SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF OTOLOGY

THE NINETY-SECOND MEETING OF THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY WAS HELD IN SEAFIELD HOSPITAL, AYR, ON SATURDAY, 21 MAY 1966. THE PRESIDENT OF THE SOCIETY, DR. I. M. FARQUHARSON, WAS IN THE CHAIR.

After the Business Meeting a paper entitled Congenital Short Oesophagus with Hiatal Hernia was read by John D. Thomson Esq., F.R.C.S., consultant thoracic surgeon.

Discussion on Mr. Thomson's Paper

DR. H. D. BROWN KELLY said that he would like to thank Mr. Thomson for his work on a subject which had interested him greatly. In 1933 Dr. Findlay Ford, in Glasgow, had collected a series of nine cases in schoolchildren and 25 years later Dr. Brown Kelly had traced six of these patients. These six were all actively engaged in productive work; indeed three of them had served in the Forces during the War. They all had symptoms of regurgitation and dyspnoea but only one required treatment. Dr. Brown Kelly thought that the prognosis of such cases on the whole was good, but expected that during the next 10 years some of them would be turning up for further treatment. Dr. J. F. Birrell remarked that he had oesophagoscoped a number of these cases in the Sick Children's Hospital, Edinburgh, and, had been puzzled as to when surgery should be undertaken and, if at all, what surgery should be recommended. He agreed that the presence of blood in the reflux is of great significance, as it indicates a material degree of oesophagitis, which if allowed to persist will eventually result in fibrous contracture. He very much hoped Mr. Thomson would give some guidance as to what to do with these cases.

MR. THOMSON replied that the endoscopist has certainly an important part to play in the management of these cases; his assessment of the extent of the inflammatory changes is of vital importance. He agreed that if the lower oesophageal segment remains inflamed and haemorrhagic for many months and the condition is not relieved by conservative measures then that child will run into difficulties. The problem is to know what to do to help these children, as there is a great variety of operative procedures recommended and it is only too clear that a state of uncertainty exists. So far as Mr. Thomson knew there has been no acceptable long-term follow up of the results of surgical treatment in congenital short oesophagus, and until such is available he felt unable to comment intelligently on the merits of any procedure. In each case there must be close co-operation among the physician, surgeon and endoscopist, and an adequate period of supervised conservative treatment must precede any surgical approach.

Discussion then followed on the clinical cases of patients who had previously

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been in attendance at the out-patient department for examination by members of the Society. These patients were under the care of Dr. C. A. P. Donaldson, Mr. A. T. Stewart and Dr. M. E. Gibb.

Dr. Donaldson's first case was Mrs. L.W., aged 36, with Bilateral Abductor Palsy of the larynx following Partial Thyroidectomy in *July 1965*; it was of interest that on the day after operation she had required tracheostomy for immobility of the vocal cords but this had been allowed to close as the left vocal cord was moving well 2 months later. By *February 1966*, however, tracheostomy was again required for stridor and dyspnoea associated with bilateral palsy which had persisted. Dr. Donaldson invited comments on further management. Dr. T. O. Howie and Dr. McLay spoke against further surgery and Dr. I. M. Farquharson was strongly of the opinion that nothing more should be done as the tracheostomy with valved Negus tube was working admirably and the patient had a good voice. Dr. A. Gibb considered there was a flicker of movement in the left cord and Dr. A. Brownlie Smith recalled a case of bilateral cord palsy of unknown origin which had shown recovery of movement after 8 years. He recommended waiting at least 2 years for possible recovery unless there was proof of actual section of the recurrent laryngeal nerves.

Dr. Donaldson's second case was Mrs. J.S., a nurse who gave a long history of attacks of dyspnoea of sudden onset with loss of voice and coughing up of considerable quantities of blood; she was quite symptom free between attacks. At the time of the most recent attack she was found to have a superficial slough over the right arytenoid and a submucosal haematoma over the left arytenoid and ary-epiglottic fold. Full haematological investigations showed no abnormalities or defects of coagulation. A course of ethinyl oestrodial 0·25 mg. daily had been tried and abandoned as unhelpful. Dr. Donaldson added further that on the last occasions of bleeding this had been almost severe enough to require a tracheostomy to maintain an airway.

