SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

President—Dr A. Logan Turner.

February 6, 1925.

Two Specimens with Sections of Salivary Glands removed from the Tonsil Bed, and One Section of Salivary Gland removed from the side of the Tongue adjoining—H. M. Wharry, F.R.C.S.—*Specimen I.* Removed by exhibitor from left tonsil bed of a baby, aged 10 months, suffering from enlarged glands in neck. Left tonsil, which was only one quarter the size of the right, removed intact; tumour found beneath it; on section salivary gland.

Specimen II. removed by Mr Julian Taylor from child aged 12. Tonsil removed intact, section made because of the abnormal appearance of one end. Abnormal part proved on section to be salivary gland, separated from the lymphatic portion by only a thin strip of fascia.

Specimen III. removed by Mr Julian Taylor from side of tongue adjoining tonsil bed in a child. Section shows a salivary gland.

All are fully functioning salivary glands.

Mr H. J. Banks-Davis asked whether these specimens were shown with the object of giving some explanation of the throat dryness occasionally seen after enucleation of tonsils. If in this kind of case the tonsil contained salivary gland, evidently entire removal would result in subsequent dryness.

Dr Logan Turner (President) asked whether Mr Wharry was able to satisfy himself that the submaxillary and sublingual glands were in their due place in this patient, or whether the glands removed with the tonsils were the only examples the patients had of this group of salivary glands. The salivary glands were evaginations from the buccal mucous membrane. In some animals, such as the cat, the sublingual gland was retro-lingual in position, hence an aberrant position in the human subject was possible.

Dr Salisbury Sharpe asked whether the enucleation of the tonsils was accompanied by more hæmorrhage than was usual, as the salivary gland seemed to be supplied by the same vessels as the tonsils.

Mr Herbert Tilley (replying for Mr Wharry) said the salivary gland tissue was encountered unexpectedly when the tonsil had been enucleated in the ordinary way. A fat-like substance was seen bulging into the lower part of the fossa, and Mr Wharry found this to be salivary gland structure. There was no abnormal hæmorrhage.

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Royal Society of Medicine

Extensive Tuberculosis of the Larynx healed by Sanatorium Treatment, Silence, and the Galvano-cautery—Sir ST CLAIR THOMSON, M.D., F.R.C.S.—Male, aged 36, was admitted to Sanatorium (Midhurst) in December 1922, with tuberculosis, Group III., *i.e.*, two lobes affected each side, tubercle bacilli in sputum. Left half of epiglottis purplish, congested, infiltrated, ulcerating on laryngeal surface. Both vocal cords, in their whole extent, largely destroyed by mouse-nibbled ulceration and overlapped by hypertrophy of ventricular bands; some thickening of left aryepiglottic fold. His business demanded much speaking.

He maintained strict silence for ten months. Treatment by galvano-cautery employed in 1923 in April, June and July.

At present gained 22 lb. in weight; steady temperature; no cough; arrested lungs. Left vocal cord quite normal; right cord intact and narrow, but much limited in its excursion except in abduction, owing to scarring. Scarring also prevents the right aryepiglottic fold from coming forward and hence sinus pyriformis not so visible on that side, but cords meet well. Faint suspicion still of thickening in outer part of left aryepiglottic fold, some compensatory hypertrophy of left ventricular band.

He lives in open-air hut and since Christmas has resumed profession as a showman of sea-lions.

Mr HERBERT TILLEY congratulated Sir St Clair Thomson on one more of his series of cases, which proved the necessity of silence treatment in this type of the disease. One case shown by himself (the speaker) at the Section was galvano-cauterised, and the patient afterwards went to Midhurst. She was still at work, and it was now practically impossible to detect which cord had been punctured. In her, the lung condition seemed to be localised and quiescent. It seemed that the œdematous mucous membrane in the present case should be punctured, as it would probably complete the cure.

Dr W. JOBSON HORNE said that a point overlooked in cases giving successful results was that there might be also syphilis. Often such a history could not be obtained, and the Wassermann reaction was negative, but the possibility of the combination should always be remembered.

