in the wall of the canal. I have recently seen a few cases of long-standing Bell's paralysis in which complete restoration of the nerve had not taken place. All had been treated on the assumption that they were due to neuritis. In all of them drooping of the angle of the mouth and of the outer end of the eyebrow on the paralysed side was noted. All such cases should be carefully tested for middle and inner ear mischief.

SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

President—Mr H. J. BANKS-DAVIS, M.B., F.R.C.P.

April 4, 1924.

Case for Diagnosis—T. JEFFERSON FAULDER, F.R.C.S.—An ex-gunner, aged 33, produces an unusual kind of stridor. His history is that he was exposed to gas (mustard) at Ypres, in September 1917, was then sent home, and was in the Military Hospital at Croydon for two months. On discharge he was sent to a camp in England on light duty. He states that in the early part of the following year (1918), while on light duty, he lost his voice, and began to have his present difficulty of breathing. For want of a better word this has been called stridor. It is audible at a great distance, and sounds like the noise of a pressure-pump or safety-valve of an engine. Nose and throat show nothing abnormal. The epiglottis is thin, flaccid, and abnormal. There is some congestion of the larynx, but no paralysis has been seen. There is no sign of ulceration either past or present.

Mr HERBERT TILLEY said he was wondering if this case would prove to be similar to one he had described in the *Journal of Laryngology and Otology*, January 1920, viz., an intratracheal tumour which was removed by peroral tracheoscopy. The man had suffered from mustard gas poisoning with such immediate tracheal symptoms as coughing, spitting of blood, etc., and within a few weeks he commenced to have increasing difficulty in breathing. When examined by the speaker, the larynx seemed normal and the upper four rings of the trachea could be seen, but nothing beyond these He then got the patient to lean over, while he (the examiner) knelt on the floor below him; a method which brought the lower end of the trachea into view. There was now seen a ball-like tumour rising and falling with expiration and inspiration. Its removal by the direct method was accompanied by free bleeding. The patient was seen last year and had never had any further trouble from the condition. Professor Shattock cut a

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section of the tumour and it was found to be a granuloma. It was considered that an ulcer had been caused by the mustard gas, and that the granulations covering it had become pedunculated. He got Mr Faulder's patient to assume the same leaning-over position, but no definite lesion was apparent in the lower tracheal region. As during sleep the breathing was said to be free and noiseless, he (the speaker) suggested that the man be given an anæsthetic, and direct peroral examination be made to see whether there was a tumour lower down.

Mr H. J. BANKS-DAVIS (President) remarked that he noticed the epiglottis was very thin, and flapping up and down, also that the voice was much altered.

Sir JAMES DUNDAS-GRANT said he supposed it would be agreed that this was a functional condition. Failing a positive result of X-ray or direct examination, his impression would be that it was due to "shell-shock." Apparently during sleep the vocal cords moved normally. The noise was louder than any tracheal stridor he had ever heard.

Mr HAROLD BARWELL said the stridor in this case was not due to a lesion in the larynx, because it was of an expiratory character. His impression was that it was functional, though he did not know what was the mechanism of its production. He asked whether Dr Hill had knowledge of any case in which paralysis of muscle between the tracheal rings had caused stridor.

Dr WILLIAM HILL (in answer to Mr Barwell) said it might be a spasm. In many cases of asthma the sound came from and was produced in the trachea as well as in the bronchi, and that was, presumably, spasmodic. Some tumefaction might be left after the poison gas, and some consequent stenosis.

Mr A. J. WRIGHT said he also regarded the case as a functional one. Recently he had seen a servant girl with a somewhat similar condition. She was propped up in bed, and medical attendant and mistress were anxiously hoping that he (the speaker) would be in time to perform tracheotomy. The condition proved to be entirely functional, and cleared up under appropriate treatment. The present patient worked very hard to produce his sounds, and there was sufficient projection in an open glottis to produce the sound if a sufficient blast of air was sent through.

