limited to the epiglottis. Five glands examined afterwards showed typical epithelioma. In former days Mr. de Santi would probably have removed the whole larynx for such a condition, but greater experience led him to adopt, when possible, a less severe operation.

Large Pulsating Vessel in the Right Posterior Pharyngeal Wall.—J. H. Connolly.—The patient, a boy, aged five, has enlarged tonsils and adenoids, associated with nasal obstruction, and would probably be benefited by their removal. This large blood-vessel is a danger—an uncommon one—and may contra-indicate operative interference. Presumably it is the internal carotid or the ascending pharyngeal artery, or perhaps it may be an abnormal vessel. Its size appears large for the ascending pharyngeal, although it is true that the pulsation is apt to give a wrong impression of the calibre of the vessel. He was inclined to regard it as the internal carotid, and, whilst prepared to remove the tonsils, thought it wise to leave the adenoids alone.

The PRESIDENT said the vessel looked like the ascending pharyngeal, and he did not think there would be much difficulty in removing the adenoids without damaging the vessel.

Dr. H. J. DAVIS agreed that the vessel was the ascending pharyngeal. It appeared to be more at the side than it really was, as the tonsils were so large, but if they were not there the vessel would be seen to be much nearer the mid-line than it seemed. He would leave the adenoids alone.

Mr. HARMER recollected a case in which the house-surgeon removed one tonsil, and there was a tremendous rush of blood, obviously from some large artery which had been cut. The bleeding lasted only a few moments, but a few hours later was repeated, and the patient died. *Post-mortem*, the girl was found to have two complete coils in the internal carotid arteries, and these coils pushed in towards the middle line, under the posterior wall of the pharynx; in cutting off the tonsil one of the coils had been completely removed.

Dr. DONELAN said that Dr. Jacobson, of New Orleans, reported a case in private practice some twenty years ago, in which he had to tie the common carotid before hæmorrhage could be arrested. It was tonsillotomy. That patient recovered, so it was impossible to ascertain the nature of the abnormality.

PROCEEDINGS OF THE SCOTTISH OTOLOGICAL AND LARYNGOLOGICAL SOCIETY.

Meeting at the Royal Infirmary, Edinburgh, November 22, 1913.

MR. J. D. LITHGOW *in the Chair.*

Reported by DR. W. S. SYME.

The Radical Mastoid's "First Dressing."—J. D. Lithgow.—(See JOURN. OF LARYNGOL., RHINOL., AND OTOL., November, 1913, p. 589.)

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The Mechanism of one form of Respiratory Stoppage under General Anæsthesia (Ethyl Chloride).—J. D. Lithgow. (See Journ. of Laryngol., Rhinol., and Otol., vol. xxviii, p. 646.)

Dr. Turner some years ago had made a number of experiments on the cadavers of children in connection with the production of laryngeal stridor, and what struck him in regard to Dr. Lithgow's explanation was that it was not quite an anatomical possibility. What he wanted to know was whether Dr. Lithgow was sure that the epiglottis was drawn against the posterior pharyngeal wall.

Dr. Lithgow replied that he had no doubt at all about the correctness of the view he had put forward. He had not only felt the epiglottis fixed to the posterior pharyngeal wall; he had seen it. He had observed this condition on four occasions, and all the patients were beyond the age of early childhood, the epiglottis being larger than that of a small child.

Carbolic Acid in Glycerine for Turbinal Hypertrophy. (Preliminary Contribution.)—J. D. Lithgow and Peel Ritchie.—Carbolic acid in glycerine solution has been used for many years as an injection into hæmorrhoids to induce fibrosis and cause shrinking. It has also been used in the same way in the treatment of small simple tumours. The nasal cases in which this method has been tried have been of vasomotor and hypertrophic rhinitis, and they have been so far satisfactory, *quâ* the induction of fibrosis. The shrinking following the injection is quite as marked, if not more so, than when galvanic cautery is used, and it appears to have the additional advantage of a sterile trauma. The operation is quite painless. The method followed is to inject two or three drops of a 60 per cent. solution of carbolic acid in glycerine into the previously anæsthetised inferior turbinate as close to the bone as possible. It is followed by a period of reaction and engorgement which quickly passes off, and a slow process of shrinking lasting a month or so. In some of the cases the turbinate tissue was at the end of a month or two sufficiently shrunk to admit free nasal respiration; in others, owing to some septal deviation, one removed a portion of inferior turbinate. We have thus been able to study the process of fibrosis microscopically at various stages, and hope to make further communication in reference to the histopathology of the process.

