Societies' proceedings

THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY

THE one-hundred-and-first and Diamond Jubilee meeting of the Society was held in the Ear, Nose and Throat Department of the Royal Infirmary, Edinburgh on 21 November 1970, the President, Mr. C. D. Weir, being in the Chair.

In the morning, cases were demonstrated in the out-patient department discussion taking place in the afternoon after the Society's Lecture had been given by Dr. Douglas Guthrie. This was the inaugural lecture and was entitled 'Sixty Years of Otolaryngology' published in the June 1971 issue of the Journal of Laryngology and Otology.

The patients attending for examination included a variety of laryngeal cases. Recurrence of carcinoma larynx after 15 years must be extremely rare but arose in a case presented by Dr. Farquharson: A man aged 62 years who had a well differentiated squamous carcinoma of right vocal cord excised by laryngofissure in 1955. He was well until 1969 when he developed haemoptysis and direct laryngoscopy then showed a granular mass involving the right ventricular band and the right lateral wall of the upper trachea. Biopsy showed well differentiated squamous carcinoma and it was treated by radical radiotherapy but persisting subglottic tumour was found one centimetre below the anterior commissure in April 1970. Total laryngectomy was carried out with hemi-thyroidectomy as it was difficult to mobilize the thyroid but it was free from tumour on microscopy. The patient progressed well after operation developing a useful oesophageal voice and returning to work.

A woman aged 72 years had adenolymphoma of right vocal cord excised by laryngofissure route in 1965 and she was presented by Mr. Buchanan at the meeting, showing no sign of recurrence.

Considerable discussion ensued when Dr. McLay showed a case of bilateral adductor paralysis following general anaesthetic for incision of perineal abscess on 29 January 1970. She was hoarse on recovery from anaesthetic and he saw her three months later when there was some improvement in her hoarseness. Indirect laryngoscopy showed failure of adduction of both vocal cords on phonation and coughing. Myasthenia gravis was excluded. As far as could be ascertained an endotracheal tube without a cuff had been used for her anaesthetic. By November 1970, her voice was markedly improved but indirect laryngoscopy showed the left vocal cord to be immobile in paramedian position with the right cord compensating very well. Dr. McLay found no account of this as a complication in the literature and wondered if the anaesthetic was a 'red herring'. He had found a marked increase in complications following influenza in 1970, including one case of bilateral abductor paralysis, several cases of anosmia and three with perceptive deafness, one of whom recovered.

Dr. Duff had seen a similar case where the cords did not adduct normally following injury to larynx or base of skull in a road accident.

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Dr. Farquharson had seen recurrent laryngeal paralysis after severe dysentery in the Middle East and this had cleared up after three months.

Drs. Gabriel, Hood and Brown had seen recurrent paralysis occurring after intubation but Dr. McLay stressed that in this case it was an adductor paralysis. He thought that the left cord was now starting to move.

Another post-intubation problem was shown by Dr. G. D. McDowall but in this case (a boy of eight years unconscious for four weeks after head injury), the endotracheal tube had been left in position for eight days for intermittent positive pressure respiration. He was very hoarse with ulceration of both vocal cords on extubation but in less than three months had made an impressive neurological recovery. Direct laryngoscopy after three months showed normal vocal cords with a clearly defined white circumferential band causing subglottic stenosis. The stenosis was dilated up at fortnightly intervals with marked improvement after two months. After a further six weeks tracheostomy was required following direct laryngoscopy with possibly super-added upper respiratory infection. Within a further four months his subglottic stenotic area had disappeared. Dr. McDowall was glad that he had been prevented from being too bold in his management of the case and Dr. Farquharson complimented him on his conservative treatment. Mr. Doig said that where stenosis develops with a tracheostomy lower down the trachea it makes a much bigger problem and he described a case of his own with a stenosis 1½ cm. above carina where there was no response to dilatation. He was referred to the Thoracic Surgeons and died from obstruction shortly afterwards while awaiting further dilatation by them as they had decided against excision. Various suggestions as to bouginage were made and Dr. McDowall advised the utmost gentleness.

Dr. McCallum showed two cases of nasopharyngeal angiofibroma with good response to radiotherapy and the President agreed that radiotherapy was preferable to surgery in many of these cases.

Dr. Buchanan showed a case of congenital anomaly of the posterior fossa (Arnold Chiari Malformation).

Drs. Dale, Duff, Bradwell and Cowan also presented cases, the billet comprising a total of 16 cases.

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