Dr IRWIN MOORE said he thought that in this patient there might be granulations or a papilloma occupying the carina. He also thought the cause of the noise might be the flaccid condition of the epiglottis. Mr Faulder said that the sound ceased if the epiglottis and tongue were held forward.

Mr FAULDER (in reply) said that the man was much worse when he first saw him that day, and that when he entered into a conversation the noise ceased. When looking into the larynx with the mirror, one could see only the flaccid epiglottis with the tip apparently behind the arytenoids, and when the tongue was effectively drawn forwards, the noise ceased. The absence of scarring or evidence of stricture would exclude the possibility of it being due to stenosis, and he did not think the cause was paralysis. No one knew, in the sense of being an eye-witness, what the epiglottis could

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do, because the mere opening of the mouth presented a complication, and depressing the tongue or pulling it out was another. Still, it was certain the epiglottis could move through nearly two right angles. Twelve years ago he showed a case in which one could see the whole larynx and epiglottis without the aid of instruments; that of an old man who for nearly forty years had had rodent ulcer of the face, which had destroyed both upper jaws, the whole of the hard and soft palate, all the nose, both sets of ethmoid cells, both internal pterygoid plates, one orbit and all its structures, and all the soft tissues of the parts he had named, hence larynx and epiglottis were visible without instruments. The epiglottis was normal, and the man could make extraordinary movements with it, and could put it in a direction downwards and backwards when he so desired. The present patient's epiglottis was not normal, but a flat flabby structure, and he (the speaker) thought the whole condition was due to the epiglottis; it seemed as if he had learned to dissociate one peristaltic act of swallowing from the rest. There was no sign of ulceration or scar tissue from the gassing, and this symptom did not appear until a good many months after his discharge from his first military hospital and when he was in a rest camp. He thought it was due to some suggestion or functional disorder. Those who were in France would have seen men exhibiting all the signs of gas poisoning when there was no gas at all, but only the ordinary odour. Also they would have seen functional aphonia spread in an epidemic manner from one man to another. He thought this was an acrobatic trick acquired by a man in a rest camp, which was probably a prolific hunting-ground for suggestion.

Mr E. D. D. DAVIS said it would do no harm to take the top off the epiglottis, as was sometimes done in the case of tubercle or malignant disease.

Laryngeal Tuberculosis in a Child aged 4½ Years—M. VLASTO, F.R.C.S.—The total duration of the illness was three weeks. It started with an attack of croup and vomiting on 14th December 1923. The condition was diagnosed as diphtheria. There was hoarseness, slight stridor with recession, but no distress. The fauces were red and swollen, but there was no dysphagia: no exudate: no other physical signs. Diphtheria cultures were negative. On 29th December and on 7th January there were attacks of acute dyspnœa, with stridor associated with mild pyrexia. The case was diagnosed as one of papilloma of the larynx. I saw the child on 10th January. There was hoarseness and inspiratory stridor. I decided to inspect and treat the laryngeal condition by direct methods later on. The child died the same night of heart failure. The post-mortem showed extensive thoracic and abdominal tuberculosis with ulceration of the laryngeal and para-laryngeal structures.

The case is reported on account of the rarity of tuberculous ulceration of the larynx in a child so young, and because of its clinical interest in presenting a contrast between its course and that usually obtaining in the adult.

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Dr JOBSON HORNE observed that the preserved larynx seen through the round glass jar presented the appearance of superficial ulceration, and not that deep ulceration, tumefaction and destruction consequent upon the infiltration and eruption of tubercle so typical of laryngeal tuberculosis.

Many years ago, as the outcome of post-mortem research he (Dr Jobson Horne) had been able to formulate the conclusions that when the disease presented those features in the larynx, cavitation had been established in the lung; further, that in miliary tuberculosis of the lungs, the prevalent form in children and without cavitation, laryngeal tuberculosis did not occur. Hence the rarity of laryngeal tuberculosis in children. However, in 1898, he demonstrated the larynx from a child aged twelve months who had died from miliary tuberculosis, and yet the larynx presented most typical features of laryngeal tuberculosis. The explanation was that a tuberculous bronchial gland had broken down into the adjacent lung and had established a cavity. Hence an exception that proved the rule he had deduced from post-mortem observations.