Sir ST CLAIR THOMSON (in reply) said his object in bringing the case was to call attention to the fact that this was a Group III. patient—*i.e.*, one of those patients who, on the average, would be, in 60 per cent. of cases, dead in three years if the larynx were free of disease, and in 80 per cent. dead if the larynx was invaded. The case was one of very extensive tubercle, and the view taken at first was not a hopeful one. Among the causes of success he placed the man's own cheerful personality, which was quite an asset to the other patients at Midhurst. He was on ten months of silence, and the cautery was not used until he had been there four months. If these patients had tuberculosis in the lungs, the older they were the more favourable was their case; but an elderly case with

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tubercle in the larynx and no tubercle in the lungs was a bad case, whereas an elderly person who had tubercle of lung and developed disease in the larynx was a favourable case compared with younger people.

He carried out the local treatment under cocain. Some sensitive persons had a hypodermic injection of morphia half an hour beforehand, and a 10-per cent. spray was used. He did it by the indirect method, and started carefully to see how the patient tolerated it. If both cords were affected, he applied it to only one at a time at first, and if it was well borne, he attacked both at later sittings.

"Puncture" was a good word, as he used only a fine-pointed electrode, and this was passed as far as it would go without encountering definite resistance; it felt as if it were being passed through butter. When the cautery reached healthy tissue, it required definite force to push it further, and at this stage it was withdrawn. If the whole cord was diseased, he made two or three punctures. The disease, as a rule, was found in the vocal cords and interarytenoid area, and when there, the case was more favourable than in other parts of the larynx.

He had used the method for relief of dysphagia in cases in which he had no hope of effecting a cure; he employed a deep puncture in each arytenoid, or two or three in the epiglottis, and in some cases it greatly relieved the pain.

With regard to scarring, he had a few cases which had healed spontaneously, and there was slight stenosis; but when marked stenosis did occur, much of it was due to the galvano-cautery.

Mr Tilley's patient came back to Midhurst after fifteen years, with a recurrence of disease in the chest, but there was no return of disease in the larynx. Owing to the cure of her laryngeal lesion, she had been able, during these years, to earn her living as a schoolmistress.

With regard to a combination of syphilis and tubercle, he was not sure what Dr Horne suggested, because, according to the books, one disease generally made the other worse. If it was suggested that improvement resulted, he had not examined his statistics sufficiently to enable him to be sure on the point. His impression was that if syphilitic patients acquired tubercle, the laryngeal condition was slightly mitigated, and was more likely to be of the fibroid type.

Fibro-sarcoma of Nasal Pharynx treated by X-rays and Radium—NORMAN PATTERSON, F.R.C.S.—Boy, aged 18, when first seen, December 1917, had swelling above and below zygoma; the naso-pharynx was blocked by a large tumour; pain and epistaxis; an operation previously performed.

14th December 1917.—Fifty mgm. radium inserted into external tumour for twenty-four hours; subsequently X-rays applied. Radium and X-rays repeated. The tumour gradually disappeared; no recurrence.

Mr HAROLD BARWELL asked why Mr Patterson named this fibro-sarcoma rather than fibroma. These cases showed the quickly growing fusiform cells of young fibrous tissue; but they did not form metastases, nor did they occur as secondary deposits in the glands.

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Mr E. MUSGRAVE WOODMAN said that microscopically these tumours looked like vascular, rapidly-growing fibromata, and they did not form metastases nor involve the glands, but locally they were very malignant; they recurred many times and gradually spread and killed the patient unless they were cured. His only case of fatality in the upper jaw was a case of the kind in a child of 15 years. When beginning to remove the tumour the bleeding was so severe that he had to stop. Radium was used, but a month later the patient was dead.

Mr E. D. D. DAVIS said he thought a distinction should be drawn between fibromata occurring in the naso-pharynx, and the very malignant round-celled sarcomata which produced the so-called "frog-face." The radium application caused sarcomata to disappear like melting ice, but the patient died of secondary deposits in other organs. He had one distressing case in a boy aged 17, a lympho-sarcoma which disappeared quickly after the insertion of 50 mgm. of radium, and he was comparatively well; but in five weeks he returned looking very anæmic and ill, and in four months he died of diffuse sarcomatosis.

