Societies' Proceedings

SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY.

TWENTY-EIGHTH MEETING, GLASGOW.

November 24, 1928.

President—Dr Ross Souper.

Dysphagia and Anæmia—Dr Munro Cameron (introduced by Dr A. Brown Kelly).—The Paper is published in the *Journal of Laryngology and Otology*, vol. xliv., March 1929, p. 168.

Discussion.

Dr Brown Kelly said he was interested to hear that Dr Munro Cameron distinguishes two kinds of dysphagia at the upper end of the œsophagus associated with anæmia ; one, he attributes to spasm, the other to non-relaxation. He (the speaker) had not met with the latter, possibly because the milder cases do not consult a laryngologist. As to whether the dysphagia or the anæmia is primary, he thought that the former leads to the latter.

Dr Harper wished to thank Dr Cameron for his very interesting paper on dysphagia associated with anæmia. Dr Harper thought it would be a good idea if before such a paper were given at the Society's meetings, a short synopsis were in the hands of the members beforehand. Dr Cameron entered into a great deal of detail and some of his words one was not able to hear, but from what he (the speaker) had heard, he thought Dr Cameron's views were very closely associated with those of Mr Hill. They both seem to agree very closely with one another. Such cases as Dr Cameron has described are not uncommon, and he (the speaker) said that up till now he had not looked upon them as of very great importance. Many cases of women present themselves complaining of difficulty in swallowing, and on examination one finds a certain degree of anæmia, and in most of them there is a gastro-intestinal derangement of some kind. The majority of these women are great tea-drinkers. In certain cases there is a quite definite glossitis with very slight changes in the mucous membrane of the larynx. Good results are obtained in the majority of cases by attention to the gastro-intestinal tract, by regulating the diet and by cutting out tea and condiments in any shape or form. Most of them get well on these lines of treatment. If, however, improvement does not take place within a reasonable time, then the possibility of these cases being malignant must be considered. The mere passage of a bougie is not sufficient. The whole of the œsophagus should be carefully examined and it is surprising how frequently dysphagia is due to malignant disease. For some time past he had been examining all cases complaining of dysphagia apart from those associated with anæmia and with acute conditions of the pharynx. He had not had time to look up the whole of the series of cases examined so far, but this morning he examined the records of the first

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51 cases and of these 21 were malignant. In only one case could they find no definite cause for the dysphagia. He was convinced that dysphagia should be looked upon as a very serious condition owing to the great probability of there being a malignant cause.

Dr HOWIE said he would like to have the privilege of reading this paper and hoped it would be printed.

Dr LOGAN TURNER said that his experience was similar to that of Dr Harper. A number of women complaining of difficulty in swallowing over a long period—in some of his (the speaker's) cases for ten, twelve, or twenty years—eventually developed malignant disease in the post-cricoid region or upper end of the œsophagus; further, that the disease occurred in some of these women at a comparatively early age. He hoped that Dr Munro Cameron would continue his investigations into the etiology of cancer in this situation.

Dr J. S. FRASER agreed with what was said about the presence of dyspepsia in these patients and always inquired about this question. It was interesting to note the ages given by Dr Cameron—41 to 60: the trouble occurs at or not very long after the menopause. He (the speaker) asked whether the word "glossitis" was justified. A word ending in "itis" is usually taken to mean inflammation. The dry, glazed appearance of the tongue resembles rather an atrophy than an inflammation. He also asked whether the nerve-endings had been found microscopically to be degenerated. He thought it would be rather a difficult matter to identify the sensory nerve-endings in the hypopharynx. Dr Munro Cameron had found degeneration of the cells of Auerbach's plexus in cases of dilatation of the œsophagus and he (the speaker) would like to know whether he had found degeneration of the sensory nerve-endings in the pharynx. Lastly, he (the speaker) said he agreed with Dr Harper that every case of difficulty in swallowing should be examined by direct œsophagoscopy. Dr Fraser had done this during recent years but he could not say that he had often found changes to explain the condition. One passes the œsophagoscope without much difficulty. All that one sees is the usual projection of the mucosa on the posterior wall at the entrance to the gullet; otherwise the mucous membrane looks normal. When one questions the patient weeks afterwards one finds that the passage of the œsophagoscope has done away with the symptoms. It would be very interesting if they could get these cases followed up on the American plan. If a list of these cases suffering from difficulty in swallowing were kept and if they were written to each year it could be found out whether the trouble had passed off or whether it went on, as is supposed, to malignant disease.

