left nostril. Professor Dott advised that this be aspirated, and that if there be no clear fluid present it be removed. This was carried out, and the tumour, which arose from the roof of the nasal cavity at the lower edge of the nasal bones, was snared off. Since operation she has been well, but there is still a small residual mass at the site of the origin of the tumour.

DR. MCDOWALL showed a case of *implantation dermoid in a fenestration cavity* in a woman, aged 47, who had a fenestration operation performed in 1951. There were recurring infections in the cavity but this was completely epithelialized two years later. At this stage a small white cyst was seen on the floor of the cavity lateral to the fenestra. Four months later this cyst had increased in size so as to encroach on the fenestra, without producing a fistula symptom or any deterioration in hearing. Dr. McDowall felt that this was not a simple cyst, but an implantation dermoid resulting either from the edge of the flap turning inwards or from pressure of the packing. DR. HALL supported this view and recalled two other cases in which a large mass of cholesteatoma had been removed. It appeared at the edge of the fenestration flap above the fenestra.

DR. P. V. WADSWORTH discussed three cases of *epistaxis due to hæmorrhagic telangiectasis* who had had various forms of treatment, including cautery, blood transfusions, injection of 5 per cent. sodium morrhuate, X-ray therapy and ligation of the external carotid arteries. DR. OTTY did not consider that deep X-ray therapy was of much help in multiple telangiectasis. DR. CAMPBELL had been using a preparation of Vitamin B with some success in epistaxis. DR. CHRISTIE recommended ligation of the anterior ethmoidal arteries for intractable epistaxis.

DR. K. MCLAY showed a boy, aged 7, with nasal speech due to *imperfect development of the palate*. The short insufficient palate was associated with a bony defect of the hard palate. DR. BIRRELL said he had had experience with a number of these cases, one of whom had had a pharyngoplasty performed by

https://doi.org/10.1017/S0022215100050350 Published online by Cambridge University Press

Mr. A. B. Wallace. All had very deep wide nasopharynges which added to the insufficient closure. All have had speech therapy, but none have shown any marked improvement. THE PRESIDENT said that the child's mother seemed to think that speech therapy had helped him to some extent.

Further cases were shown by the President, two cases of angiofibroma of the nasopharynx; Dr. Farquharson, tuberculous infection of larynx, complicated by a syphilitic infection; Dr. Birrell, collapsed lung due to tuberculosis; and Dr. McDowall, œsophageal case for diagnosis.

Exhibits

DR. HALL gave a demonstration of sixteen photomicrographs in colour illustrating an instance of otosclerosis in identical twins. These slides illustrated the fact that in this case the otosclerotic process had proceeded to a similar stage in both twins, notwithstanding environmental differences, thus suggesting that the hereditary factors in the development of otosclerosis are the more important.

DR. SMITH showed X-rays to demonstrate the limitations of endaural surgery in a well-pneumatized mastoid.

DR. BIRRELL presented X-rays and histological slides of a fatal case of sarcoma of the petrous bone in a child aged 8.

DR. I. M. SEEX had three demonstrations—clinical photographs and X-rays of (*a*) a bilateral mixed parotid tumour; (*b*) a pedunculated tumour of the nasopharynx; and (*c*) osteomyelitis of the temporal bone associated with acute mastoiditis.

https://doi.org/10.1017/S0022215100050350 Published online by Cambridge University Press