Mr CYRIL HORSFORD said he had at present under his care a case which seemed, clinically, to be similar to this, namely, a child, aged 6. There was marked laryngeal stridor. He took the patient into hospital and, under chloroform, carried out direct inspection. There was no papilloma, but some thickening of both ventricular bands and the inter-arytenoid space. He had not yet heard the result of the full examination, and before the report of Mr Vlasto's case was published he would like to ascertain whether tuberculosis was present in his own case.

Epithelioma of Vocal Cord, treated by Thyrotomy—Sir JAMES DUNDAS-GRANT, K.B.E., M.D.—Male, aged 35, was first seen on account of hoarseness. The hoarseness had been present for four or five years, and appeared to have commenced with attacks of bronchitis both during and since the war. He was referred to the Throat Department of Brompton Hospital by Dr Burrell, and it was then found that the whole length of the right vocal cord was occupied by a papillated swelling which extended well into the anterior commissure. There was diminished mobility of the cord. A diagnosis of epithelioma was made, and it was confirmed by microscopical examination of a portion which I removed by means of my intra-laryngeal forceps.

On 29th November I performed laryngo-fissure, but in view of the fact that the growth extended into the commissure and probably across the middle line, I sawed through the thyroid cartilage, as recommended in such cases by Chevalier Jackson, avoiding any section of the soft parts until the alæ were drawn apart; the whole of the right cord and a portion of the left were then removed.

Mr HAROLD BARWELL said Mackenty, of New York, stated that infiltration into the anterior commissure was a contra-indication to removal of malignant growth by laryngo-fissure; but the present case was an example to the contrary, and did not support that dictum.

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Dr IRWIN MOORE said Sir St Clair Thomson had operated by laryngofissure on a large number of cases in which the anterior commissure was infiltrated and they were still alive. He asked whether Sir James anticipated some difficulty in swallowing in this case.

Dr CAVENAGH asked how long an interval elapsed before Sir James removed the growth after taking away a piece for examination.

Sir JAMES DUNDAS-GRANT (in reply) said that in this case he carried out the method recommended by Dr Chevalier Jackson, avoiding any section of soft parts until the alæ were divided and drawn apart. In cases in which the disease was confined to the middle of one vocal cord, it was best to open the larynx by means of a curved bistoury from within, so as to make sure of getting between the vocal cords from below. In this case the disease went across the middle line, and those who were at the Paris Congress would know Dr Chevalier Jackson's counsel that it was advisable to saw through from the outside. He took out so much of the soft parts on both sides that he felt apprehensive as to the patient having some difficulty in swallowing liquids at least for a day or two.

The interval between taking away a portion for examination and the performance of the operation was longer than he would care to allow if it could be avoided: in this case it was probably a month. But he did not think the patient's interests suffered from the delay. The voice was chiefly produced by the ventricular bands, and it was as good as could reasonably be expected.

Tracheal Stridor from Pressure—Sir JAMES DUNDAS-GRANT, K.B.E., M.D.—Male, aged 38, was first seen in October 1923, complaining of dyspnœa when recumbent; this symptom was quite recent but he had had more or less huskiness of the voice since December 1922. He had signs of tuberculosis in the chest and bacilli in the sputum. On laryngoscopic examination the vocal cords were seen to be infiltrated, but, below them, the view of the trachea was interfered with by the presence of an obstruction of a pale pink colour, the outlines of which were not perceptible, but it was probably a bulging of the anterior wall. To the left of the trachea, just below the level of the cricoid cartilage, there was a swelling perceptible on deep palpation. Direct laryngoscopy, so far as permitted by the state of the larynx, gave no further information; an X-ray examination was made; it suggested that the trachea was curved forwards by pressure from behind. The cervical vertebræ were carefully examined, but there was no evidence of caries such as might account for abscess formation. The patient subsequently reported that he could only lie on the left side, and that when he bent his head over to the right the throat seemed to close. The swelling in the trachea gradually diminished to such an extent that it was possible to see past it and note that it projected chiefly from the anterior wall. On 27th December he coughed up a small crescentic piece of bone, the nature of which is not evident; he had felt something loose in the

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throat the night before. From that time the breathing improved and, on 1st January, it was obvious on laryngoscopic examination that the bulging from the anterior wall had considerably diminished and allowed of fair breathing space. He has steadily improved as regards his stridor.