Dr SOUPER (the President) asked whether the condition was frequently found in women of younger age. In the series they had listened to to-day all the women were from 40 to 60. The only case he had had himself occurred in a woman of 23. She had marked dysphagia and well-marked secondary anæmia. There was nothing found in the œsophagus to account for the dysphagia. The œsophagoscopy itself relieved the dysphagia considerably and he found that the frequent passage of mercury bougies improved the condition so much that the dysphagia

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disappeared. Her anæmia also improved. It occurred to him that this was undoubtedly a case of this type although occurring in a woman considerably younger than the series they had heard about to-day.

Dr MUNRO CAMERON (in reply) thought most of the points raised in the discussion, except one of Dr Fraser's, had been dealt with in the paper. He was glad to have the confirmation by experienced observers like Dr Logan Turner and Dr Brown Kelly, of the association of malignant disease and spasmodic dysphagia, and this emphasises again the importance of the early recognition and treatment of this syndrome. As regards the age of the patients, a point referred to by Dr Souper, the average age in Vinson's 69 cases was 48·5 years; in Moersch and Conner's 65, the youngest patient was 23 and the oldest 63, the average being 45. Dr Fraser had asked if actual alterations in the nerve-endings had been seen by him (the speaker). No example of this syndrome has yet been examined by him post mortem, but with modern silver staining there is not much difficulty in ascertaining the state of the nerve-endings on a mucous membrane. Atrophic glossitis is not perhaps an ideal term for the state of the tongue in these patients, as atrophy of the papillæ and not glossitis is the chief characteristic; but he took it that atrophy in this case presupposes a previous form of inflammation, so that to that extent to refer to the condition of the tongue as one of atrophic glossitis is justified.

The PRESIDENT said they were much indebted to Dr Cameron for the very interesting address which he had read to the Society, and he (the speaker) was sure that the editors would see that the work duly appeared in the *Journal of Laryngology*.

Persistent Urticaria cured by Enucleation of Septic Tonsils—JOHN L. HOWIE.—Miss T., aged 47, suffered for six years from recurrent attacks of urticaria, distributed in large areas over the trunk, arms and legs. Treatment directed by her own doctor towards the gastro-intestinal tract was of no avail. Vaccines were suggested by Dr W. H. Brown, but were also futile. Septic teeth were extracted three years ago, with remission of symptoms for a time.

Other two teeth were extracted in September 1927, with no improvement. Dr Brown suggested enucleation of tonsils, which I did in November 1927. Since then she has been perfectly free of the disease.

Dr J. S. FRASER said that frankly he did not think the recording of a single case like this was of any value whatsoever. It was only a year since the urticaria had passed off. It would be very interesting to hear whether in two or three years the urticaria had recurred.

Dr HOWIE said this patient was not present. He did not bring her because there was nothing to be seen except a perfectly clean throat. The case was of interest, of course, as one of the many conditions which one hears a great deal about, of the beneficial effects of removing septic tonsils.

Fibroma of the Palate—JOHN L. HOWIE.—M. R. M., aged 56, has had a palatal tumour for eight years—commenced as a small red

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swelling on the palate, and has gradually grown to the size of a walnut. It was treated by injections by Mr I. Russell without effect. As the tumour has not at any time interfered with deglutition or respiration, he considered it inadvisable to remove it by operation, as result might be unsatisfactory.

Suggestions as to treatment will be welcomed.

Dr GAVIN YOUNG asked why this had been called a fibroma and on what the diagnosis rested. He suggested that it might quite well be of a mixed parotid type. He asked how long that small ulcerated area had been present and if it was not a little suggestive of a breaking-down focus in the tumour. Naturally if it was of the mixed parotid type, he thought the condition ought to be dealt with.

