some suitable occupation. In only one case did a relapse occur; this was after a nightmare, the aphonia being now complicated by stammering, but rapid recovery followed a renewal of treatment.

REFERENCES.

(1) A. F. HURST.—*Seale Hayne Neurological Studies*, vol. i, 1918, p. 106.
(2) F. E. ANSTIE.—*Lancet*, vol. ii, 1872, p. 842.
(3) G. LIÉBAULT.—"Grandes Questions médicales d'Actualité: *Rev. Gén. de Path. de Guerre*," p. 245. Paris, 1917.

SOCIETIES' PROCEEDINGS.

ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

November 2, 1917.

President: Dr. A. BROWN KELLY.

(*Continued from p.* 176.)

The PRESIDENT: Dr. Irwin Moore has taken much trouble with this case, and has been well warranted in doing so, because we are not clear as to the significance of the appearances. On the one hand, he adduces evidences of the presence of tuberculosis, and, on the other, the Wassermann test came out strongly positive. Are we to regard the appearances in the pharynx and larynx as tubercular or as syphilitic? I am unacquainted with tubercular manifestations such as here seen, but I have had two or three cases similar in aspect in which congenital syphilis was undoubtedly present. I would therefore regard the case as one of congenital syphilis of the throat in a tubercular subject. I think Mr. Hunter Tod and Dr. Lambert Lack have also shown cases with similar appearances in syphilitic patients.

Sir STCLAIR THOMSON: I suggest that Dr. Irwin Moore treats this patient more thoroughly for syphilis and reports to the Section.

(Prof. SHATTOCK demonstrated the slides of the case.)

Prof. SHATTOCK: We must allow that pathologically this is an obscure case. It is obviously a mixed one of tuberculosis and syphilis; but the problem to settle is whether the local condition is due to a tubercular or to a syphilitic infection. I am inclined to view the chronic œdema of the uvula and palate as having a tubercular genesis for the following reasons: (1) It was originally continuous with the site of the adenoid disease of the nasopharynx, which is, histologically, undoubtedly tubercular: a post-operative infection can be excluded, therefore, as a cause of it. (2) The secondary disease of the cervical gland is tubercular. (3) The condition improved after subcutaneous injections of tuberculin. The chief histological feature in the uvula is the remarkable proliferation of the endothelium of the lymphatic capillaries, some of which are quite blocked; amongst the large endothelial cells there are no red blood-corpuscles nor polymorphs, but a moderate number of multinucleated cells, some containing two or three nuclei; and one as many as nine, peripherally arranged. The microscopic findings suggest that the disease of the uvula is due to the transference of tubercle bacilli by the lymph-channels, and their subsequent location

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in the lymphatic endothelium, with a resulting endothelial proliferation and a scanty giant-cell formation—a tubercular capillary lymphangitis. The improvement under tuberculin injections points to a tubercular genesis of the lesion, in spite of the fact that no tubercle bacilli (nor other organisms) were found in sections of the piece of the uvula removed at the first operation; and that no tuberculosis was set up in the guinea-pig inoculated with the second, basal, portion of the uvula excised. Short of an actual transference of bacilli, the changes might be attributed to the access of toxin produced in the nasopharyngeal tubercular lesion. This would put them ætiologically on a line with lupus erythematosus, whether of skin or buccal mucosa, many cases of which presumably result from the action of tubercle toxin apart from a growth *in loco* of the tubercle bacillus, since a large proportion of the subjects of lupus erythematosus are tubercular, although the lesion as a rule contains no tubercle bacilli: yet not only may giant-cells occur in lupus erythematosus, but tubercle bacilli have been found in some cases. Clinically the amelioration of lupus erythematosus is not to be observed under the use of tuberculin. This suggests that the condition in Dr. Irwin Moore's case is more than toxic, and that there may be bacilli, few and far between, in the tissues. The alternative view would be to regard the œdema as due to syphilitic infection, and to look upon the presence of the adenoids and their tubercular infection as things independent of the other condition. There is one point in conclusion which I venture to suggest in connection with the cases of chronic œdema occurring in the adult, and that is whether some may not have a gouty pathogenesis. I do not mean that the tissue would show microscopically the cell proliferation, necrosis, and deposition of urate occurring in a proper gouty lesion, but whether the condition may be a manifestation of what is clinically sometimes called "goutiness."

Dr. Irwin Moore (in reply): The patient has not had any treatment for syphilis. Since he was exhibited here he has lived in Devonshire, and had no treatment of any kind. My conclusion is that tuberculosis is the main factor in the case, superadded to congenital syphilis. It is my intention to give the patient antispecific treatment, as suggested by Sir StClair Thomson.

