SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

November 6, 1925.

President—Dr W. H. KELSON.

Chronic Pharyngeal and Œsophageal Stenosis—WILLIAM IBBOTSON, F.R.C.S. Ed.—A female, aged 28, apparently suffered from this condition since early childhood. The nasopharynx is almost completely shut off from the lower region of the pharynx by bands of scar-tissue. There is extensive scarring of the posterior pharyngeal wall. In the larynx (as viewed by indirect laryngoscopy) the glottic opening is free, and the cords move in a healthy manner. The upper entrance into the laryngeal cavity is narrowed by a ring of scar-tissue, so that the pyriform fossæ are not seen, while the cricoidal and lower pharyngeal regions are completely hidden. The epiglottis appears to have been very largely destroyed and replaced by scar-tissue. The obstruction seems to be only to deglutition, not to respiration.

Various forms of treatment have been carried out, including œsophageal dilatation and tracheotomy (wound now closed), but owing to the extensive areas of cicatricial contraction, the patient is unable to swallow solid food. The Wassermann reaction is negative.

Sir JAMES DUNDAS-GRANT thought the condition might be scleroma.

Mr W. STUART-LOW advised a trial of violet-rays.

Sir WILLIAM MILLIGAN said he considered the condition was either post-diphtheritic or post-scarlatinal cicatricial contraction, even though the history to confirm this was lacking. Where so much œsophageal obstruction existed, there was a definite call for gastrostomy, to ensure adequate nourishment. Subsequently an attempt could be made, by means of bougies, to overcome the contraction. He did not think operation on the scar-tissue was of any real value.

Mr G. W. DAWSON said he had exhibited two young people at the Section with a similar condition, and as far as he could ascertain, it came on at puberty, and was due to syphilis, the Wassermann reaction being strongly positive. In those cases the nose was completely cut off from the pharynx. With the aid of the dentist, who made a plate with a hollow prong, which was passed up through the scar-tissue into the nose, relief was afforded. The patients complained of an accumulation of mucus, so that the nose could not be cleared.

Mr H. TILLEY referred to two cases he showed many years ago which were operated upon. In one, he could only pass a probe through the aperture into the nasopharynx. Adhesions were divided thoroughly on each side in order to free the palate. At the completion of the operation it was

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possible to pass two fingers into the nasopharynx. The insertion of plugs, either hard or soft, had been found to be useless. The question arose as to whether there was a method of holding the soft palate forward while the epithelium crept in. After the adhesions had been divided, two silver wires were passed on each side of the median line through the soft palate, just beyond the border of the hard palate ; carried over the back of the soft palate, they were brought forward again just above and through its free margin. The wires were fixed anteriorly between and over the incisor teeth and were retained until they cut out through the soft palate, in seven to ten days. The patients retained a permanent opening which would admit a finger twelve months afterwards. The point was to provide some means of epithelialisation of the raw surfaces, so that the parts would not cicatrise again after having been divided. If a permanent space, the size of an ordinary lead-pencil, could be secured, mucus could be cleared from the nasal cavities, and the pain in the ear would cease. A month's trial of violet rays might he made, but he (the speaker) favoured the operation which he had described.

Dr BROWN KELLY said he considered the cicatricial contraction due to lupus. In his experience of such cases it was very difficult to keep the soft palate from reuniting with the posterior pharyngeal wall. His best results had been obtained with a hook which passed behind the palate and was attached to a dental plate.

Extraction of Two Farthings from the Œsophagus—M. VLASTO, F.R.C.S.—A girl, aged $3\frac{1}{2}$, was playing on the floor with various articles which included two farthings. When the mother returned, it was noticed that the two farthings were missing. The child appeared to be as usual and made no complaint. Owing to the absence of a witness, no history was obtained of coughing, choking, etc.

From that time, the child began to show a disinclination to take her food and occasionally vomited after a meal. As she appeared otherwise well, a medical man, who was consulted three days after the event, suggested that the child was "shamming."

Six days after the event the child was taken to Queen Alexandra Hospital, Millbank, when the X-ray showed the presence of "a coin" in the œsophagus at the suprasternal level.

Two farthings were removed with ease with a single grasp of Paterson's forceps.

The case is shown on account of the peculiar history, the complete overlapping of the coins and the rarity of such an occurrence.