Dr HOWIE said this case was referred to him by Mr Russell, the surgeon. It was in his ward. He did not feel justified in removing it. The question which arises is, Would it be possible to reduce it even partially by diathermy?

Dr HARPER said about a year ago he had a similar case. The growth had been present in the soft palate for two years. It appeared to be about half the size of that in Dr Howie's case. He (the speaker) removed it by operation without difficulty and the pathologist reported the condition as being a carcinoma.

Dr STEPHEN YOUNG asked if there was any Wassermann reaction done in this case.

Dr KEITH ROBERTSON asked what the injections were that Dr Russell gave.

Dr HOWIE said the case was referred to him only the other day and he had had no opportunity of going into it further. It was in Mr Russell's hands till now.

Cases of Paroxysmal Rhinorrhœa treated with Lime Salts—JOHN L. HOWIE.—All had a more or less profuse watery nasal discharge, associated with sneezing, and paroxysmal in character. Mucosa was swollen and sodden in appearance, in some it had the characteristic pale bluish tinge. In several cases the inferior turbinates were swollen, almost filling the nares. These were cauterised with little result.

The administration of the lime salts has in every case restrained the discharge, and in some has completely cleared up the condition and restored the mucosa to a normal condition.

The PRESIDENT asked Dr Howie in what form the lime salts were administered.

Dr HOWIE said he brought forward these cases as one meets with them fairly frequently in general practice. They always seemed to him very unsatisfactory cases to treat. He had no intention, of course, of

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going into the ætiology and the pathology of the disease. This was fully discussed at the Laryngological Section of the Royal Society of Medicine, on 25th April 1925. The report could be seen in the *Journal of Laryngology* for September 1925. There were papers by Freeman, Brown Kelly and others. His (the speaker's) object was to bring before them a line of treatment which he had not tried before. There is very little reference made to it in the text-books. Cauterisation of the enlarged turbinals is usually of little avail. In these two cases he had shown to-day, they were not cauterised at all. One knows the common characteristic appearance. The mucosa is swollen and sodden in appearance, and some have a pale bluish appearance. He said he would like to distinguish this from other kindred diseases. They are very often mixed up with hay fever and asthma. To his mind these cases are not hay fever at all, they are simply cases of spasmodic rhinorrhœa of a modified type. The cases he had come across mostly are in women after the menopause. One can get them in younger people but most of the cases he had come across are women after the menopause. He had tried of course, as they all had tried, and as the text-books suggest, the usual atropine and strychnine mixture, or the triple valerianates, and these do help some cases. He had got far better results with lime salts. The one he had used was "kalzana." He simply used that because it was in the convenient form of a tablet combined with sodium lactate. Ordinary calcium lactate is not so convenient to take. There is evidently a deficiency of lime retained in the body which reacts on the endocrine system and other cellular elements of the body. A deficience has a very definite damaging effect on the nuclei of the cells. It has been tried both on vegetable and animal cells, and in the latter case the blood is altered biologically and chemically. Calcium not only increases the coagulability of the blood but stimulates cellular activity in every organ. One thing he had noticed in all these patients was the general improvement of their health, and the condition is altered in the nose. Instead of that soft bleached mucosa, a comparatively healthy mucosa is established. In conclusion, he would say definitely that these cases, to his mind, were not of a neurotic type. One often sees in the text-books that it is in neurotic patients that one gets this disease, but one gets it in perfectly placid, calm people. None of them, as far as he could make out, had asthma, and none of them had hay fever. There is a difference between a typical hay fever when exposed to the grasses, etc. One gets these cases in winter time. A great deal is written about anaphylaxis. He used to try protein tests but it was very difficult to get a satisfactory result. This was a very fine job for some of the younger members to tackle; this was a very good field for some of them to start in.

