SOCIETIES' PROCEEDINGS.

ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

December 7, 1917.

President: Dr. A. Brown Kelly.

Abridged Report.

(*Continued from p.* 256.)

Foreign Body (Collar-stud) in Left Bronchus of a Child, producing Collapse of Lung of a Year's Duration.—J. Dundas Grant.—A boy, aged nine, was taken ill suddenly on December 6, 1916, with vomiting, pain on the left side of the chest, and cough, which soon subsided. He was ill in bed for weeks, and then went away for five weeks.

In August, 1917, he was admitted into hospital. Dr. Perkins found that the right lung extended to the left parasternal line and that there were physical signs of supplemental breath-sounds, with no crepitations; the left side was flat and contracted, the lung collapsed, and the stomach elevated. Von Pirquet's test was negative. He complained of pain in the left basal region; there was cough and expectoration; the leucocytes were 9000. X-ray examination on the left side showed general diffuse opacity, obscuring the heart and diaphragm, the latter being made out with difficulty and appearing to be raised (stomach translucency was higher than normal); the heart was withdrawn to the left; there was no evidence of effusion but of general pleural thickening.

Another examination by Dr. Melville on October 1 showed at the level of the left bronchus a shadow of characteristic shape suggesting the appearance of a collar-stud at the spot where an indistinct shadow had been previously noted.

On October 17 I endeavoured, with suspension laryngoscopy, to introduce a tube through the larynx, but found that a large tube would not pass. I therefore performed a high tracheotomy and painted the trachea down to the bronchi with 20 per cent. cocaine, and then introduced a bevelled-ended bronchoscope, 8 mm. in diameter, for a distance of $4\frac{1}{2}$ in., when I was able to detect the foreign body and to seize it with Killian's pronged forceps, drawing it out with the bronchoscope tube. A good deal of mucus escaped. A Durham's "lobster-tailed" tracheotomy tube was introduced, as the attempt at translaryngeal bronchoscopy had caused œdema of the larynx. The tube was removed in two days.

The condition of the patient rapidly improved, but expansion of the lung must necessarily be slow, and to assist this he is learning suitable exercises in breathing under Mr. Courtland MacMahon.

Dr. D. R. Paterson: Dr. Dundas Grant was wise in doing a low bronchoscopy, because if the foreign body was displaced in getting it out, it might easily have slipped into the other bronchus, and then there would have been very great difficulty, as the lung on the affected side was

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totally collapsed. Such cases require tubes of as large calibre as possible to facilitate the easy extraction of the foreign body.

Dr. H. J. Banks-Davis: In 1912[1] I exhibited before the Section a pathological specimen, now in the Museum of the Royal College of Surgeons, of the larynx of a child, aged three, with a collar-stud impacted between the vocal cords, which caused death. The case had been mistaken by the casualty officers for diphtheria, and treated as such with antitoxin. Later a tracheotomy was performed, but in spite of this the child died.

Pre-tracheal Abscess of Acute Development in a Middle-aged Woman, producing Dysphagia and Dyspnœa.—J. Dundas Grant.—The patient, a woman, aged forty, was seen at Brompton Hospital on October 30, complaining of occasional loss of voice for two years. The larynx was normal, with the exception of paresis of the internal tensors of the cords; the posterior wall of the pharynx was glazed with yellow secretion. The sinuses were clear. There was a perforation of the quadrilateral cartilage from a simple ulcer, and active lupoid ulceration on the anterior edge of the right inferior turbinate. A solution of chloride of zinc was applied to the vocal cords and she was ordered a nasal wash.

A fortnight later she attended with a painful swelling in the neck, difficulty in breathing and pain on swallowing. She stated that before leaving the hospital on the previous occasion her voice failed, and next day she had "an inflamed throat and high temperature."

On November 13, beyond the paresis of the internal tensors the larynx was otherwise normal, but there was a red, tender swelling over the region of the thyroid body. On the following day I opened the swelling. Pus was evacuated by Hilton's method. The abscess-cavity was cleaned out and drained; two days later the tube was removed and a plug of gauze inserted. After ten days the wound had practically healed. The pus contained no tubercle bacilli, but streptococci and staphylococci.