Dr WILLIAM HILL said that the piece of bone coughed up might be the upper or lower border of the cricoid. He (Dr Hill) had shown the patient here two or three months ago; he was the subject of tuberculosis.

Extensive Lupus of the Upper Air Passages treated by Radium—H. M. WHARRY, F.R.C.S.—Female, aged 28, attending Mount Vernon Chest Hospital.

History.—Tuberculosis of right apex, which has been quiescent for some years.

1918.—Suffered from nasal obstruction.

1919.—Her voice became hoarse and completely disappeared.

1920.—Tuberculosis of larynx diagnosed. Wassermann reaction negative.

For four years she lived the life of a recluse for fear of infecting others, and also owing to her being unable to speak to anyone.

June 1923.—Seen by me; lupus diagnosed.

Condition when first seen.—General condition good. Tuberculosis of lungs quiescent. *Nose*—Cartilaginous part bulging as if from large polypi, but in this case bulging caused by extensive crusting within the vestibule. Posterior edges of vestibule and anterior ends of inferior turbinates were covered with large crusts, which also surrounded a perforation of the septum about the size of a threepenny-bit. The nose was almost completely obstructed by the crusts. On removal of a crust a swollen and bleeding surface was revealed. *Post-nasal space*—In right choana and resting against the septum was a rounded white tumour about the size of a hazel-nut. *Pharynx and Fauces*—Uvula was rigid and much swollen, with granular surface. Granulations extended down posterior left faucial pillar and both right pillars and right tonsil bed. Pharynx was scarred from healed lupus. *Larynx*—Epiglottis scarred, deformed, and apparently healed. Both ventricular bands and vocal cords were covered with fine granulations, and there was swelling of interarytenoid region with granular surface. *Phonation*—Whole larynx stiff, and cords did not approximate. *Voice*—Nil; whisper very feeble.

5*th to* 9*th November* 1923.—Treated by Dr Teichman at Radium Institute.

21*st November* 1923.—Crusts escaped from nose; airway established.

5*th to* 19*th December* 1923.—Voice returned; uvula and fauces improved.

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14th to 18th January 1924.—Treated by Dr Teichman with radium. Whole condition much improved. Tumour of right choana broke down and disappeared. Further improvement in state of larynx. Voice easier, but still a little husky.

Dr WILLIAM HILL said it had not been usual to treat lupus in the air passages by radium on account of its very indifferent action, unless it was carried to the point of producing necrosis. In the present case it had been used practically as a cautery, and when pushed to that degree one never quite knew where the process would stop ; the same applied sometimes to diathermy in the air passages. He had been chary of using diathermy in the larynx because of the cartilages. As, however, radium seemed to have had a good result in this case, he supposed such a view would have to be revised. If cauterising agents were required, there were several which could be better controlled than radium, and cutting operations were very precise.

Sir JAMES DUNDAS-GRANT said he would like to hear details as to how radium was used. Excellent results had been recorded from light treatment, uncovered by glass, such as was used so much at the London Hospital.

Mr NORMAN PATTERSON said he hoped to show, at the next meeting, a case which had been treated by artificial light. The results in that case had been extraordinarily good.

Mr HERBERT TILLEY said he would remind those members who were present at the Paris Congress, in 1922, of the cases of lupus of the nose which they had seen treated by diathermy, and without, so far as could be judged, any results in the way of bone necrosis. Patients came to the out-patient department, cocain was applied to the diseased areas, and the diathermy current passed through the metal seat of the patient's chair. The lupoid material in the nose was removed with very great efficiency, and there seemed to be no damage to neighbouring bones or cartilage.