Dr ADAM agreed with Dr Howie that these cases have nothing to do with hay fever. He (the speaker) had cured a number of cases by stopping milk. He had oftener failed. It is only a minority of cases in which he had found that milk was the exciting factor. He suggested to Dr Howie that it would be very interesting if he would refer these cases for a blood examination for calcium and amino-acids to Dr Cameron. It was interesting also to hear that Dr Howie had hit on a form of calcium salt which the blood can fix.

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Dr HARPER asked Dr Howie if he had examined into the condition of the sinuses in this case. It is surprising how frequently these cases with œdematous mucous membrane are associated with sinus trouble. The nasal condition clears up if the sinus involved, which is usually the antrum, is given free drainage.

Dr ADAM suggested that both the antra and the ethmoids should be left alone. It was quite obvious that it was a general condition and the weakness in Dr Howie's cases was that he had not investigated the blood.

Dr BROWN KELLY said in treating a case of profuse watery nasal secretion one must consider whether it is due to a vasomotor disturbance or some other cause. A vasomotor case is usually distinguished by the paroxysmal characters of the rhinorrhœa, namely, its sudden onset and cessation and its severity while it lasts. Administration of lime salts is only one of the dozens of methods of treating such cases, and is merely a shot in the dark unless one knows the special indications for their use. The detection of the underlying disturbance is of chief importance in vasomotor rhinitis.

On the other hand, one meets with patients who complain of a constantly wet nose, especially in a cold atmosphere, although structurally the nasal fossæ are normal or too free. These persons have no paroxysms of rhinorrhœa and no excessive sneezing or sudden blocking of one or both passages, consequently no vasomotor rhinitis as generally understood. Such patients—and in this category he would include several of those shown—may benefit decidedly from lime salts.

Dr HOWIE (in reply) said he had not much more to add, but he was very glad he had brought the subject before the meeting. It had led to quite an interesting discussion and he certainly would have the blood examined, and report at a later meeting.

Acute Otitic Meningitis: Recovery—J. W. LEITCH.—G. F., male, aged 18, was admitted late on 25.7.28 unconscious and delirious. His illness was stated to have begun about a week previously with a "chill" and severe pain in the left ear. He became delirious on the forenoon of the day of admission after a night of pain which appeared "worse than ever." He had had chronic ear discharge since the age of ten years, cause unknown, no infectious history.

Examination.—Very irritable and restless. Slight discharge—not very fetid—from left ear. No mastoid swelling. Kernig both legs—especially the left—and marked "*tache cerebrale.*" Nothing of note in heart or lungs. Temperature, 101.4°; pulse, 80; respirations, 18.

Operation within two hours of admission, left mastoid. Cholesteatomatous material in antrum and middle-ear. Mastoid cortex was eburnated. Perisinus abscess with pus under pressure, and massive granulations over the sinus. Bone removed until healthy dura appeared towards middle fossa and cerebellum. Cerebellum explored, but no pus found. Wound packed and left open. Bacteriological report on

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pus from abscess showed a Friedländer bacillus, a diphtheroid bacillus, streptococci and pneumococci. Bacteriological report on cerebrospinal fluid (obtained by lumbar puncture, very turbid, and under pressure)—staphylococci and small Gram-positive cocci, no growth on culture after seventy-two hours.

26.7.28.—Fairly quiet and sensible. Marked nuchal rigidity and double Kernig.

28.7.28.—Left facial paralysis appeared; deafness extreme. Otherwise improvement has been satisfactory.

29.7.28.—Wound has been dressed daily and looks well. Cerebrospinal fluid still very turbid, and under pressure. Given 50 c.c. of 10 per cent. saline intravenously.

3.8.28.—Hypertonic saline injections continued until to-day. Report on cerebrospinal fluid still shows no growth on culture though staphylococci and Gram-positive cocci are present in direct film. Large granulations still present over sinus, and temperature chart indicates sinus infection though the rises have not been accompanied by "rigors." Jugular ligatured under a general anæsthetic. Sigmoid sinus opened and found to be filled with greyish pus which was reported bacteriologically to show a Gram-negative bacillus, a streptococcus, and a diphtheroid bacillus.

30.8.28.—Wound covered with healthy granulations. Left facial paralysis still complete.