Tertiary Syphilis of the Pharynx in a Female, aged forty-four, clinically resembling Tuberculosis of a Lupoid Type.—Irwin Moore.—This case was shown at the previous meeting of the Section on July 1, 1917,[1] and described in the agenda as "lupoid" tuberculosis, on account of the clinical appearance. A positive Wassermann reaction was obtained the morning of the meeting. Since showing the case the following investigations have been carried out:

On June 5 the uvula, also pieces from the pharynx, were removed, and several sections examined by Dr. Fletcher. He reports that "they show thick infiltration of the tissues by small round inflammatory cells. This is especially marked near the surface, while the deeper areas are densely fibrotic. The surface epithelium is puckered but there is no ulceration. No giant-cells nor epithelioid cells were found, nor was there evidence of vascular thickening. The features are those of a chronic inflammatory condition. The Wassermann reaction being positive, the condition is presumably syphilitic" (Dr. Eastes' Laboratory). On June 12 an intravenous injection of galyl (0·25 grm.) was given with

[1] *Proc. Roy. Soc. Med.*, 1917, xi (Sect. Laryng.), p. 4.

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remarkable results, as may be seen by comparing the drawing of the pharynx made on May 22 (Fig. 1) (which represents also the condit on when shown at the Section meeting on June 1) with that on July 10 (Fig. 2).

It will be observed that in the space of one month almost the entire lupoid-looking infiltration had disappeared, and its place been taken by cicatricial tissue. The nodular-looking uvula seen in the first drawing (Fig. 1) is not seen in the second drawing (Fig. 2), since it was removed for microscopic sections. The tongue, which was to a great extent fixed (Fig. 1), could be protruded further (Fig. 2), and the larynx, which was not previously seen, could be easily examined with the laryngeal mirror.

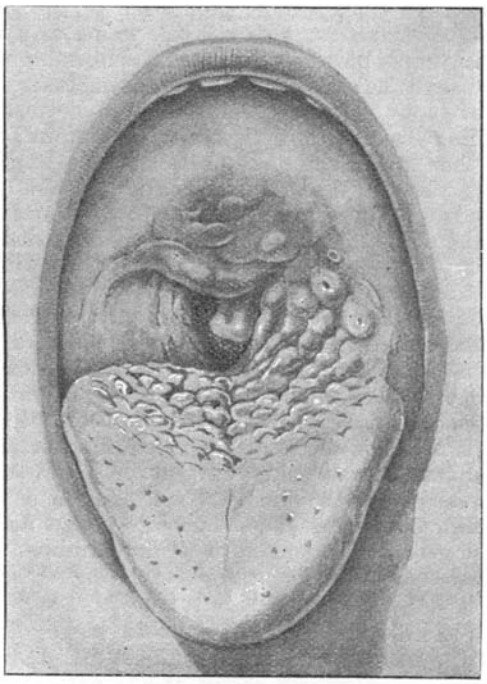


FIG. 1.—Tertiary syphilis of the pharynx in a female, aged forty-four, clinically resembling tuberculosis of a lupoid type. Shows extensive nodular infiltration of the tonsils and fauces, which has extended on to the soft palate, uvula, and base of tongue. The posterior faucial pillars are scarred, and have become approximated, and united to the posterior pharyngeal wall. The oropharynx is markedly stenosed. Case shown June 1, 1917. Drawing made May 22, 1917.

Patient's condition has so much improved since the injection, and the airway has become so free, that respiration can now be carried on with the tracheotomy tube corked. It is, however, being retained a little longer for safety.

Complete Paresis of the Left Vocal Cord due to a Mediastinal Growth.—Irwin Moore.—Patient, a male, aged forty-five, attended the Great Portland Street branch of Golden Square Hospital on September

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18, complaining that three weeks previously a piece of meat had stuck in his throat and was only released by being pushed down by a bougie. Since this he has had a sore throat, hoarseness of the voice, and has only been able to swallow semi-solid food. His former weight was 11 st., but since this occurrence he has lost 2 st. When first seen by the exhibitor on October 5, considerable œdema of the arytænoids and upper part of the larynx was observed and the vocal cords could not be seen.

There has been progressive emaciation during the past two months. Patient has a cough, with slight sputum and dyspnœa. His previous health has been good, and there is no history of syphilis.

On October 12, the œdema having cleared up, the left vocal cord was seen lying in the "cadaveric" position.