Mr. Peel Ritchie said this method had been in use for many years for piles, and his experience of it was very satisfactory; he had also tried it in other conditions. The advantage was that without producing any ulcerated surface one got the same results by fibrosis as by removing the growth. The process took some time—a number of weeks. That was one point on which they hoped to get information by further examinations. There was an immediate reaction involving swelling and œdema of the parts; this, however, passed off fairly rapidly. It required a certain amount of experience to know just how much of the carbolic solution to inject.

Dr. Keer Love asked if in removing a portion of the large turbinate there was less bleeding than usual.

Dr. Lithgow replied to Dr. Love's query in the affirmative.

Malignant Disease of the Buccal Pharynx and Laryngo-pharynx, both after Operation. Parts Involved in First Case—Tonsil, Alveolus, Tongue, Lateral Pharyngeal Wall; in second one—the Right

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False Cord, Aryepiglottic Fold and Adjacent Laryngo-pharynx.—J. D. Lithgow and Peel Ritchie.

Mr. Peel Ritchie said there was extensive involvement of the glands on one side and a preliminary operation was done for this. The cheek was split up short of the masseter; the growth was outlined by the fine point of the cautery; the mucous membrane was snipped through with scissors. The broad blade of the thermo-cautery was used for division of the muscles, and the raw surface was covered in completely with membrane. The right side of the split uvula was turned over to cover in the raw area. The very tip of the uvula projected down on the left side into the mouth where the adhesion was not quite complete. He did not think there was any advantage, for the purpose of obtaining a better view, in operating from the opposite side. Moreover, it was an advantage to have the primary wound and the wound for the gland operation on the same side in the after-treatment.

Chronic Subglottic Infiltration, Probably Specific in Origin.—W. T. Gardiner.—The patient, a married woman, seen for the first time five months ago. She then complained of "thickness of voice and some difficulty in breathing for the past six weeks." She thought it came on after an attack of "rheumatics." She also had a cough and some expectoration. Husband died of general paralysis ten months ago. She has six children; no history of miscarriages. The patient had a hard, almost brassy cough, and there was some inspiratory difficulty after coughing. The epiglottis and arytænoids were normal. There was slight fulness of the interarytænoid region, especially on the left side, where it seemed to become continuous with a pale, smooth, rounded infiltration situated below the left cord. This infiltration was most marked beneath the posterior part of the cord. The movements of the cord during respiration were very slight, and both adduction and abduction were limited. The pallor was very marked. The patient was given potassium iodide. She reported herself slightly improved one month later, but on examination, although the original infiltration was smaller, and the movement of the left cord a little improved, there was now a swelling similar to the first one on the right side below the right cord. The right cord moved perfectly. The iodide was now increased, and the condition is slowly improving. Examination of the sputum for tubercle bacilli was negative. A month ago the patient brought her son, aged ten, to the dispensary to have his tonsils removed, when it was discovered that he had active interstitial keratitis in the right eye.

Dr. Fraser asked what the condition of the chest was and whether Wassermann had been performed.

Dr. Brown Kelly thought the want of movement very suggestive of malignant disease, and asked if it had not struck any of the members in that light. The temporary improvement, of course, did not necessarily exclude malignant disease.

Dr. Syme thought, like Dr. Kelly, on first looking at the patient that the condition was malignant. The woman's age (thirty-five) did not put that out of court; also the fact that the thickening was confined to one side was in favour of a malignant condition. Had it been specific, one would have expected some evidence of breaking down. Altogether it appeared to him more like a malignant than a specific condition. He suggested that a portion should be removed for examination, and this could be done without doing any harm if it did turn out to be specific.

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Dr. KERR LOVE thought Dr. Gardiner should take the case into hospital and give large doses of iodide. He thought it was specific.

Dr. FULLERTON thought it might be tuberculous. In a case which he had had the patient went away for a change for two or three months, and came back very much better. The condition in that case was practically the same as in this one.