Mr NORMAN PATTERSON (in reply) said that it was difficult to decide whether these growths were sarcomata, fibromata, or fibro-angiomata—he had heard them called all three by eminent pathologists. Locally they were malignant, and attained a great size, and that form of tumour eventually produced "frog-face." If this boy had been left alone he would have been dead years ago. He thought the term fibro-sarcoma was an appropriate one: the tumour responded to radium, and he did not think fibroma responded in the same way.

Large Laryngeal Growth—NORMAN PATTERSON, F.R.C.S.—Woman, shown by Dr Bond, in May 1902.* Extract from *Proceedings:* "Husky voice, thirteen months, no cough, no difficulty or pain in swallowing, no night sweats, temperature normal. One severe attack of stridor, no enlarged glands: on right side of larynx large red mass, firm on palpation, extending from below cord to level of epiglottis. Right arytenoid and aryepiglottic fold merged in mass." In discussion general opinion favoured tubercle. One member suggested sarcoma. Dr Bond would not commit himself. Eighteen years ago Dr Bond performed tracheotomy as patient was in poor state of health. Tumour still present, exhibitor thinks it must have enlarged considerably. The patient will not consent to removal.

Dr LOGAN TURNER (President) said he thought it might be a chondroma of the larynx. He did not investigate the feeling of resistance which it offered; this was an important diagnostic point.

Sir JAMES DUNDAS-GRANT said that if one saw this case for the first time now, without learning the history, one would say—as he did twenty-three years ago—that it looked like sarcoma. In view of the history, however, that idea could not be persisted in and the growth might possibly be an enchondroma.

* Bond (J. W.), "Case of large laryngeal growth in a woman," *Proc. Larynx. Soc.*, London, 1902, vol. ix., p. 124.

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Dr W. H. KELSON said he thought it might be a lipoma with a good deal of fibrous tissue in it. Mysterious swellings of this description had been shown from time to time, and they usually turned out to be lipomata.

Mr NORMAN PATTERSON (in reply) said he did palpate this tumour, and on the surface it was rather soft. He might be able to get permission to remove the tumour, and if so, he would show the case again.

Diffuse Osteomyelitis of Skull from Acute Frontal Sinus Suppuration—H. BELL TAWSE, F.R.C.S.—Male, aged 19, had in June 1923 severe pain over bridge of nose and left orbit; high temperature; delirium; no nasal discharge.

9th July.—Abscess in left inner canthus burst; a few days later tender swelling appeared over forehead, followed by one on top of head and another further back, both in middle line.

During following four weeks he had almost continuous headache and feeling of weight on top of head, and swellings increased.

On 3rd September was first seen by exhibitor. Nose showed marked septal deflection to left; middle turbinal not seen; no pus visible right or left nose; discharging sinus in left inner canthus; marked thickening over frontal eminences — two swellings size of pigeon's egg in mid-line extending from this thickening nearly to occiput.

Skiagram showed pus in left frontal sinus, doubtful in right. Numerous sequestra scattered from front to back of skull.

5th September.—Swellings incised, glutinous pus, numerous sequestra removed, left frontal sinus opened and drained.

24th September.—Resection of septum and amputation of anterior ends of both middle turbinals.

5th November.—Boggy swelling in mid-line of forehead opened by extending original incision. Left frontal sinus again opened up and incision joined to vertical one. Intersinus septum necrosed, pus and polypi in both sinuses, dura mater exposed by disease in posterior wall of left.

Howarth's operation on left side; intersinus septum removed, drainage tubes passed into both nasal cavities and secured; external drainage of both sinuses. Uninterrupted recovery.

The interesting feature was the extensive osteomyelitis involving the whole frontal bone and much of the parietal without apparently any temperature, etc., after 20th July.

Pathological Report.—*Staphylococcus aureus.*

Mr HERBERT TILLEY said he had often had the impression that if one saw a case of early frontal osteomyelitis supervening on disease one could cure it by operation. He had published in the *British Medical Journal* 1917, a case in which there was most extensive disease. He made the incision in the hair-line from the parietal bone to the level of the zygoma and forwards to the eyebrow so as to throw the flap

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towards the middle line. The patient was a lady in the prime of life, and the line of the incision could not now be seen. He had to take away the whole of the left half of the frontal bone; the dura mater was adherent to the cortex and portions of this came away with the diseased bone. When the limit of the inflamed bone was reached, the wound was lightly stitched up, and she recovered. Osteomyelitis which started secondarily to operation he had rarely seen cured, except in one or two cases which Mr Mollison showed. Mr Tawse had obtained an excellent result in his patient.