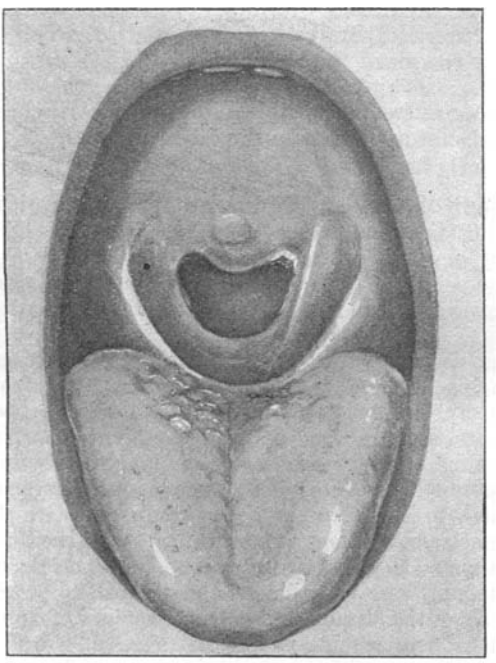


FIG. 2.—Shows the result, one month later, of an intravenous injection of galyl (0·25 cgrm.). Case shown November 1, 1917. Drawing made July 10, 1917.

On October 18 Dr. Halls Dally kindly saw patient for me, and reports as follows:

Examination of the chest revealed impaired percussion note over the upper two-thirds of the left lung, front and back, the note being dull from the lower border of the clavicle to the third rib. Over this area the breath-sounds are feeble, and crepitations were audible above and below the left clavicle, and in the left interscapular space at the level of the sixth and seventh thoracic vertebræ.

Blood-count.—Red cells, 5,000,000 per cubic millimetre; white cells, 12,000 per cubic millimetre; colour index, 0·7 per cent.; hæmoglobin, 70 per cent.

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The radiogram of the chest shows a shadow with ill-defined outline extending from the mediastinum over the left upper lobe and upper portion of lower lobe. The appearances of this shadow suggest a mediastinal new-growth invading the left lung (H. D.).

Dr. SYME: I should like to mention two cases of recurrent paralysis. A man was operated upon under ether for hernia, and a week later he lost his voice. I saw him three weeks after his operation. He had complete paralysis of his left cord. The œsophagoscope and screen showed no cause. In October his voice had returned. He has now abductor paralysis. I thought there might have been dragging on the chin at the time of the operation and hæmorrhage into the sheath of the nerve, but there was no trouble with the anæsthetic. The other case was that of a girl with a scar on the left side of the neck, the result of a removal of glands three years previously. Two months ago she lost her voice, and had complete paralysis of the left cord. This is passing off, and there is now paresis of the abductor.

Dr. W. HILL: I think it is mediastinal growth, but it is curious there should be recurrent paralysis, unless the aorta has been pulled down, which does not appear to be the case. It might be due to a gland higher up

Illustrations of Nasal Endo-rhinoscopy (Epidiascope).—P. Watson-Williams.—This series of twenty-nine drawings, illustrating endo-rhinoscopy, emphasises the value of the exact inspection of the naso-pharynx and the posterior portion of the nasal passages, more particularly for the detection of pathological conditions which, by all other means, are invisible.

Some of the cases illustrated show small streams of muco-purulent discharge from one or both sphenoidal sinus ostia, or from the middle meatus posteriorly, and in some of the examples probes are shown entering the sphenoidal and frontal sinuses. Examples of minute polypi in the spheno-ethmoidal region of early malignant growths in the naso-pharynx are included. Other illustrations show changes in the opening of the Eustachian tube in swallowing as compared with the appearance during quiet respiration. The great majority of the illustrations have been taken with the Holmes' modification of Valentin's nasopharyngo-scope; there is only one example of the picture obtained by Wolff's instrument to show the disadvantage the inversion of the image yields, the more restricted area coming into view.

Dr. KELSON: When working with this instrument, I was so disappointed in my results owing to pus and mucus getting on to the reflecting surface of the instrument, so that one could not see, that I gave it up. How does Dr. Watson-Williams prevent the mirror being soiled by the discharge, as it is in cases when such is present that it should be most useful?

Lieut.-Col. PERRY GOLDSMITH: I know this instrument, as I saw it when first exhibited. It is Valentin's instrument, with the curve slightly altered, to which somebody else's name has been attached. While that is common in the United States, it is not unknown in this country. When I saw the instrument exhibited by Dr. Holmes, in Boston, I could not see very much with it—nothing as much as he saw—nor could I do so for some time until I had the instrument and used it. I find it of value in a limited number of cases. It shows you are in the Eustachian tube when passing a bougie; not infrequently we think we have passed it there, and it is not so. Secondly, there are cases with chronic catarrhal otitis which do not clear up, and the nasopharynx is invisible. With this

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instrument you can examine the fossa of Rosenmüller, and occasionally the opening of the sphenoidal sinus and a polypus in the posterior ethmoidal region. I regard the instrument as of great value, and the more one uses it the better one likes it. It is not a toy, and one can see better than with a post-pharyngeal mirror.