Dr OSKAR TEICHMAN said this case was treated in the routine way. During the two years he had been connected with the Radium Institute he had not seen a case of necrosis.

This patient was first treated in November 1923, when she received an irradiation of the larynx externally for twenty-five hours, with the equivalent of 156 mgr. of radium bromide, screened with 2 mm. lead, so as to produce the Gamma, or deep, radiation. The nose was treated for two hours with 25 mgr., screened with 1 mm. silver, so as to get some of the Beta destructive rays also. On 14th January 1924, she received an irradiation of the larynx externally by plates, 110 mgr. for fifteen hours, screened with 2 mm. lead. Then she received six hours' irradiation with 25 mgr., screened with silver, 1 mm. to the uvula, right nasal fossa and the right nostril. The radium salt was in a little tube, held in position, after cocainising the spot. This treatment was carried out at the Institute fairly frequently, and he knew of no cases of necrosis. The treatment was elaborated by Mr Hayward Pinch, Director of the Radium Institute, who, the speaker believed, had practised it for eleven years.

Mr WHARRY (in reply) said that, from the clinical point of view, radium had a great advantage over any other method he had seen. The diseased

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area seemed to heal up without the formation of scar tissue. In one case he had seen recently, which had been treated by scraping, there was complete obliteration of one side of the nose by scar tissue. In the present case, however, after the first application of radium, the crusts came off, and left a smooth, pink surface, which gradually shrank down, and eventually the nose condition cleared up. Recently the patient had had a slight relapse and that had cleared up.

With regard to the larynx, the infected surface became œdematous and was covered with a sticky secretion, and during that reaction some mucous membrane appeared to grow over the surface, but it shrank down later. That had been going on in stages after each application of the radium. The whole aspect of the case was entirely altered in a short time, though previous to this treatment the condition had been going on for four years. The voice returned and the patient could breathe through her nose fairly well six weeks after the first application of the radium.

Tumour of the Left Vocal Cord—T. JEFFERSON FAULDER, F.R.C.S., and F. C. ORMEROD, M.D.—Female, aged 60, gave a history of hoarseness which is said to have followed an operation for removal of a tumour (lipoma?) from the shoulder five years ago. The hoarseness is very marked and has persisted continuously with the exception of a short period three years ago when the voice returned. Previous to the operation, five years ago, tumours—probably papillomata—had been removed from the skin over the knee and the scalp.

A papilloma was attached to the uvula and a smooth rounded swelling of the left vocal cord chiefly involved its anterior two-thirds. The cord appears freely mobile but is somewhat hindered in adduction by the tumour. Nothing abnormal was found in the chest and there were no tubercle bacilli in the sputum.

Mr TILLEY regarded the condition as simple papilloma, and thought that removal in the ordinary way should have an excellent result. If it were considered to be anything else, an alternative diagnosis lay in the direction of epithelioma, but such a large growth of that nature would have infiltrated the cord, which was now moving freely.

Six months ago he had had an apparently identical case in a man 50 years of age. He thought it was malignant, and he took the growth off. It was sessile, and was removed by the direct method, a cure resulting. It was said that the present patient had papillomata on other parts of the body. A patient was sent to his department from the Gynæcological Department of the hospital—a woman from whom a uterine fibroid had been removed—and she was hoarse on account of fibroma of the vocal cord. In that case, as in this, he thought the association in the same patient was no more than a coincidence.

Mr FAULDER (in reply) said that the case resembled one shown before the Section a year ago. To-day the tumour was smaller than he had yet seen it. At the present time she had a papilloma of the uvula. The case shown last year was diagnosed as fibroma, and that patient also had a papilloma of the uvula. He asked what happened to these cases if nothing

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was done. This patient has had a hoarse voice five years, and the other patient he mentioned had been hoarse six years, and refused treatment, yet in her nothing seemed to have developed.

Tumour on Right Side of Larynx—H. J. BANKS-DAVIS, M.B.—Woman, aged 43, with a tumour on right side of larynx was exhibited at the November meeting, 1923, as a case for diagnosis.