Dr. WHITEHOUSE remarked that both cords were implicated; he thought it was bilateral and specific.

Dr. LOGAN TURNER had seen the case with Dr. Gardiner before treatment was commenced, and it was then bilateral. That was rather against malignant disease.

Dr. WALKER DOWNIE thought the want of movement was partly due to fixing of the arytænoid.

Dr. GARDINER replied that the chest had been examined on three occasions, with negative results. No Wassermann was done. He was considering having it done when the mother brought her child who presented evidence of specific disease, which seemed to render a Wassermann unnecessary. He would have one done, however, and he would report the further progress of the case at the next meeting.

Bleeding Polypus of Nasal Septum; Microscopic Specimen shown.—W. T. Gardiner.—The patient, a female, aged eighteen, came in the beginning of August suffering from nasal bleeding. History of epistaxis, more or less constant for four weeks, becoming much worse in the last week, so that patient had lost a great deal of blood, and was having attacks of giddiness. The right anterior naris was filled up with blood-clot. On removal of this a smooth rounded mass, dark red in colour, was seen occupying the front part of the inferior meatus. It was movable on a narrow pedicle, and bled readily when touched with the probe. It was attached to the anterior part of the septal cartilage near the floor of the nose. It was removed by the snare, and the base cauterised with chromic acid. The polypus was about the size of a small bean. One month later the patient returned, complaining once more of epistaxis. On examination there was a red mass in the original position, and apparently as large as before and bleeding as readily. It was again snared, and this time the base was cauterised with the electric cautery. Reported (November 3) no further hæmorrhage. Site of the polypus indicated by a firm scar. *Histology.*—The section comprises a portion of the tissue the size of a pea. The surface is fairly regular, but with one or two minute slightly polypoid projections. The surface is covered with a layer of stratified squamous epithelium. The greater part of the section is made up of collections of young cells of connective-tissue type, arranged for the most part in relation to vascular spaces, which vary greatly in size. In some parts the amount of fibrous-tissue is greater and closely surrounds the blood-spaces. The condition is evidently angiomatous and blood-corpusles are visible in many of the spaces. The extremely cellular character of the greater part of the tissue makes it difficult to exclude a sarcomatous element in the case. It was reported by Dr. Theodore Shennan as probably not angio-*sarcoma*.

Dr. FRASER had had the opportunity of dealing with three or four similar cases. His practice had been to inject the base with novocaine and adrenalin, make a lozenge-shaped incision round the growth and dissect it off the cartilage. In this way one removed it entire and also obtained a better specimen for microscopic examination.

Dr. BROWN-KELLY thought the interesting point of the case was the

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difficulty of excluding sarcoma. He had had a case of much the same kind. The patient, a young man, came with a diffuse growth on one side of the septum; he had been sent as a case of sarcoma. As there was some doubt a piece of the growth was removed for examination. While the matter was still *sub judice* the patient suddenly disappeared. Two years later he came back complaining of something else, and stated that he had not returned after his previous visit because he had been in prison. On examining the site of the growth it was found normal, and the septum, which has been pushed to the opposite side, and the upper lateral cartilage, which had been elevated, had regained their normal position. On inquiring as to the result of the microscopical examination, the pathologist reported that it was suggestive of sarcoma.

Dr. LITHGOW said in his last case there was a very narrow pedicle; he snared the growth off. He saw the patient some time afterwards and no evidence of the growth remained, and when seen a year later there had been no recurrence. It was a typical papilloma, the size of a hazel-nut. The smallness of the pedicle was unusual in papillomata.

Dr. GARDINER, in reply, said that at a future period should another case occur he would endeavour to remove the growth by the method recommended by Dr. Fraser, the advantage of which was that the base of the polypus could be got away practically completely. By snaring one did not see the entrance point of the vessel.