Dr. DUNDAS GRANT: I have not used this endo-pharyngoscope as often as I might have done, because I am constantly doing posterior rhinoscopy, and getting a good view. To-day, however, I had a case of slight adhesion, owing to which I could get a good view with the posterior rhinoscope, and this instrument got me out of the difficulty, which was to prove absence of disease at the mouth of the Eustachian tube. No doubt one has to study and correct one's own eyes, but I do not find the instrument easy.

Major WATSON-WILLIAMS (in reply): After cocainisation one is much less likely to have the mirror clouded. If that should happen, I draw the instrument out, clean it, and replace it. But once or twice I have had to mop out accumulations of pus. My experience at the beginning with the instrument was much like Dr. Dundas Grant's. I am now using it almost constantly, and in many cases would feel lost without it, so I keep three instruments at hand lest I should get stranded.

A Piece of Mutton-bone removed from the Entrance to the Œsophagus.—Sir William Milligan.—A large piece of bone removed from the entrance to the œophagus. Patient, a soldier, swallowed the bone while taking a hurried meal in the trenches. Complained of severe pain, and experienced the greatest difficulty in even swallowing fluid. Was sent home at once. First attempt to dislodge the bone (under general anæsthesia) failed. Second attempt, forty-eight hours later, succeeded. Irwin Moore's forceps were used upon both occasions.

Fibro-papilloma of Trachea; Removal by External Operation; Recovery.—Sir William Milligan.—M. W——, aged twenty-nine, female. Gradual and progressive dyspnœa for a few months before becoming a hospital out-patient. While attending medical out-patient clinic, June, 1917, developed pneumonia. Admitted as an in-patient, and, after recovery, was transferred to the Throat and Ear Department, August, 1917. Upon indirect examination an elongated growth was seen upon the posterior wall of the trachea and apparently occupying about five-sixths of its lumen. The slightest exertion caused great dyspnœa.

Direct examination showed that the growth was springing from the posterior wall of the trachea, and was about $\frac{3}{4}$ in. in length, firm and resistant to palpation with a probe and presenting a slightly lobulated surface.

Tracheotomy was performed under local anæsthesia, followed at once by a crico-thyrotomy. The growth was removed piecemeal by forceps and scissors, and its broad attachment to the posterior wall of the trachea rubbed freely with chromic acid (40 per cent.) The external wound was immediately closed, but the tracheotomy tube was retained for a week. Complete recovery. Patient able to resume her work as a table-maid.

(Slides demonstrated by epidiascope.)

Dr. WILLIAM HILL: I wrote an article on this subject for an encyclopædia, and I described it as Tilley's method of combined bronchoscopy and screen examination. I employed a method which was published by one of my assistants at St. Mary's Hospital, with skiagrams. We saw the pin grasped, and it gave way. We again seized the pin, drew it down, then altered the position of the forceps, grasping the point, and

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we got it up with ease. I did this, having seen Mr. Tilley do it at University College Hospital eight years ago.

Dr. DUNDAS GRANT: I have on a former occasion mentioned the case of a child on whom I did tracheotomy on account of papillomata of the larynx. I found, however, that the child did not breathe better. I removed the tube and discovered a portion of growth presenting at the tracheotomy orifice. I removed a large papilloma growing from the wall of the trachea, and the breathing was restored. I do not remember another such case, and agree that it must be a rare condition. In operating on the bronchial tubes under the fluorescent screen, the difficulty would seem to consist in looking into the screen and manipulating the forceps at the same time. All that I have done in that way with the screen has been to pass an œsophageal bougie in a case of dilatation of the œsophagus from "cardiospasm": by that means I was able to guide it through the abdominal œsophagus and the cardiac orifice, steering clear of the dilatation in which the bougie is so apt to lose itself.

Dr. KELSON: Was the diagnosis verified by microscopical examination, as so many of these growths are found to consist of thyroid tissue?

Sir WILLIAM MILLIGAN (in reply): I have used this method for years, but as this was a particularly good case I thought it might be interesting to record it. With regard to the case of tracheal growth, I am sorry there has not been more discussion, as it opens up a very important matter. Many of us are doing Army work, and must have seen a good number of men wearing tubes which they cannot do without. The question arises as to how to deal with these cases, and how to deal with this girl also becomes an important question. I have always found it very difficult to re-establish the patency of a trachea which has been occluded in the manner described. I have not much sympathy with a laryngostomy, because it is very difficult to get success with after-treatment. In answer to Dr. Kelson, the report on the character of the growth was made by Prof. Dean, our pathologist.