Laryngo-fissure was performed on 5th January, and a tumour of considerable size was removed from the right side of the larynx and arytenoid region. The tumour, which shelled out easily, looked like a fibroma. The woman left the hospital to all intents and purposes relieved of her obstruction. The pathologist was certain it was malignant, but I do not think there is the same certainty now. She has now a recurrence at the site of the original growth, and peri-chondritis, great difficulty in breathing, and granulations on the larynx; the latter I could easily remove with Mackenzie's forceps. I shall be glad of assistance in regard to the diagnosis. Wassermann reaction is negative.

Dr W. HILL said it was admitted that there were columns of epithelium in the section, and a large amount of œdematous structure. He did not know whether the tumour was made up of ordinary enlarged glands from the ventricle.

Mr G. W. DAWSON said it was a very large tumour occupying the right side of the larynx, and if it had been malignant it probably would have ulcerated by this time, because of its size, but it had not done so.

Mr HAROLD BARWELL thought the tumour was possibly septic.

Sir JAMES DUNDAS-GRANT said it looked like an adenoma.

Mr H. J. BANKS-DAVIS (President) (in reply) said that Mr Elworthy considered it should be regarded as a low-grade malignant type of growth. An aspirating needle showed that it was solid. He (Mr Banks-Davis) thought it likely that the patient would have been better off if he had done nothing, but she pressed for an operation owing to occasional stridor. To-day the left side had not a normal appearance. Four months ago he tried the effects of mercury and iodide of potassium, but without result.

Tumour in the Posterior Wall of the Pharynx—H. J. BANKS-DAVIS, M.B.—Male, aged 45, exhibited in November 1923.

He had a tumour in the posterior wall of the pharynx pressing down the epiglottis and occluding the airway. Thinking that he had a posterior pharyngeal abscess I incised it and found it was solid, resembling a lipoma.

Wassermann reaction was positive. The patient has been treated with iodide of potassium only and the tumour has almost entirely disappeared. If it had been a gumma, it would have ulcerated, and it would have left a scar.

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Mr T. JEFFERSON FAULDER said that Sir Robert Woods had reported a case of retropharyngeal tumour in which there was said to have been no difficulty in diagnosing it from abscess; therefore, he (the speaker) reported a case of his own in which it could not be settled which it was. What was the proper incision by which to approach this case? Sir Robert Woods' case was operated upon from in front of the sterno-mastoid; he (Mr Faulder) did his operation from behind the sterno-mastoid, which was the correct route for chronic abscess or retropharyngeal tumour. The tumour in his case seemed to be underneath the prevertebral fascia, and it was 6 in. or 7 in. long. He did not see why a gumma should not develop in the fibrous tissue there.

Mr E. D. D. DAVIS said an incision at the anterior border gave much better access. A retropharyngeal abscess usually pointed at the posterior border of the sterno-mastoid and could be approached from this position.

Mr NORMAN PATTERSON said he did not agree with Mr E. D. D. Davis' view. In a case of his own an attempt was made by the house surgeon to open in front of the sterno-mastoid, but it failed, and he himself had to open posteriorly. If one made a long incision and pulled the sterno-mastoid forward, it was easy to get a good view of the retropharyngeal region, and one did not then interfere with the carotid sheath.

Mr H. J. BANKS-DAVIS (President) (in reply) said that at one time it was taught that in all these cases the opening should be made from the neck, as the cases became septic. But it had been found that the abscesses could be opened from the mouth with perfect safety. In a case of retro-pharyngeal abscess in a baby, with much œdema, he made his incision in the neck, behind the sterno-mastoid as he thought, but he was really in front of it. The patient did quite well, however.

Laryngeal Growth (? Cyst)—JOHN F. O'MALLEY, F.R.C.S.—Female, aged 33, complains of hoarseness of thirteen years' duration. A smooth semi-translucent mass is seen on the left side, on the upper aspect of the vocal cord and overhanging its free border. It prevents the approximation of the two cords on phonation, hence the blurring of the voice.