13.9.28.—Flap cut and posterior wound stitched.

27.10.28—Reported to-day. Mastoid wound sound and ear practically dry. No change in facial condition though some movement of the affected eyelids is noticed—probably "associated" movement. Hearing, left ear, amounts to loud speech at 1 ft.; right ear, whisper at 1 ft. (Tested with noise-box in other ear.)

Dr J. S. FRASER congratulated Dr Leitch upon the successful outcome of this case. Dr Fraser did not think there was any doubt but that it was a case of meningitis. He was sure that Dr Leitch would admit that cases in which meningitis is associated with another intracranial complication do better than those in which the meningitis is the only intracranial complication. Recently he (the speaker) had had a case in which the patient had an acute otitis media with no evidence of mastoiditis, no bulging of the drumhead or sagging of the meatal wall. Paracentesis was performed. The patient went straight on to meningitis. He (the speaker) consulted with Dr Logan Turner and they agreed it was useless to operate on the ear at all. From the findings at the post-mortem examination, operation would have done no good. Dr Fraser thought they might summarise matters as follows:—Cases in which there are no organisms in the lumbar fluid do best; cases in which there are organisms but no growth on culture sometimes recover; but cases in which there are organisms which grow on culture are almost invariably fatal.

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Dr HARPER said he was glad to see that Dr Fraser was stressing the point which he (the speaker) brought before the Society some time ago, *i.e.*, that cases with no micro-organisms in the cerebrospinal fluid are in a totally different category from those in which micro-organisms are present. There are, he was convinced, two different stages in the same condition and these two different stages should be recognised.

Dr GAVIN YOUNG hoped that when Dr Leitch told them how often lumbar puncture was carried out that he would say whether in subsequent punctures, if any, there were organisms found or not.

Dr J. P. STEWART said in his examination of 114 cases of acute purulent meningitis following middle-ear disease he had found that 8 of the cases presented cerebrospinal fluid in which no organisms were found either on direct examination or on culture. Of these 8 cases, 4 recovered and 4 ended fatally. A post-mortem examination was made on the four fatal cases. Macroscopically well-defined purulent meningitis was present in all. The pus coating the brain was examined for organisms in three of the cases. Organisms were obtained in all three cases. This proves that an acute purulent meningitis can occur with a sterile cerebrospinal fluid.

Dr C. E. SCOTT suggested that these cases fall into the category of cases which were described in the July number of the *Archives of Otology*, 1928, and which were termed "aseptic purulent meningitis" by the author, E. Schmiegelow, Copenhagen, who emphasised the value of lumbar puncture and examination of the cerebrospinal fluid.

Dr ADAM asked Dr Leitch how often he did a lumbar tap.

Dr LEITCH (in reply) said the reason for bringing this case before them was that it answers in part the question he asked at the last meeting—Does a case where pus cells and bacteria are present on films from C.S.F. ever recover? Here micro-organisms seen on films from the perisinus abscess and subsequently in the pus found in the sinus, grew on culture, but similar organisms seen on direct films from the C.S.F. did not grow on culture, and the bacteriologist—very wisely Dr Leitch thought—would not commit himself to a more definite opinion. He (the speaker) was therefore still looking for a case of recovery where organisms have been actually identified in the C.S.F. by growth on culture. In military language the position is that after long preparation the invading forces have delivered their final attack and have actually entered the citadel itself in considerable numbers. The defending forces have put forth a desperate effort, and at an opportune moment most unexpected help has come to them. The invaders' trenches and immediate sources of reserves have been wiped out. Events show that the defenders have dealt faithfully with those who forced an entrance into their citadel and are busy for days in the work of disposing of the corpses of friend and foe. Had a few—even one—of these "storm troops" survived, would that have meant exhaustion of the defending forces and ultimate disaster for them?

With regard to Dr Fraser's point, Dr Leitch quite agreed that as a matter of experience such cases seem to recover more readily if there is a further complication, *e.g.*, a brain abscess or a sinus thrombosis. Why this should be he could not tell.