Temporo-sphenoidal Abscess; Recovery.—W. G. Porter.—Male, aged twenty-one, was first seen on August 7, 1913, complaining of otorrhœa since infancy. The discharge had increased during the previous week, and he had also suffered from severe headaches during that period. On examination a large polypus, bathed in very fœtid pus, was seen nearly filling the right meatus. Functional examination showed complete deafness on that side, and the labyrinth did not respond to stimuli. Left ear healthy. Temperature and pulse normal. A radical mastoid operation was performed on the following day. The antrum was filled with granulations, and the dura of the middle fossa was found to be exposed and covered by granulations. The ossicles were not seen, and the oval window was empty. On smoothing the anterior surface of the spur with the chisel the face twitched once, and on waking from the anæsthetic the patient was found to have a facial paralysis, which became complete, but which is now fortunately passing off. A few days after the operation the patient began to complain of headaches; he slept badly, and was slightly delirious at night; the radical cavity appeared clean; there was very little discharge; the temperature was normal; the pulse did not fall below 60; and the examination of the nervous system was negative. Ten days after the operation a profuse discharge came from the ear during the night, soaking the pillow; the headaches were at once relieved, and the patient felt very well. It was supposed that a subdural abscess had evacuated itself, but as the patient appeared very well there seemed to be no indication for interference. The patient continued to feel well, and the discharge to be slight, till August 24, when the headache returned, and there was more discharge; pulse, 50; temperature, 98·2° F. On the 25th the wound was reopened, and pus was seen lying on granulations springing from the dura. On probing this area the probe slipped directly upwards into the brain. The bone was freely removed, exposing an area of dura larger than a penny piece; the granulations were removed, the dura incised, sinus forceps passed into the brain, opened and withdrawn, and at once about 2 oz. of very fœtid pus

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evacuated. (The pus showed a streptococcus in pure culture.) A large drainage-tube was inserted into what was felt to be quite a large cavity, the posterior wound was left open, and the patient returned to bed. Considerable difficulty was experienced in maintaining drainage. The pulse, which fell to 40 after the operation, continued to be slow (40 to 48) for a fortnight, and the temperature subnormal (97·8° to 98·2°). The pulse rose to 50 on September 8, and the discharge thereafter gradually diminished; the tube was finally removed on September 29. Since that date the patient has done well, the posterior wound has closed, and he has gained in weight, and is now thinking of returning to work.

Dr. KERR LOVE asked what method was used to enter the middle fossa; did he go straight in through the squamous bone or did he extend the wound upwards from the mastoid opening?

Dr. PORTER said the dura was exposed by the disease, and the opening enlarged at the operation.

Apparent Post-operative Osteomyelitis of the Frontal Bone; Recovery after Wide Removal of Diseased Bone.—W. G. Porter.—The patient, a female, was referred from the Eye Department. She complained of double vision and a swelling just above the right eyeball towards the external canthus, and there was also definite proptosis.

After examination a diagnosis was arrived at of empyema of the right frontal sinus and ethmoidal labyrinth with orbital abscess. Killian's operation was performed on May 14, 1912. The frontal sinus was found to be filled with creamy mucopus (pure culture of streptococcus obtained), but the lining membrane was not thickened; hence it was thought that the case was one of an infected mucocele. The floor of the sinus had given way rather far back, and pus was lying on the orbital periosteum, which at this spot was covered with granulations; there was a very well-marked orbital extension, fully 1½ in. in depth. In smoothing off the bone close to the intersinus septum the latter was unfortunately cracked, exposing the sinus on the opposite side. The wound was entirely closed, and healed by first intention. Three weeks later the upper eyelid became œdematous; the wound was reopened and a quantity of pus evacuated. The discharge continued in spite of the administration of an autogenous vaccine and endeavours to obliterate the sinus by pressure.

A second operation was performed on October 3, 1912. The inner end of the bridge was removed, and a sinus was traced to the hole in the septum, where pus was seen coming from the left frontal sinus. The outer part of the right frontal sinus was obliterated by dense fibrous tissue, as was the opening into the nose. A Killian operation was performed on the left side; this sinus also had a deep orbital extension. The inner part of the incision was left open after the operation, sutures being passed but not tied till forty-eight hours had elapsed, there being then no discharge. The wound healed at once, but a few days after the upper eyelid became swollen, and pain was felt at night; there was no pyrexia.

On November 11, 1912, the swelling was more marked, and there was marked tenderness on pressure over the bridge. The wound was reopened, the inner end of the bridge was divided, and it was then found to be loose, a sequestrum, consisting of the bridge and part of the malar bone, being removed; no pus was evacuated. The wound was left freely open and packed. The pain was not relieved by the operation

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and the upper eyelid remained swollen. The temperature varied between 98·4° and 99·2° F.