Dr. Brown Kelly stated that these cases were certainly very difficult to treat. He himself had a young man with a similar history whose bleeding is controlled by continuous oestrogens; he had lost his voice and now had enlarged breasts but Dr. Brown Kelly considered this was a small price to pay for freedom from these desperate attacks of bleeding. This patient's brother had had his nose removed for bleeding. Dr. Brown Kelly could not believe this at first but he wrote to the surgeon concerned and found that he had indeed removed the external nose together with the anterior ends of both middle and inferior turbinals and the septum. The patient had been given a plastic nose on a spectacle frame and was completely satisfied with the result!

Dr. Baillie also found this a very interesting case; he suggested that it was an example of a rare condition called "angina bullosa haemorrhagica"—in 50 per cent. of such cases there was a demonstrable clotting defect in the blood. He thought this a more likely diagnosis than haemorrhagic telangiectasia. Dr. Farquharson and Dr. Russell agreed with this as there was no sign of telangiectasis of the visible skin or mucous membranes.

Dr. Donaldson added that he had hoped to show a case of Telangiectasia of the nasal septum which had derived no benefit from radiotherapy in 1965. Unfortunately a further gross bleeding had necessitated her admission for

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urgent blood transfusion to Kilmarnock Royal Infirmary. Dr. Farquharson suggested that Dr. Donaldson might consider excision of the nasal septum mucosa and replacement by a split-skin graft.

Among Mr. A. T. Stewart's cases was Mr. J.D., aged 17, a case of osteomyelitis of the frontal bone secondary to frontal sinusitis. He had just presented himself to a general surgeon in *June 1964* with an abscess of the forehead; this was incised on several occasions before he was referred to the E.N.T. Clinic in *February 1965*. At that time he was found to have frontal sinusitis and radiological evidence of antral infection. Intra-nasal antrostomy and antibiotics produced clinical and radiological improvement but by *July* the abscess had recurred and the decision taken for radical measures, after consultation with Mr. J. C. Mustardé, the plastic surgeon. On *28 July 1965* via a large forehead flap, removal of the whole anterior wall of both frontal sinuses—much of it necrotic—was carried out together with obliteration of these sinuses. Healing was rapid and after 8 months on *1 April 1966*, the forehead flap was again raised and the whole frontal bone found to be healthy. The defect was then filled with a silicone rubber prosthesis and the flap replaced. The cosmetic result was good and the patient symptom free. Dr. Gibb congratulated Mr. Stewart on the excellent result; he was surprised that the second operation had been so soon after the first. Mr. Stewart said that he had shown the case as an example of fruitful co-operation between a plastic surgeon and an oto-laryngologist. The decision to repair the defect had been a joint one; in point of fact the patient had successfully weathered three attacks of common cold during the winter without any sign of sinus infection. Mr. Stewart further explained that silicone rubber came in two forms, a powder and a liquid, which form an inert solid when mixed. For small defects it can be cut with a knife but for large and complicated defects it is better to take a mould first of all so as to cast in silicone rubber an exactly fitting prosthesis which could later be put into place.

The next case was a Mr. R.G., aged 18, for whom Mr. Stewart had carried out a myringoplasty for a subtotal perforation of the right drumhead, using vein as the grafting material. At the time of operation he had noted fixation of the stapes although the incudo-stapedial joint was intact. Audiometry had demonstrated a very considerable improvement in hearing but Mr. Stewart was considering re-opening the middle ear with a view to carrying out some form of stapedectomy. He sought comments from other members.

Dr. W. G. Hood congratulated Mr. Stewart on the present result and advised him to leave well alone; this advice was supported by Dr. Gibb, Dr. Farquharson and Dr. McLay. Dr. J. F. O. Mitchell, however, said that in his experience re-elevation of a repaired drumhead was a reasonable procedure; he himself had occasion to do this in several cases. In some the ankylosis of the stapes was caused by frank otosclerosis and in some by tympanosclerosis. Operation was tedious but well worth while. In this he was supported by Mr. J. W. Dixon.

Mr. Stewart also showed two cases of conductive deafness in both of whom the history of discharge and the scarred appearance of drumheads were likely to lead to a diagnosis of chronic otitis media; in both, however, exploratory tympanotomies had revealed otosclerotic fixation of the stapes and stape-

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dectomy with vein and polythene strut had resulted in complete closure of the air/bone gap on audiometric testing.