Exhibitor would like opinions (*a*) as to its proper nomenclature on pathological lines; (*b*) its exact attachment; and (*c*) suggestions for best method of removal or treatment.

Dr JOBSON HORNE said that the attachment seemed to be to the anterior commissure. As he considered it an innocent growth, he would remove it by the indirect method with a pair of Krause forceps.

Mr HERBERT TILLEY suggested that a cocain solution and some ordinary curved probes should be provided for cases of this kind so that they might be more easily inspected. He could not see the tumour in this case.

Mr G. W. DAWSON said he saw the tumour; it was flapping about underneath the vocal cord.

Mr HAROLD BARWELL said that removal should not be particularly difficult by the indirect method, and he would remove it in that way, as suggested by Dr Jobson Horne.

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Mr J. F. O'MALLEY (in reply) said that it was his intention to try to effect removal by the indirect method. Curved forceps should get on to the main mass; he did not think the attachment would be very broad, and no severe lesion would be likely to follow the attempt to remove it.

(?) Carcinoma of Anterior Portion of Floor of Mouth with another quite Separate Growth (? Carcinoma) in the Larynx—NORMAN PATTERSON, F.R.C.S.—Male, aged 60, had for six months noticed a small lump on the right side of the tongue; for three months a swelling on left side of neck, slowly increasing. He was a pipe smoker.

A large indurated area occupied the floor of the mouth on the right side; the tongue and alveolus were also involved; tumour involved the epiglottis and aryepiglottic region. A large mass of glands was situated high up on left side of neck.

Sir JAMES DUNDAS-GRANT said he understood that this case was not as typical of epithelioma as the appearance led one to think it would be.

Mr NORMAN PATTERSON (in reply) said that the patient was sent to him by a surgeon for treatment by diathermy. The growth was on the right side of the mouth, and the mass of enlarged glands was on the left side of the neck. On examining the larynx he found a secondary growth involving the epiglottis and the structures round the orifice of the larynx. All the lesions seemed to be typically malignant; still, he had sections from them cut, taking what he thought to be a characteristic section from the floor of the mouth, and another from the epiglottis. The report stated that there was no evidence of carcinoma, and that the Wassermann was negative. What was the condition? It was not considered to be actinomycosis. He would be glad to give any further evidence possible, and would try to show the patient on another occasion.

Distortion of the Larynx producing Tracheal Obstruction due to Cicatricial Contraction following an Abscess—Sir JAMES DUNDAS-GRANT, K.B.E., M.D.—Male, aged 35, complained of difficulty in breathing and loss of power of concentration. His difficulty began with the occurrence of an abscess in the neck when twelve years old, attributed to a fall.

At present there is a stridor of tracheal rather than of laryngeal character, worse when the head is bent to the left and more audible on inspiration than on expiration. On laryngoscopic examination the larynx is seen to be contorted as if bent over to the right, the left vocal cord being entirely hidden by the ventricular band, while the right vocal cord which is visible, is seen to be immobile; presumably the left cord moves normally. There is a deep cicatricial pit behind the sterno-mastoid at the level of the thyroid cartilage and another in front of the muscle, but much lower down. From the upper depression there is apparently a short fibrous band passing to the thyroid cartilage and probably drawing the right cornu of the hyoid

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bone downwards. The exhibitor would like opinions as to whether liberation of the larynx by operation on the fibrous adhesions is advisable.

Mr MUSGRAVE WOODMAN said that the larynx was drawn over, and that he would advise operative treatment, though it would prove a difficult operation. There was a deep and tense band passing obliquely from the larynx towards the inner end of the clavicle, and when the sterno-mastoid was drawn outwards, it was found to be drawing up the subclavian vein, and it was closely connected with the internal jugular vein, and probably with the dome of the pleura. The larynx having been straightened, how could it be kept so? It was of no use to sew up and allow a blood-clot to form, as there would be recurrence. One might take a layer of fibrous tissue from the fascial planes, turn it in, and protect it from fibrous tissue. Or there could be carried out a method which was originally suggested by Mr Wilfred Trotter, which the speaker had used several times for approaching the side of the pharynx and the œsophagus, namely, sewing the sterno-mastoid down to the prevertebral muscles in front of the carotid sheath and internal jugular vein; there would then be a layer of muscle outside the sterno-mastoid passing down to the prevertebral muscles, and one could see the larynx from the side. The great difficulty would consist in safely isolating the larynx, dividing the fibrous tissue, and getting the condition rectified.