On the 17th œdema of the skin was noted over the frontal sinus; this spread rapidly, and on the 20th extended up to the hair margin and across the middle line; there was, however, very little discharge from the wound, which was still kept widely open. It was believed that osteomyelitis had set in, and wide removal of the frontal bone appeared to offer the only hope of recovery. Accordingly, the following day a mesial incision was made upwards from the root of the nose, and a triangular flap of skin and periosteum turned back. The bone appeared glazed on the surface; a large circle of bone was removed with hammer and gouge; the bone was about half an inch thick, very soft and vascular, and did not give the usual ring when struck. The margins of bone were further removed with bone forceps until a firmer consistence and diminished vascularity appeared to show that the limits of disease had been reached. There was no pus in the substance of the bone, and the dura appeared healthy. The skin was then replaced and fixed in position by a few interrupted sutures. There was considerable discharge from the wound for some days, but healing gradually took place, undoubtedly assisted by the administration of an autogenous vaccine.

The patient had no further trouble in the operation area, and she remained in excellent health until three weeks ago, when she had an attack of pneumonia which carried her off in a few days.

Dr. Fraser thought the microscopical sections shown by Dr. Porter showed a mild condition of osteomyelitis. The bone itself was almost normal, but there was evidence of a subacute inflammatory process in the marrow spaces, and new bone staining faintly with eosin was deposited round the margins. The same condition was seen in the chronic form of mastoiditis. Personally he had no doubt that it was a case of osteomyelitis.

Dr. Logan Turner had had the opportunity of seeing the case before the operation. Speaking from the clinical point of view, he would have said there was no doubt at all about the case being one of osteomyelitis secondary to frontal sinus disease, having himself had previously a fatal case of this kind.

Dr. Porter, in reply, said he was indebted to Dr. John Fraser for the sections of bone, who was inclined to think the process was not an acute osteomyelitis. If it was a case of osteomyelitis, it was the first post-operative case which had recovered.

Foreign Body (Halfpenny) in Œsophagus of Child for Eight Years.—W. G. Porter.—Male, aged eleven, complained of indefinite gastric symptoms of three weeks' duration, but on the history being elicited the father stated that the boy had swallowed a halfpenny at the age of four, and had never been the same boy since. The boy weighed 2 st. 10 oz. on admission, and was small for his age and poorly developed.

An X-ray photograph was taken and showed a foreign body in the œsophagus between the fifth and sixth dorsal vertebræ. He was referred to me for œsophagoscopy, which was done under general anæsthesia; the halfpenny was seen lying low down in the œsophagus nearly edge on. On introducing the forceps to seize the coin it slipped away out of sight into the stomach. On carefully inspecting the œsophagus where the coin had been lying, no ulceration or lesion of any kind could be detected. The patient remained in hospital for a fortnight after this procedure; he improved markedly in health and increased 5 lb. in weight. A skiagram

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was taken again before his discharge, and the halfpenny was not seen in any part of the œsophagus or abdomen. The boy stated one day that he had passed it, but it was not found in the stools.

Dr. TURNER thought this case of great interest as showing how long a foreign body could remain in the gullet without giving rise to symptoms. He did not know whether any case of such long duration had been recorded. Sir StClair Thomson had recorded a case in which the foreign body had remained in the œsophagus for three or four years. He himself had seen a case in which a halfpenny had remained in the œsophagus for only one week and the patient died; in that case death, he believed, resulted from the old-established methods used for the removal of the coin, and not from the presence of the coin.

Dr. WALKER DOWNIE asked if any permanent injury to the gullet had followed. He had had among many such cases one of a child who had a halfpenny lodged in the gullet for eighteen months. The child was in Ireland at the time the accident happened, and he was treated there at first, but as nothing passed by the rectum his story was not believed. He was sent to the Western Infirmary in Glasgow later, when the coin was seen with X rays and removed. No permanent injury to the gullet was observed.

Dr. BOOTH asked if it was not rather unusual for a halfpenny to stick in the œsophagus of a boy of eleven years of age.