In July she had erysipelas, but had no evidence of tubercle except lupus in the nose. There was no previous swelling to indicate a thyroid cyst which might have suppurated. I am at a loss to trace the causation of this abscess.

A Surgical Contretemps, illustrating the Value of Endoscopy.—Herbert Tilley.—On November 15 I performed a submucous resection of a septal deformity on a young lady, aged seventeen. The anæsthetist asked if he might give intratracheal ether by means of a new tube. The latter consisted of two parts: (1) a narrow rubber tube occupied by a coil of wire so that the patient could not obstruct the entry of vapour by biting the tube; and (2) a distal tube about 5 in. long, with a funnel-shaped proximal end to occlude the larynx. The distal end of (1) was intended to fit tightly into the funnel of (2). The conjoined tube was passed through the larynx by direct vision by the anæsthetist, anæsthesia was induced, and the operation went off without a hitch. When it was completed he attempted to withdraw the tubes, but only the proximal portion (1) came away. Passing my finger to the upper aperture of the larynx I was unable to feel the funnel-shaped portion of the distal tube (2)—it was obviously in the trachea! A friend motored to my house for my endoscopic outfit, and after some fifteen minutes' interval

[1] Journ. of Laryngol., Rhinol., and Otol., p. 98.

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I was able to see and withdraw the funnel-shaped tube from the trachea —no harm has resulted from the accident. Obviously the only alternative would have been a tracheotomy, and in pre-endoscopic days a difficult "situation" might have been created.

(Intratracheal tubes exhibited.)

Mr. FRANK A. ROSE: Recently, when doing submucous resections of the septum, Mr. Boyle has anæsthetised for me *per rectum*. In all these cases, including bronchoscopy, the anæsthetic has been very satisfactory.

Mr. W. M. MOLLISON: I have operated upon one or two septa with intratracheal insufflation of ether. The object of this method is to prevent blood entering the trachea. There is one disadvantage in this method, for the back stream of air through the nose is embarrassing: bubbles of air come through the nose and form a froth with any blood present. I have given it up for that reason, though it is an ideal anæsthetic for most nose operations. Rectal anæsthesia does not prevent blood going down the trachea.

Mr. TILLEY (in reply): The object is to prevent blood entering the larynx, and from that point of view the intratracheal method is ideal, but, as Mr. Mollison said, the only inconvenience of the intratracheal method is that blood tends to froth forwards into the nasal cavities. For bigger operations about the nose and throat I think the intratracheal method is ideal. I have not seen rectal anæsthesia induced for two or three years, but the objection used to be that the patient afterwards suffered from tenesmus and diarrhœa and bloody stools.

Osteoma of Left Frontal Bone.—Hunter Tod.—Male, aged thirty-three. For eighteen years he had noticed that the left eye was becoming more prominent and was being gradually pushed down and outwards. He had suffered constantly from headaches, worse on stooping. There had never been any discharge from the nose.

He was operated on in April, 1913, by a surgeon in Lincolnshire. I saw him first in December, 1913, and admitted him into the London Hospital in January, 1914, for operation. A curved incision was made just beneath the eyebrow. On exposing the bone the roof of the orbit was found to be irregular and nodulated, and a great deal of very hard bone was chipped away from the roof, but the frontal sinus could not be found. The dura mater was not exposed for fear of setting up meningitis, and it is possible that owing to this the operation was not sufficiently extensive. The wound healed well after the operation and the patient was much relieved of his headaches. I have not seen the patient since he left the hospital, but as his medical man has written to me saying that there is a recurrence of the severe headaches and apparently of the growth itself, I have asked the man to attend this meeting in order that the members may see his present condition, which I cannot for the moment foretell.

Mr. TILLEY: The recent increase or recurrence of headaches is probably due to re-appearance of the condition which Mr. Tod dealt with in the early stage. If you pass a finger as far backwards as possible over the upper surface of the globe you can feel a small hard tumour.

Dr. PERRY GOLDSMITH: In view of what the patient says I should suggest that he is better left alone.