MR. GRISTWOOD agreed that such cases are well worth exploring and quoted a series of 180 cases of conductive deafness; twenty-two of these had scarring of the tympanic membranes, atrophic areas or calcareous patches, suggestive of intra-tympanic adhesions. All were explored and twenty-one of them had stapes fixation due to otosclerosis. Only one had a mobile stapes.

DR. MURIEL E. GIBB showed a number of cases the first of whom was Mr. H.H., aged 51, who gave a history of removal of nasal polypi seven times between *July 1961* and *January 1966*—at that time Prednisolone therapy had been commenced at a dosage of 15 mg. daily for 10 days and he was now on a maintenance dose of 2·5 mg. daily. The patient was completely free of polypi and the sense of smell had returned after many years' absence.

Congratulations were expressed by Dr. Hood and Dr. Mitchell. Dr. Farquharson and Mr. Dixon, however, were not enthusiastic about the idea of long continued steroid owing to the later general complications. Dr. Gibb, however, said that she has consulted the Ayr biochemist and he has assured her that Prednisolone in a dosage of 2·5 mg. daily is unlikely to lead to any side effects. In any case she proposed to follow the example of Dr. Forbes Walker who 4 years ago had treated a case similarly with similar gratifying results; after 18 months he had been able gradually to withdraw steroid and 2 years later no recurrence of polypi were present.

DR. GIBB also showed Mrs. A.N., aged 49, who first presented in 1962 with nasal obstruction and crusting of long duration, with aphonia since age of 11, and a history of "treatment for her blood" at the age of 18. She had a saddle-shaped nose with narrowing of the right nasal vestibule and a very large septal perforation involving both the cartilaginous and bony portions; crusting in nose and nasopharynx was marked; the soft palate was distorted with scarring and a small perforation was present just in front of the uvula. In *October 1962* the blood W.R. was negative but was positive in *March 1963*. Between *January 1963* and *September 1966* three courses of penicillin had been given, each of 1 mega unit daily for 28 days. The nasal condition had greatly improved and only slight crusting was present in nasopharynx.

DR. WILLIAM C. BROWN asked about the laryngeal condition but Dr. Gibb stated that the larynx could not be seen in a mirror owing to distortion of tissues and the patient had refused a direct laryngoscopy.

DR. BIRRELL said he did not think such septal perforations were often seen nowadays. He recalled the case of an Army Officer he had seen during the war; the officer having had a previous nasal operation. Dr. Birrell had found opacities of the left frontal, ethmoid and antrum and lavage of the latter revealed pus; he did a Caldwell-Luc operation and sent some granulation tissue from the antrum for a biopsy—reported as non-specific granulations.

DR. BIRRELL then went on leave and when he returned he found the nasal septum had perforated. He then took blood for W.R. and of course received a positive report.

DR. GIBB also showed a case of lupus vulgaris of the nose in Mrs. A.D., aged 27. This patient had presented in *May 1964* with a history of nasal obstruction, crusting of the nares and slight swelling of the nasal tip for 1½ years. Typical

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"apple jelly" nodules at that time were noted on the nasal septum floor of nose and on one inferior turbinate. Chest and sinuses were clear on X-ray although there was a history of pleurisy in 1958. Biopsy of the nasal tissue showed a few endothelioid cell follicles with giant cells and scanty A.A.F.B. Treatment with a standard course of Streptomycin, P.A.S. and I.N.A.H. was given for 3 months and later Pycamisan was substituted.

The nose had healed. Dr. Farquharson and Dr. Dixon commented on the rarity of such cases and Dr. T. M. Russell said he has recently seen a nursing sister from Stornoway with a similar condition; it seemed likely that this lady's next door neighbour in Stornoway also suffered from nasal lupus.

Discussion on Mr. Zalin's Paper

MR. WILLIAM MCKENZIE (London): The variation in response to the routine clinical tests of the labyrinth may be due to two other causes besides the end organ itself, which forms the subject of Mr. Zalin's interesting communication.

The differential caloric test is never easy to perform, because the end point is not sharp. A limit of error in the order of 10 or 15 seconds is reasonable.

If electrical recording is made of the nystagmus induced by the caloric test, the response is longer than it is in the usual clinical test, because of the absence of fixation of the eyes. The response may, however, vary in the same patient if the test is made with sedation, and then repeated without sedation.

To add to the difficulty of interpretation, the recording may vary with the same patient at different times, but under the same conditions, suggesting that the activity of the cortex and supranuclear fibres must be taken into account in the interpretation of the caloric test.

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