Sir JAMES DUNDAS-GRANT (in reply) said that the stridor was tracheal, and particular attitudes had to be adopted by the patient to enable him to breathe. He considered that the cicatricial mass involved the recurrent laryngeal nerve, as there was no movement of the right vocal cord. The chief complaint made was that of inability to concentrate, and it was possible by means of a good-sized tracheotomy tube to enable the blood to be oxygenated and in this way to allow the patient to recover his nerve. He hoped to show the case again after the operation.

Diathermy Removal of Epithelioma of Left Tonsil, Soft Palate, Faucial Pillars, and Tongue—DAN M'KENZIE, M.D.—Female, aged 70. The operation was performed on 27th June 1923. The external carotid was ligatured and a chain of small glands removed. In the diathermy puncture of the tissue between the neck wound and the growth in the pharynx the internal jugular vein was accidentally punctured by the diathermy needle, and had to be ligatured.

The growth in the throat was removed in one mass, except for an infiltrated area in the lateral pharyngeal wall behind the tonsil, which was destroyed by the diathermy as far as possible.

During convalescence the patient was found to have glycosuria. It did not affect the healing of the wounds in the slightest degree.

Sir JAMES DUNDAS-GRANT said that there was no return of the disease, nor sign of glandular involvement, and, so far, the case seemed successful.

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Mr H. J. BANKS-DAVIS (President) asked what was the object of tying the external carotid and jugular if removal was to be by diathermy?

Mr NORMAN PATTERSON said that in a case of high blood-pressure to be treated by diathermy, ligature of the external carotid at the time of the operation reduced the risk of hæmorrhage. But he now seldom tied this vessel, since he used a button instead of a sharp-edged electrode. Ligature of veins seemed likely to increase hæmorrhage rather than to diminish it.

Mr MUSGRAVE WOODMAN said that in the first case of this kind in which he operated the carotid was not tied, and there was severe hæmorrhage. Now, however, he seldom tied the carotid, and there was no trouble. In the opinion of general surgeons the vein also should be tied; either both should be tied or neither. When only one was tied there was much bleeding and oozing, he thought. If hæmorrhage was anticipated, it would be mainly secondary. If the carotid were tied at the date of the operation, secondary hæmorrhage would supervene in from seven to ten days, and if secondary hæmorrhage seemed likely to occur, it would be wise to tie the vessel seven to eight days after the primary operation, to circumvent the collateral anastomosis which so quickly resulted after ligature of the external carotid.

SECTION OF LARYNGOLOGY AND OTOLOGY—BRITISH MEDICAL ASSOCIATION, BRADFORD.

23rd and 24th July 1924.

President, Dr W. JOBSON HORNE.

(*Abstract of Proceedings by Dr J. S. Fraser*).

DISCUSSION ON CHRONIC TONSILLITIS: INDICATIONS FOR AND RESULTS OF TREATMENT.

The discussion was opened by Dr A. Brown Kelly, who said that the two conditions mainly accountable for chronic inflammation of the tonsil were hypertrophy and sepsis. The two were commonly associated. The most usual affection of the tonsils was enlargement in children. An enlarged tonsil, though apparently healthy on pressure, was found to be diseased when examined microscopically; indeed, from the bacteriological standpoint, every tonsil was diseased, but, as we could not use this criterion, it was necessary to base our opinion on the clinical history, concomitant signs, and local aspect. Experience had shown that tonsillectomy did not destroy any important function from the deprivation of which the patient would suffer. The faucial tonsil differed in no way from any solitary lymph nodule excepting in size and complexity.

When the tonsil was removed its functions were carried on by lymphadenoid tissue elsewhere. In children whose tonsils and

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