Mr. HUNTER TOD (in reply): I agree with Mr. Tilley that on examining with the finger one can feel a growth. At the first operation

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that was the chief characteristic. I removed bone as far back as I could, but did not completely remove the growth, being afraid to injure the optic nerve. I have not seen him since the middle of 1914. The pain in the head may be due to pressure. Mr. Gilbert Scott has shown a case in which, after one of these growths was removed, the patient, a year afterwards, came up suffering from headache with rattling in the head. A skiagram showed the brain to be compressed and, above the level of the brain, a layer of fluid and air. Probably some puncture had been made through the dura mater in removing the osteoma. It was the recollection of this case which made me fear to do more here.

Stenosis of the Glottis, from a Combination of Tubercle and Syphilis, requiring Tracheotomy.—Sir StClair Thomson.—This patient, a woman aged fifty-one, was shown before the Laryngological Society of London on November 2, 1906.[1]

Mrs. D—— first came under notice in 1906 for hoarseness and marked dysphagia. The condition in her larynx at that time was entirely attributed to tubercle, for although tubercle bacilli were never found in her sputum, there were signs in the upper lobes of both lungs. Low tracheotomy under cocaine was performed in February, 1906. Since those days the Wassermann test has been discovered, and later on we found that the patient gave a positive reaction. Patient has quite a good voice. Although warned on the subject, the patient has neglected to come up as frequently as necessary to have a worn-out tracheotomy tube replaced by a new one. (Her tube has been worn, unwashed and unchanged, for seven years.) It will be noticed that the one I show is a mere shell, and that the vertical limb has completely worn away. The interesting points of the case are the following: (1) Combination of tubercle and syphilis; (2) comfort of a low tracheotomy; (3) the permanency of the cicatrisation of the larynx; (4) the absence of pulmonary symptoms in spite of wearing a tracheotomy tube for eleven years; (5) the necessity of renewing tracheotomy tubes; (6) the risk that some patients will run, even although warned.

Stenosis of the Glottis from Combined Tubercle and Syphilis requiring Tracheotomy.—Sir StClair Thomson.—The patient, a male, aged forty-one, was discharged from the Navy two years ago for tubercular laryngitis. Tubercle bacilli were reported to be present. When he passed under the care of a county tuberculosis officer repeated examinations failed to find them, and his Wassermann reaction was reported negative. He came under observation in June, 1917, with marked stridor, general infiltration of the larynx, ulceration of the cords, the glottic space reduced to a chink, no dysphagia and no enlarged glands, and the temperature was normal. The Wassermann reaction was positive; tubercle bacilli were found in his sputum. A low tracheotomy was done under cocaine, and he has since been treated with salvarsan and mercurial injections.

Both these patients will have to wear a tracheotomy tube permanently. A Durham tube, inserted as low as possible in the trachea, appears to me the best.

The PRESIDENT: The first case would be a remarkably good cure if it were tubercular; the only unfortunate feature now is double abductor paralysis.

Dr. IRWIN MOORE: As is so well shown in this case, when a low

[1] *Vide Proc. Laryng. Soc. Lond.*, 1906, xiv, p. 4.

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tracheotomy has been performed patients wear their tube without any discomfort—in fact they scarcely know that they are wearing a tube at all.

Dr. SMURTHWAITE: I have tried to elicit a movement of the arytænoid joints, but they do not seem to work at all: they are fixed. If the patient says "*e*," the cords come together and are made more tense by the action of the internal tensors, but there is not the slightest movement in the abductor direction. I think the fixation is of a fibroid nature, due to the former tubercular or specific implication of the joints.

Dr. DONELAN: I have had under observation a case which has been examined by other members, in which fixation of the arytænoids was the earliest symptom, and there was difficulty in deciding whether or not it was tuberculous. The articulations on both sides were fixed for eighteen months, and only in the last month has the patient shown definite signs of tuberculosis. It appears to be a primary case. The present case I thought was one of fixation of the arytænoid articulation. I was uncertain as to the evidence of tuberculosis in the notes. Perhaps Sir StClair Thomson will tell us what was said at the meeting of the old Society.