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In reply to Dr Adam and Dr Young, lumbar puncture was done daily until 2nd August, and cultures made from the C.S.F. several times, but no growth obtained after seventy-two hours though organisms were quite visible on direct films. The organisms in the pus from the perisinus abscess and from the sinus itself when it was opened grew on culture. He had not seen the article referred to by Dr Scott, but the use of a term like "aseptic purulent meningitis" in print seemed to him most unfortunate. Otitic meningitis is better, and it commits one to nothing beyond a belief that the meningitis is secondary to otitis.

Laryngofissure for Epithelioma of Cord—JAMES ADAM.—Robert S., aged 46. 30.8.28.—Hoarseness four months, slight cough. Right cord seemed on indirect examination to be fixed by a growth occupying its anterior two-thirds, and extending slightly across anterior commissure, but with the direct laryngoscope the arytenoid and cord could be seen to move. Wassermann reaction negative. Patient smoked much. 5.9.28.—Laryngofissure under chloroform. Whole of right cord and tiny piece at anterior end of left removed, together with part of thyroid ala. Pathologist's report—epithelioma. 7.11.28.—Granuloma removed from anterior commissure. Granuloma can also be seen on mucous aspect of tracheotomy scar.

Malignant Disease of Larynx—G. B. BRAND.—A. G. B., male, aged 62, epithelioma of the left vocal cord. Laryngofissure with removal of the thyroid ala, 9.11.27. History—loss of voice for two years, no pain or difficulty in swallowing, general health good. Indirect examination of the larynx showed two warty-looking growths on the left vocal cord which was injected and impaired in its movements. Direct laryngoscopy showed a considerable extension of the growth in the subglottic region. A piece removed was reported "epithelioma with the presence of cell-nests and large indippings." Patient was edentulous and the mouth was healthy. Wassermann reaction negative. The laryngofissure was done on 9.11.27. At 6.40 P.M. on the same day patient could swallow water comfortably and the tracheotomy tube was removed. On 10.11.27 the patient was up; on 11.11.27 he was up for several hours; and on 15.11.27 the stitches were removed. Patient went home on 22.11.27 and has been at work ever since. Copy of chart and slide shown.

Dr LOGAN TURNER drew attention to the fact that in one of the cases shown the affected vocal cord was fixed, and in the other there was considerable subglottic extension of the disease. The question therefore arose whether either of these cases was very suitable for laryngofissure as had been practised. He thought the Society should have an opportunity of seeing them at a later date, as recurrence of the disease was a possibility.

Dr ADAM (in reply) agreed that it was a case for watching and said he would be pleased to report in future. One thing that struck him about

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it was that the cord looked much less fixed on direct laryngological examination than when he examined it with the mirror.

Dr BRAND (in reply) said, with regard to what Dr Logan Turner said, the cord in his (the speaker's) case was impaired in its movement and was injected, and the hoarseness had been present for two years. On direct examination they realised the case was just on the border-line, but he thought the result had justified the laryngofissure so far and he would report on the case later.

Otosclerosis and Brittle Bones—JAMES ADAM.—Three brothers Blaney—all under 5 ft., all with scoliosis and kyphosis of spine, so that in each the olecranon is considerably below iliac crest. All have had multiple fractures, six or more, the first occurring about the age of 6; the last at the ages of 51, 48, and 14. Each has pronounced arcus senilis, blue sclerotics, grey irides and soft arteries. Blood calcium and cholesterol normal; X-ray of limb bones (Thomas and Charles) shows nothing distinctive.

James, the eldest, aged 55, is not deaf, had "wax" in his ears and has no otosclerosis. Hearing is nearly normal.

William, aged 52, first paid attention to his deafness when 39, but thinks it began before that and in the left ear. At first he had tinnitus, but this has disappeared. Admits paracousis. The right drum shows retraction and a calcareous deposit, the left is retracted and shows scar of old perforation anteriorly. C.V. at 2 or 3 in. on right and 1 in. on left; W. not heard on contact. There is slight lowering of upper tone limit and distinct raising of lower. C. 256 is lateralised to right but is not heard A.C.; B.C. prolonged. This man has a son of 19 and a daughter of 21; the former is "deaf" in one ear.

