Societies' proceedings

THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY

Report by the Assistant Honorary Secretary, R. W. BAILIE

THE One Hundred and Second Meeting of the Scottish Otolaryngological Society was held in the Western Infirmary, Glasgow, on Saturday, 22 May 1971, the President, Dr. H. M. Urquhart, being in the chair.

A paper entitled 'Histopathology of the Temporal Bone' was given by Mr. A. Baxter.

Arising from Mr. Baxter's paper, an interesting discussion took place on the possibility of ingrowth of squamous epithelium during the use of grommets in the eardrum. Mr. Ivan Thomson felt that such ingrowth did not happen with central perforations and thought that lateral grommets should perhaps be avoided. Dr. Hood thought that Schuknecht's tubes were safer with less risk of epithelial ingrowth. Mr. McKinlay described the use of a Silverstein tube left in position for over a year without ingrowth. Mr. Brennan reported a case where a grommet was retained for $2\frac{1}{2}$ years without trouble, but Mr. Finlay Brown and Mr. Mitchell wondered whether the grommet in such a case might not be sitting on the surface of the perforation which had healed.

Mr. K. J. Zachariah read a paper on 'Malignant Melanoma of the Nose' which was followed by some discussion. The President described a patient with melanoma which persisted for thirteen years, death then occurring from natural causes. Mr. McNaughton and Mr. Munro recommended the use of Cryosurgery for some of these cases. Dr. Hood presented a case of Malignant Melanoma of the left mid-meatal region of the nose in a male aged 56 years with a past history of pulmonary tuberculosis. Ten applications of Cryosurgery had made little impression and excision via lateral rhinotomy had to be done. Mr. Russell said that in his experience with an alveolar carcinoma, cryosurgery reduced the size of the tumour and made it suitable for excision.

Dr. Chandrachud showed a female aged 38 years with conductive deafness dating from childhood with a familial history of deafness which was found to be due to the absence of incus, the stapes being normal and mobile. X-ray of facial bones showed hypoplasia of mandible and condyles.

Dr. Hood showed a similar case (a girl aged 15 years) who had a right-sided conductive deafness. Exploratory tympanotomy revealed the absence of the stapes crura, the footplate being mobile. Head and neck of stapes was attached to the incus with a mobile joint, the incudo-malleolar joint also being mobile. The gap was bridged by insertion of a 3 mm. polystrut with a good result.

In discussion, Mr. Gibb thought that if this was a developmental defect of the second arch type, the long process of incus would also be missing.

Another congenital defect was demonstrated by Dr. Hood in a female

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patient, age 27 years, with a history of fragilitas ossium with severe bilateral deafness of five years' duration. At left-sided stapedectomy, when the footplate was perforated by the burr, there was a massive escape of perilymph fluid which at the end of operation even lifted up the eardrum. The escape of fluid finally ceased on the fourth day but strangely, this patient had no postoperative vertigo.

Considerable discussion ensued and Dr. Hood quoted Paul Wood as saying that in these cases, there is a direct fracture into a focus of otosclerosis which caused the fluid to escape. Mr. Bailie described a case where the stapes fixation was associated with congenital fusion of cervical vertebrae and where the escape of fluid was so massive on attempting to fracture the stapes crura that it could only be controlled to some extent by pushing the footplate back into the oval window and the operation was abandoned. Mr. Doig had such a case which he was able to control by tilting the operating table until the patient was almost vertical. Mr. McLay recommended hypotensive measures which tended to reduce the cerebro spinal fluid pressure but Mr. Mitchell said this had no effect in his case.

Among other interesting laryngeal cases, Mr. McKinlay showed a case of multiple squamous papillomata of larynx found unexpectedly during induction of anaesthesia for cystoscopy when emergency tracheostomy had to be performed. The papillomata were treated by ten applications of cryoprobe at about monthly intervals with restoration of an adequate laryngeal airway but the report from the last biopsy showed *in situ* carcinoma.

In the discussion after this case, Mr. McKinlay suggested that preoperative preparation was not always what it should be and he recollected being involved previously in a similar way with a patient whose aberrant thyroid was causing laryngeal distortion. Mr. Russell supported the present management of the case. He also said it was feasible to apply liquid nitrogen via a bronchoscope to lesions as low as the carina when used with care.

The laryngeal problem in the form of a subglottic stenosis in a 22-year-old female patient was described by Mr. Bratten. This followed on the use of a cuffed naso-tracheal armoured intubation tube of latex which was left *in situ* postoperatively. Tracheostomy was required, followed by dilatation and the use of steroids but eventually excision with split skin grafting of the stenosed area was carried out. Mr. Bratten also showed a case of sarcoid of the epiglottis in a 41-year-old male patient. The original pathological report was 'granuloma without caseation ? tuberculosis'. Kveim test was positive. No evidence of generalized sarcoidosis was found and no treatment was given as the patient's only symptom was hoarseness.

A total of fifteen cases attended for examination.

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