Mr JEWELL said that, six years ago, he had a similar case, that of a child, 3 years old, who had two halfpennies in the œsophagus at about the sternal notch ; there was no sickness, and the child could swallow well. He passed an œsophagoscope over the coins without seeing or dislodging them, but on withdrawing it and pressing back a fold of mucous membrane, he saw the two coins distinctly, and removed both simultaneously with Brünings' forceps. A skiagram in the antero-posterior position showed only one coin,

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and the radiologist said that from the lateral aspect he saw two edges which merged into one : therefore he believed that only one coin was present and that the aberration was due to obliquity of position.

Dr LOGAN TURNER mentioned two similar cases. In one, after dinner, the patient's husband threw a handful of pennies into the air. At that moment his wife, who was laughing, with her head thrown back, accidentally swallowed apparently one coin. A skiagram suggested the presence of one, but on passing the œsophagoscope, Dr J. S. Fraser removed three pennies ; the patient then stated that two other coins had been missed.

The other case, under the care of Dr G. E. Martin, was that of a child who swallowed two halfpennies simultaneously. The skiagram showed a somewhat oval shadow suggesting partial overlapping of the two coins.

Dr IRWIN MOORE said that the case related by Mr Vlasto emphasised four of the points recently brought out by Chevalier Jackson in relation to foreign bodies ; (1) the failure to consider the possibility of a foreign body being present ; (2) the absence of a history in a patient too young to speak of the accident, and occurring when older observers were absent ; (3) scepticism as to the possibility of the existence of a foreign body, even in face of a positive circumstantial history of the accident ; (4) a symptomless interval. In reference to these four chief factors, Chevalier Jackson advises that whenever a general practitioner is called to a sick or ailing child, he should first think of the possibility of a foreign body, and this should not be excluded until he has satisfied himself, by every means at his command, that no foreign body is present.

Mr VLASTO (in reply) said that the period following the swallowing of the coins was not quite free from symptoms, since the child had shown no inclination to take food and there had been occasional attacks of vomiting.

Œsophageal Carcinoma treated by Intubation with Souttar's Tube—M. VLASTO, F.R.C.S.—A male, aged 53, first complained of dysphagia in April 1925. On admission to hospital, in September, he was swallowing liquids with difficulty. A 6-mm. Souttar tube was introduced, and the patient is now able to swallow minced meat with ease.

The case is shown with a view to eliciting information from members of the Section as to their experience of this form of treatment.

Mr T. B. LAYTON quoted a case in which this method of treatment had been of great benefit to the patient.

Mr WALTER HOWARTH said that he could claim a fairly long acquaintance with this method since it dated from the day that Mr Souttar's article appeared. He happened to have a suitable case, so he borrowed a tube from Mr Souttar and inserted it. This was done in May 1924. The after-history of the case was remarkable, as the patient, an old lady who lived in Somerset, wore the tube continuously until she died in September 1925, a period of sixteen months, and it functioned all the time. Her local practitioner X-rayed her from time to time to see that the tube was still in position, and at her death, a few weeks ago, he made a post-mortem examination. This showed that the carcinoma then involved the whole

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circumference of the œsophagus, encircled the aorta and had perforated the bronchus. The duration of this case was of course unusual, and he would say that six or seven months was the average time. He had found that the cases most suitable for intubation were not the fungating ones, but the intramural growths or extra-œsophageal growths which narrowed the lumen.

Previously he had used gum elastic or vulcanite tubes, but they required cleaning and replacing once a month, whereas the metal tubes did not require to be changed. If blocked by food, sipping hydrogen peroxide in water was often sufficient to clear the tube. Mr Souttar often dilated these strictures very forcibly before inserting the tube, but he (the speaker) was rather afraid of doing this and so was often content with a smaller tube. It was extraordinary what a great deal could be swallowed through a tube with a very small lumen.

Dr W. S. SYME added his testimony to the efficacy of the Souttar tube, and exhibited three skiagrams showing the type of stricture with the tube in position, indicating that a narrow stricture would bear a fair-sized tube. Three days after its insertion, the man was able to travel to Devonshire, and said he was comfortable and was able to swallow minced meat.