Thomas, aged 46, says he first noticed deafness three years ago (?). Right drum perforated, left much retracted; C.V. at about 1 in. Upper tone limit little altered on right, distinctly lowered on left. Lower tone limit raised; bone conduction slightly prolonged; forks not heard A.C.

This man has a son, Charles, aged 10, who has had six fractures, has blue sclerotics and grey irides like his father. Though both membranes are much indrawn he hears a whisper at 30 ft. There are five other children, none deaf. One of these was seen; irides blue, not grey, sclerotics not blue; no fractures. The eldest, a girl, seems to have had one fracture.

Dr J. S. FRASER was interested in the appearance of the drumheads in the two adult cases. Of the four drumheads only one was normal. The other three drumheads showed evidence of past otitis media. He did not dispute the diagnosis of otosclerosis, but he would like to point out that there had been an inflammatory condition present in the middle-ear

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in these cases. They could not restrict the diagnosis of otosclerosis entirely to cases with normal drumheads. He admitted it was more difficult to make the diagnosis when the drumhead is abnormal, but if the patient's deafness is progressive and associated with marked tinnitus and paracousis, and if there is a history of deafness in the family, one may be sure that otosclerosis is present. Of six cases of otosclerosis which Dr Fraser had himself examined microscopically, all had suppurative otitis media.

Dr ADAM (in reply) said that was one reason why he brought forward the cases—to show that these cases did have otitis media. With regard to the otosclerosis there was no doubt at all. He asked Dr Gray to look at one of the cases and he quite agreed with him about the diagnosis. The other interesting point was that certain members of the family who have brittle bones have not otosclerosis. He (the speaker) did not know that these cases advanced them very much further in the ætiology. Another point was that as far as the blood examination went the calcium content was normal. The boy, of course, was too young for otosclerosis, but he has got to be watched. What is the relationship of sepsis to the onset of otosclerosis? Is it more than a coincidence? Of three brothers with fragilitas, two who have had middle-ear sepsis have otosclerosis; the one who has not had the former, has not the latter.

Malignant Disease of Tongue and Pillar treated by Diathermy—G. B. BRAND. — D. G., male, aged 63. First seen in August 1928, complaining of pain at the back of the tongue for about three months. On examination, there was an ulcer on the left anterior faucial pillar and at the adjacent part of the tongue. Glandular enlargement anterior to sterno-mastoid on left side. Patient had some very bad teeth. A piece of the growth was removed and patient was told to have the teeth extracted. The pathological report showed that the growth was epitheliomatous in character, and on 7.9.28 the growth was removed by diathermy. W.R. negative.

Dr BRAND said the interesting point about this case was that at the time he saw him the ulcer was in a very early stage and the gland in front of the sterno-mastoid was markedly enlarged and quite hard. They had to wait for three weeks from the time he (the speaker) saw him till his mouth became clean, and the gland was getting bigger. After the diathermy operation the gland disappeared in about a fortnight's time. The conclusion was that the enlargement of the gland was due to inflammatory change and not to malignancy.

Malignant Disease of Left Pyriform Sinus—G. B. BRAND. —Mrs M., aged 53. Epithelioma of the left pyriform sinus. Growth was removed by a lateral pharyngotomy, November 1927. History.—Complaint of pricking sensation on swallowing for about six months. Examination.—Small shallow ulcer about the size of threepenny-bit in the left pyriform sinus; piece removed "epithelioma." W.R. negative.

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Mr James Russell did a lateral pharyngotomy following Trotter's technique. The growth was easily removed with a wide margin of healthy tissue, without interfering with the arytenoid. There was a slight leak into the neck for three or four days and then an uneventful convalescence. Patient has been in good health since and has put on weight.

Dr BRAND said that this case was done about a year ago. The woman was a physical wreck at the time; she was very thin and very nervous. She did remarkably well at the operation, has put on weight and has had a year of good health. During the last few weeks it seemed to him that there had been a recurrence in that region. There is certainly some granulomatous tissue there now which was not there a month ago and he proposed to remove a piece of that, and if it is malignant radium would be applied.