Mr NORMAN PATTERSON said he had had a case which was operated upon for disease of the frontal sinus at Shanghai. The patient came to England, and had a second operation, which was done by Mr Lambert Lack. During Mr Lack's absence he developed more trouble in both sinuses, and the speaker took charge. Extensive osteomyelitis occurred, and finally the whole frontal bone was taken away. The patient was now back at Shanghai, and was very busily engaged on important work. He was quite well.

Dr LOGAN TURNER (President) said he did not consider the prognosis in these cases was as bad as Mr Tilley implied; he (the speaker) had notes of nine recoveries from spontaneous, and four of post-operative osteomyelitis, gathered from the literature and in answer to a questionnaire which he had sent out.

Mr A. J. HUTCHISON said he hoped to be able to show a case of post-operative osteomyelitis which he hardly dared yet to claim as cured, though he hoped it was. It started with the extraction of a tooth, and both antra, both frontals, the ethmoids and both sphenoids were involved. The last of several operations was done two months ago, and since the scars healed the man had been apparently well.

Mr TAWSE (in reply) said that, contrary to what the notes stated, the occipital bone was not involved, but the entire frontal bone was. He made a long incision through two big swellings from the parieto-occipital suture down to the frontal region, opening up the left frontal sinus, through a separate incision, and put in tubes. He did nothing more for some weeks. He did no chiselling and no curetting. After all was clean he opened it up again, and dealt with the right frontal sinus.

Specimens and Microscopic Slides of Polypus of Nasal Septum—H. BELL TAWSE, F.R.C.S.—(1) Female, aged 29, with epistaxis so serious during confinement that she was almost pulseless; removal of polypus twenty-four hours later. *Pathological Report.*—Hæmangeioma.

(2) Female, aged 34, with free epistaxis in last fortnight of pregnancy; polypus blocking anterior naris. *Pathological Report.*—Capillary angeioma.

(3) Female, aged 36, with occasional epistaxis during last month of pregnancy; free bleeding during confinement, and to a less extent for three months after; polypus blocked anterior naris.

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Pathological Report.—Sections show very vascular and fibrous and rather dense granulation tissue which has resulted from the superficial erosion of a simple muco-fibrous polypus. The remains of the epithelium, though disordered and inflamed, are typical in construction. All three polypi arose from the same area—the anterior quarter of the septum.

(4) Woman, aged 55. *Pathological Report.*—In the sections one area shows an irregular adenomatous condition, due apparently to a proliferation of mucous gland tissue. Another area shows an angeiomatous condition.

Rhinolith of Large Size—T. B. JOBSON, M.D.—Female, aged 60, had obstruction and discharge of yellow matter from left nostril over thirty years; of late years obstruction had been complete; necessity of wiping her nose frequently had become a social disability; no pain or headache.

Transillumination was dull on left side. Large polypus blocked left nostril.

Caldwell-Luc operation; after removal of polypus a large rhinolith was found; antrum full of thick caseous pus. Rhinolith delivered through nose with some difficulty, a few fragments breaking off in the process.

The main mass exhibited weighs 157 grams. On section it shows a light-coloured friable core—the exact nature of which is unknown.

Chemical composition: calcium phosphate and carbonate.

Dr WILLIAM HILL said he had had two cases of rhinolith, which he had been obliged to crush. This case looked like rhinitis caseosa, and the association was fairly common. He did not know which appeared first. Caseous rhinitis of the antrum had been recorded many times when there were rhinoliths of any considerable size.

Dr W. T. GARDINER said that four years ago he operated on a case which was thought to be one of a large sequestrum of the nasal septum with a defect in the hard palate. Wassermann reaction negative. Access was obtained through the antrum but the sequestrum could not be removed. A fortnight later he tried partly through the antrum and partly through the hole in the palate. The sequestrum broke up and proved to be a rhinolith, the nucleus of which was a bone trouser-button. There had been a unilateral foul discharge for over forty years.