Dr. LITHGOW had seen some years ago a boy in whom a half sovereign had stuck in the œsophagus. He removed it in a coin-catcher. In another case he had removed a halfpenny. He did not think, within limits, that the size of the coin made much difference.

Dr. PORTER, in reply, said the patient was not a child of eleven: he was four when he swallowed the coin. The boy remained a fortnight in hospital and gained 5 lb. in weight. The point that struck him especially was that dysphagia was not complained of at all, but only indefinite gastric symptoms.

Hoarseness from Birth; Patient shown; Opinions invited.—J. K. Milne Dickie.—B. M'K——, aged seventeen, seen first on June 9, 1913. Complained of sore throat. Had been hoarse from birth. Birth had been precipitate. *Condition at time of examination:* Slight tonsillitis and pharyngitis. The left vocal cord showed only very slight movement. On middle of upper surface of cord there was a small red oval area. Slight subglottic swelling in front. Right cord moved freely. Nothing abnormal in heart or lungs. X ray negative. Two months later condition still the same.

Dr. DOWNIE remarked that there was here a chronic pharyngitis. There appeared to be pus on the cord.

Dr. SYME said it had appeared to him that there was thickening of the upper part of the left cord, but it did not seem to be sufficient to cause the hoarseness for such a long time. It was a condition one would have expected to pass off. He suggested that the irregular, pearly thickening was a lymphangitis due to some interference with the lymphatic return. There was some pus below the cords.

Dr. BROWN KELLY thought there was a tiny nodule on the left cord and indications of one on the right.

Dr. MILNE DICKIE, in reply, said the reason the case was brought forward was that when the patient was first seen the left cord was fixed. First of all, some injury at birth causing paralysis on the left side was suspected. She was kept under observation and treated with silver

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nitrate; after some months the cord began to move. The patient, who is a weaver, works in a very dusty atmosphere—fluffy dust—and uses a green dye. Her condition had changed since she was last seen.

Laryngeal Stridor; Tracheotomy; Recovery.—J. K. Milne Dickie.—Mrs. S——, aged forty-three, seen first on June 19, 1913. History of bronchitis and asthma for six weeks with loss of voice and shortness of breath. *Examination:* Great inspiratory stridor with some cyanosis. Vocal cords in apposition; right cord could be abducted slightly; left one not at all. False cords swollen. Admitted to hospital. Tracheotomy performed during the night. A few days later cords could move quite freely. No shortness of breath.

Seen again on July 7, 1913. Larynx normal. Scar of tracheotomy wound seen below aperture of larynx. No discomfort at all now.

Dr. Adam said the patient stated that her asthma dated back some years. She also states that she had distinct sore throat before the attack of stridor came on. He did not think it was connected with the asthma. Asthma rarely caused spasm of the larynx in adults, though laryngismus was a common form of it in children. He would like to know what the effect of the general anæsthetic was on the stridor. He thought the vocal cords were swollen.

Dr. Syme asked if there was not some connection between the bronchitis and the laryngeal stridor. He thought it probable that in this case there was an acute infection and enlargement of the bronchial lymphatic glands, and that by irritation of the recurrent nerves laryngeal spasm and stridor had been caused. As the acute enlargement of the glands subsided the stridor disappeared. The loss of voice was suggestive of spasm rather than of abductor paralysis. He asked if the patient had had any attacks of vertigo.

Dr. Brown Kelly had shown a case before the Society a year and a half ago of a child in whom the vocal cords, after having been together for months (? adductor spasm), subsequently moved normally. Possibly in this case also an adductor spasm had been present, and not a paralysis.

Dr. Whitehouse asked if there had been any other treatment, and how long the patient was in hospital before operation.

Dr. Milne Dickie, in reply, said the patient was admitted at five p.m., and the operation was done in the early hours of the morning by the Resident. No anæsthetic was used. Personally he thought Dr. Syme's suggestion the most likely. The patient had a distinct amount of bronchitis as well as the laryngeal condition; she had a good deal of secretion. The false cords were swollen, but not enough to cause any real obstruction. No other treatment was carried out at all; the patient was only in hospital for about a week altogether. She could breathe perfectly normally through a natural opening after two days; since then there had been no trouble at all. She has no general nervous affection as far as could be made out to account for the condition.

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