Fracture of Four Rings of the Trachea; Urgent Dyspnœa; Operation; Recovery.—Sir William Milligan.—A. S——, female, aged twenty, a munition worker, while at her work got a scarf which she was wearing round her neck caught in rapidly revolving machinery with the result that she was all but strangled. Owing to the scarf giving way the patient's life was probably saved. Urgent dyspnœa, pain in the neck and expectoration of blood immediately followed. She was admitted to the Manchester Royal Infirmary and a tracheotomy was at once performed under local anæsthesia. On opening the wind-pipe four tracheal rings were found to be fractured. At the end of three weeks the tracheotomy tube was removed and the patient transferred to the throat department. Owing to increasing dyspnœa the tube was re-inserted. Direct examination showed a mass of granulation-tissue occupying the greater part of the lumen of the trachea opposite the second, third and fourth rings, and nearly occluding it.

By passing bronchoscopic tubes of increasing size the stricture in the trachea was dilated, and at the present moment the girl is wearing a large O'Dwyer's intubation tube.

Suggestions as to further treatment will be welcomed.

Case of Complete Laryngectomy.—Walter Howarth.—The larynx was removed for carcinoma on June 3. As there does not appear to be any development of a pharyngeal whisper, the question

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of speaking apparatus arises. Opinions are invited as to the advisability of this, and the form of apparatus most likely to be useful.

Congenital Deformity showing a Nose with Four Nostrils.—Sir StClair Thomson.—The patient is a female infant, aged four weeks. The extremity of the nose shows three good-sized vestibules with two columellæ, and, on closer inspection, a smaller fourth orifice is visible. Further examination with a probe shows that it is the most external orifice on each side which is the true air-passage, the two supplementary orifices being internal to them. These latter orifices are blind *cul de sacs*, the smaller one being only about $\frac{1}{4}$ in. long, while the larger one passes inwards for $\frac{1}{2}$ in. There is a deviation of the end of the septum to the right: this is interesting in view of the general agreement that nearly all deviations are acquired and that most of them are traumatic.

Opinions are invited as to (*a*) the embryological origin, (*b*) the operation advised, and (*c*) the age at which treatment should be undertaken.

Nasopharyngeal Growth for Diagnosis.—Buckland Jones.—Patient, a male, aged twenty-eight, complains of nasal obstruction and occasionally of feelings of suffocation. There is no history of pain or hæmorrhage or of any previous operation. Opinions are requested as to (1) the nature of the growth, and (2) as to the advisability of operative interference.

Case of Fibrosarcoma?—A. L. Macleod.—Patient, a male, aged seventeen, by occupation a labourer. Duration of the disease, eight months. In January last he began to bleed from left nostril; this continued every few days, and he found difficulty in breathing. In March there was yellowish discharge from left nostril. No feeling of growth in the throat was present. He came to Leicester Infirmary in October. Two attempts to remove the growth with the snare failed, even a very thick wire breaking.

Pathologist's Report.—The section shows huge masses of bacteria (probably staphylococci) throughout the granulation-tissue. There is no evidence of neoplasm in the section.

ROYAL SOCIETY OF MEDICINE: THE SUMMER CONGRESS OF THE SECTION OF LARYNGOLOGY.

Her Highness Princess Marie Louise visited the Summer Congress of the Section of Laryngology at the Royal Society of Medicine on Saturday afternoon, May 3. She was received by Brig.-Gen. Birkett, C.B., C.A.M.C. (Montreal), Hon. President of the Congress, Dr. James Donelan, President of the Section of Laryngology, Sir Humphry Rolleston, K.C.B., President of the Royal Society of Medicine, Dr. W. Pasteur, Hon. Treasurer, Mr. J. Y. W. MacAlister, Secretary, and by Dr. Irwin Moore, one of the Hon. Secretaries of the Congress.

Her Highness was greatly interested in the exhibits of Plastic Facial War Injuries from the Queen's Hospital, Sidcup, shown by Major H. D. Gillies, R.A.M.C.

She availed herself of the opportunity of inspecting many of the rare books and manuscripts with which the Library is so richly endowed, as well as a most interesting collection of manuscripts and instruments belonging to the late Sir Morell Mackenzie, recently presented to the Royal Society of Medicine by Mr. Mager, upon which we hope to publish an account in a future number of this Journal.

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