Traumatic Stricture of Œsophagus—G. B. BRAND.—C. B., male, aged 11 years; admitted to the hospital with a story of being unable to swallow his food and with blood-stained vomiting. There is a history of his having been poisoned, in May 1927, with spirits of salt. Since then there have been numerous attacks of vomiting, with pain behind the breast-bone and difficulty in swallowing anything but soft food. On 21.10.28, while taking soup, he felt that a pea had stuck in his throat. His parents tried to make him vomit by passing fingers down his throat but were unsuccessful. Three days later he was very sick, the vomiting being dark coffee-brown in colour, and he had a headache. Since that date everything given him was returned immediately. The stools were dark and tarry. X-ray of the œsophagus showed a stricture with complete obstruction to the passage of the barium, but he managed to take fluid fairly well after that. On the evening of the 28.10.28, he vomited very actively and an ordinary-sized, undecomposed pea was vomited up. He expressed immediate relief and has been very well, taking a soft light diet without any trouble since. X-rays shown.

Dr BRAND said he could only add that he did an œsophagoscopy in this boy and found a fibrous stricture, not a tight one; it admitted the passage of a 7 mm. œsophagoscope, and there was no evidence to account for the blood-stained fluid and the tarry stools. The boy was now swallowing everything quite well. He is a mental defect. For the last two years he has smoked about thirty cigarette ends every day. He gets up at night and smokes the ends he has picked up during the day. The interesting point was that whilst that pea was there, there was no passage whatever for the barium, although after the barium meal he managed to swallow fluids for several days. He then vomited the pea with immediate relief of symptoms, and since the œsophagoscopy is swallowing quite well.

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Dr ADAM said that perhaps swallowing the cigarette ends three days after explains why the boy vomited coffee-ground material and passed tarry stools.

Retrograde Dilatation of Traumatic Œsophageal Stricture (shown at the November Meeting, 1927).

Dr BRAND thought most of the members had seen this case last year when he demonstrated the technique of retrograde bouginage. The patient continued to progress and she had a retrograde bougie passed once a week till the end of February, then once a fortnight till the middle of April. On the 17th of May the note says she had been swallowing well for a month without having recourse to the gastrostomy tube at all. On that day he (the speaker) managed to pass a large olive quite easily into the stomach. The gastrostomy tube was removed on the 17th of May and she has swallowed well ever since.

Large Aural Polypi—Dr T. O. HOWIE (introduced by G. B. Brand).—J. W., male, aged 46. History of discharge from both ears for twenty years. Growths have shown at the ear passage on the right side for ten years and on the left side for seven years. Deafness, now very marked, has gradually developed during the past three years.

Dr T. O. HOWIE said he would just like to say that these polypi were much larger than this three weeks ago, having been reduced by spirit dressings in the interval.

Laryngeal Case for Diagnosis—T. O. HOWIE. — Mrs A., aged 41. History of huskiness for the past eight years with partial recovery; complete aphonia occasionally. No pain, short cough, some expectoration and no hæmorrhage.

Dr GAVIN YOUNG suggested that this was a case of lupus.

Dr J. S. FRASER confessed he had never seen anything quite like this before. It looked almost what one might call a leukoplakia of the vocal cord. There were these little white rectangular, hexagonal scales on the vocal cords, like what one sometimes sees on the roof of the mouth in smoking.

The President (Dr ROSS SOUPER) asked Dr Fraser what he thought of the edge of the cords.

Dr J. S. FRASER said they were hollowed out, but he did not think they were ulcerated.

The President (Dr ROSS SOUPER) said it struck him that the edge was rather mouse-nibbled, rather a saw-tooth edge.

Dr BROWN KELLY said in places secretion seemed to be adhering to the cords. He suggested that the larynx be syringed with an alkaline solution and then examined.

Dr T. O. HOWIE said there was some congestion to begin with; to-day the congestion is quite absent.

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