Mr VLASTO (in reply) said that, from the remarks made by various members of the Section, one might be led to think that the passage of a Souttar's tube was always a comparatively easy procedure and that their efforts had been attended with uniform success; this had not been his (the speaker's) experience.

The statement had been made that the tube could be passed through any ordinary œsophageal tube. He wished to emphasise the fact that the bore of the œsophageal tube so used must be at least 16 mm., and that such a tube did not, as a rule, form part of the usual hospital theatre equipment.

His (the speaker's) experience of this treatment had been confined to three cases. In the first case he had been unable to dilate the œsophagus sufficiently to admit the passage of a tube. In the second case he had been obliged to remove the tube three days after inserting it, because the patient had been totally unable to swallow; in that case the Souttar tube had been blocked by growth and blood-clot. The third case was the successful one which he had now exhibited.

Chronic Lymphatic Leukæmia associated with enormous Enlargement of the Faucial Tonsils—M. VLASTO, F.R.C.S.—A woman, aged 50, attended the West London Hospital complaining of a lump in the neck. On examination the tonsils were found to be very enlarged. The following is typical of the many blood-counts that were carried out:—

Total red cells	3,813,000	Total white cells	38,200
Hæmoglobin	62 per cent.	Small lymphocytes	88 per cent.
Colour index	0·8 „	Polymorphonuclear leucocytes	7 per cent.
		Mononuclears	2 „
		Eosinophils	1 „

The Wassermann reaction is negative. There is a slight enlargement of the spleen, and glands are enlarged in the axillæ and groins.

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As the size of the tonsils is beginning to cause dysphagia, expressions of opinion are invited as to the best form of treatment.

Dr H. SMURTHWAITE said that two years ago he had had a patient with tonsils larger than in this case, and with a mass of enlarged glands on each side of the neck, suggesting a malignant condition. He (the speaker) had dissected out one tonsil and examined it, and had found that it consisted mainly of fibrous tissue, containing epitheliomatous cells. There was severe bleeding at the time of operation, and later the patient was put on to a course of arsenic. She now looked ten years younger; and the other tonsil and the glandular masses had greatly diminished in size. The patient had now lost all her anæmia after being put on to increasing doses of arsenic. He (Dr Smurthwaite) did not think that his case could have been malignant.

Sir JAMES DUNDAS-GRANT suggested the possibility of benefit following the insertion of radium needles, or exposure to X-rays.

Mr W. STUART-LOW said that good results had occurred in a similar case following repeated puncture—once a month—with diathermy needles. Large doses of collosol calcium were also used. The very large tonsils gradually became smaller and firmer; after six months' treatment they were enucleated in the usual manner and there was no excessive hæmorrhage.

Sir WILLIAM MILLIGAN said he did not think any operative interference was required. The tonsils were not sufficiently large to call for diathermy or dissection. He agreed with Dr Smurthwaite that if arsenic were given intravenously or by the mouth in these cases, there was a marked improvement. Operation for such a condition was always accompanied by considerable danger and the underlying disease was a blood disease.

Mr H. TILLEY said that for many years it had been recognised that arsenic caused a diminution in the growth, sometimes amounting to complete absorption. Then there was a recurrence, and if the administration of arsenic was then pushed, the patient suffered from arsenical neuritis.

Sir ST CLAIR THOMSON said it was desirable to be on guard about tonsils enlarging in middle-aged people. He was once asked to see a lady who insisted on having her tonsils removed. Finding the lingual tonsils also much enlarged, he had her blood examined; lymphatic leukæmia was found to be present, therefore he declined to operate. He was thereupon dismissed from the case, and she was operated upon by a colleague, who knew what was the matter with her, he also having had a blood-count done by another pathologist. He (Sir St Clair) consulted several pathological friends, and they said that removal of the tonsils could not make any difference. The lady died two years later. He suggested that a systematic examination of lingual tonsils in these middle-aged people would sometimes warn the examiner of the possibility of lymphatic leukæmia.

Dr IRWIN MOORE advocated the use of London paste in this case.

Mr Vlasto (in reply) said that, although the tonsils were still very large, they were very much smaller than when the patient first presented herself for examination. The diminution in size had no doubt been achieved by local X-ray therapy, to which the tonsillar region had been subjected.

It was difficult to correlate Dr Smurthwaite's experience with the well-known pathology of the disease.

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