Dr JOBSON HORNE said that in a case of his the rhinolith had formed around cotton-wool, and there was a good deal of rhinitis caseosa, which he considered was secondary to the rhinolith.

Mr J. ALDINGTON GIBB said that when he was a house-surgeon a spur in a lad's nose was spokeshaved, not treated by septal resection. Six months after there was rhinitis caseosa, caused by the spur becoming wedged in the nose. Its removal brought about a rapid cure.

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Mr G. WILKINSON mentioned a case in a child in which he found the nucleus was a piece of rolled-up newspaper, which had become impregnated with calcium salts. It closely resembled, at first sight, an elongated sequestrum of bone.

Dr JOBSON (in reply) said that he had had the rhinolith bisected. It showed a central core the nature of which he did not know. The antrum was full of caseous material, as one found in rhinitis caseosa.

Larynx removed for Malignant Disease under Local Anæsthesia—W. S. SYME, M.D.—Local anæsthesia was employed because of debilitated state of patient, man aged 50. Anæsthesia, induced by infiltration of 1 per cent. novocain solution, was altogether satisfactory. The man, however, died of heart failure the following day.

Atrophic Rhinitis treated by the Implantation of a Piece of Cartilage—W. M. MOLLISON, M.Ch.—Adult female had suffered for years from atrophic rhinitis with large crusts which caused much discomfort by falling into naso-pharynx.

On 18th December 1924 tissues on floor of nose lifted up through incision under upper lip, and a piece of rib-cartilage inserted along floor of nose.

No crusts have formed since and the patient finds great relief.

Sir JAMES DUNDAS-GRANT said the nasal cavity was still large enough to be compared with that in ozœna. It seemed as if the cartilaginous graft had some dynamic effect. Sometimes the injection of a very small quantity of solid paraffin produced a marvellous improvement; even though it was too little to make any appreciable difference in the size of the cavity. At present the mucous membrane looked as if it could scarcely have been the seat of atrophic rhinitis.

Mr PHILIP FRANKLIN said that, in our present state of knowledge, caution was necessary in ascribing cures to any particular treatment whether operative or palliative. Some cases underwent spontaneous cure, and others reacted favourably to various kinds of treatment.

Mr E. MUSGRAVE WOODMAN congratulated Mr Mollison on his result. He (the speaker) said he had used cartilage in the nose in ozœna. In three cases improvement resulted, but the cartilage sloughed and came away through a hole in the septal wall. He was careful not to perforate the muco-periosteum. There was much transmigration of sepsis through the naso-septal wall. The method in this case was better.

Dr W. H. KELSON said the above treatment raised a large question. Anyone reading these notes might think there was a suggestion that reducing the size of the cavity had cured the atrophic rhinitis. He asked whether Mr Mollison meant that. He (the speaker) did not think that atrophic rhinitis with its very peculiar odour could be cured by merely reducing the size of the nasal cavity. He had never seen such a case.

Dr W. S. SYME said a larger piece of cartilage would have reduced the lumen of the nose still further. He still treated cases by displacement of the antro-nasal wall, and the results in the cases he reported to the

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Section last June had so far been maintained. It was necessary to wait two or three years to see whether there was any recurrence of symptoms. In some of the cases so treated there was considerable retraction for a time, there was no further crusting formation, and the sense of smell returned in some. The appearance of the nose suggested that there was at least an œdematous condition which kept the mucous membrane moist. The operation could be done under local anæsthesia, and was not difficult.

Mr J. ALDINGTON GIBB asked whether the narrowing of the channel was supposed to bring about the destruction of the causal micro-organisms in the disease. If this was not brought about, the case could not be said to be cured.

Carcinoma of Left Vocal Cord, one year after Operation—W. H. JEWELL, O.B.E., M.D.—Male, aged 61, previously shown to Section, when general opinion was in favour of epithelioma; opinion also expressed that the infiltration was subglottic.

Laryngo-fissure performed February 1924. Larynx and skin united with sutures at time of operation and tracheotomy tube left in for twenty-four hours. Larynx and rings of trachea ossified.

Pathological Report.—Squamous-celled carcinoma.

Mr G. W. DAWSON said he remembered the case and the growth was an extensive one. He had seen one or two others even more extensive that had done perfectly well on the conservative operation as opposed to the major operation of laryngectomy.

Mr JEWELL (in reply) said that the tracheotomy tube was left in twenty-four hours, and there was no trouble. He did not think there was any immediate need to leave the tube in, but as he was not going to see the patient for a week, he thought it would be safer to leave it. The cartilages of larynx and trachea were ossified. One or two spicules came through, but there was no trouble. No resection of lateral plate of larynx. Patient made an uninterrupted recovery, taking liquids on the evening of the day of operation and semi-solids the next day. Highest temperature, 99° F. Patient said his voice was better than before the operation, and at times he had a normal voice. Respiration was free and tranquil, and there was no shortness of breath. On laryngoscopic examination there was no evidence of recurrence.

Nasal Growth: Sarcoma of Ethmoid: Removal by Lateral Rhinotomy—Dr IRWIN MOORE.—Female, aged 19, was previously shown 7th November 1924, as a "Case of Nasal Growth" (*Journ. of Laryng. and Otol.*, vol. xl., p. 117, 1925).

Moure's lateral rhinotomy, on 20th November, fully exposed the growth. Fibrous hardness and smooth surface of anterior portion confirmed; the remainder found to be soft, cystic, and easily broken down. Tumour originated from right ethmoid cells, which had been destroyed. Sphenoidal sinus was also involved. The right antronasal wall was partly absorbed by pressure of growth, which occupied the

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greater portion of the maxillary antrum. Cartilaginous portion of septum, and greater portion of vomer also absorbed. Soft parts stretched across the left nasal cavity, adhering firmly to the antronasal wall, while the site of the left nasal cavity was occupied by growth.

Microscopically, a round-cell sarcoma (A. N. Leathem).

Recovery marred by severe outbreak of erysipelas—fourteen days after operation—which attacked side of face involved by growth, but did not break down wound, nor interfere with operation area.

15*th January*—A tube of radium—34 mgm. strength, with 2 mm. lead screening—placed in nasal cavity for twenty-four hours.

Naso-pharyngeal Growth—F. BRAYSHAW GILHESPY.—Patient, aged 21, seen early in 1923, with post-nasal space filled by very vascular growth, causing complete nasal obstruction; malignant endothelioma; radium 65 mgm. inserted with rapid disappearance of neoplasm. Seen one year ago with slight recurrence in same position. Radium inserted —35 mgm. twelve hours—again six months ago. X-ray photograph taken 20th January 1925, shows antra clear, ethmoids dim: nasal space appears filled up.

At present, growth seen in nose and roof of naso-pharynx.

Mr E. MUSGRAVE WOODMAN said Mr Gilhespy showed the case to him five months ago with a small growth at the back of the nose, and he (the speaker) asked him to try further radium before submitting the case to operation, because of the high mortality which took place when dealing with malignant growth at the back of the pharynx, contrasting with the results from removal of the upper jaw; further, he did not think mere retraction of the palate was sufficient. At present there was a big growth at the back of the pharynx, and it had extended along the floor of the nose on the left side, and had not reached the antrum. He thought the best method of approach was by a combination of upper jaw and post-pharyngeal operation, removing the upper jaw partially on the left side, leaving the orbital plate, and removing the hard palate on that side and leaving the soft palate. There need not be much loss of blood.

Sarcoma of Nasal Septum treated by Radium—PHILIP FRANKLIN, F.R.C.S.—Male, aged 51, shown as a case of ulcer of the nasal septum (*Journ. of Laryng. and Otol.*, vol. xxxix., p. 344, 1924).

In January 1925 there was destruction of septum extending from just beyond vestibule to within half an inch of posterior edge, and from roof to floor of nose. Examination under anæsthetic one week later; large piece of growth removed.

Microscopical Report.—Mixed cell sarcoma with a delicate fibrous stroma.

Fifteen mgm. radium applied for twelve hours to roof, floor, and posterior part of septum. Result satisfactory except for a portion in roof. Another application of radium will be given later.

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