Sir STCLAIR THOMSON (in reply): With regard to the first case, it was accepted by myself and by all who spoke as one of tuberculosis. In those days the Wassermann reaction had not been discovered, and we saw no other signs of syphilis. It was thought to be a rare case of tubercle of the larynx, which had not only healed spontaneously, but in doing so had produced stenosis, which is rare in my experience. The patient turned up after four years; in the interval the use of the Wassermann test had come in, and we found it was positive. From my own experience I think we were all wrong, and that though she may have tubercle in her lung, I think the condition really is syphilis, because it is rare to get tubercle in the larynx advanced enough to produce contraction in a patient who is not a good deal worse in health than this woman ever was. I view it as a false ankylosis. I do not think it could be a case of involvement of both recurrent laryngeal nerves or their centres, and that would not account for the interarytænoid space having disappeared, and the two arytænoids being so closely locked together. With regard to the second case, we must not rely implicitly on the pathologist, as many are inclined to do. We should trust to our own clinical acumen more than we do. The man tells me he has not been to a sanatorium, but has gone to live in his cottage. He has put on a lot of weight, and he comes back feeling well. We cannot now find any symptoms in his lungs, and the tubercle bacilli have disappeared. Dr. Emery made three examinations with the same result. Tracheotomy in both cases has been not only necessary, but I think that in both it will be permanent. I plead again for prompt and low tracheotomies. Mr. Hunter Tod's case was allowed to go on—not through any fault of Mr. Tod's—to dyspnœa and stridor before tracheotomy was done, and then tracheotomy was done on the same day as a fairly extensive operation on the larynx. Dr. Banks-Davis has handed round a picture of a child with a stud in its glottis, and that child had extreme dyspnœa; tracheotomy was performed, and yet the child died. That often happens in hospitals because people will not do tracheotomy in time, and the patient gets back-pressure on the heart.

Cyst of the Epiglottis of Unusual Size.—W. Jobson Horne.—The patient is a woman, aged twenty. No symptoms noticed before last August. Since then there has been a steadily increasing difficulty in

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swallowing. Sufficient food can still be taken, but "a meal" cannot be made. The voice has become "deeper." The patient sleeps comfortably. The tumour springs from the left ary-epiglottic line and occupies the greater part of the brim of the larynx, so that the right ary-epiglottic ligament alone is visible. The absence of any material discomfort or inconvenience with so large a tumour in the brim of the larynx is remarkable.

A Larynx with a Cystic Tumour of the Epiglottis.—W. Jobson Horne.—The cystic tumour of the epiglottis gave rise to no symptoms during life. It was accidentally found at the *post-mortem* examination.

Dr. PERRY GOLDSMITH: I once had a comical experience in a case like this, which I showed at the Laryngological Section of the Toronto Medical Society. Everybody said they failed to see any tumour at all. I put my mirror on to look, and it had gone. The man then said something had "given way" when he was coming to the meeting, but he had said nothing about it.

Paralysis of the Left Vocal Cord in a Woman, aged Thirty-two.—W. H. Kelson.—I first saw the patient in August, 1916, when she complained of hoarseness. She gave the history that eleven months previously the left tonsil had been removed by a surgeon, and a month after this a gland, said to be tubercular, was removed from the neck on the same side. Immediately after this operation great hoarseness and difficulty in swallowing came on.

On examination the left vocal cord was found to be almost immobile, and the mucous membrane of the larynx when touched with a probe appeared somewhat insensitive. The voice was very husky. Since then the voice has somewhat improved and the difficulty in swallowing very much so. The patient, who before marriage was a nurse, says she has never had any lung trouble, nor children, nor miscarriages. She tells me she also had food regurgitation through the nose after the operation for removal of glands.

"Fibrosarcoma" of Nasopharynx.—Norman Patterson.—Patient, a boy, aged eighteen. Two years ago noticed small swelling in left cheek. In September, 1915, a portion of the swelling was removed at Eastbourne and reported on as a myxo-fibroma. He complains of long-standing obstruction on the left side of the nose, alteration in speech, pain in the left cheek and over the left eye. There is a firm swelling in the temporal fossa and another below the zygomatic arch; the zygoma itself lies in a hollow. The nasopharynx is occupied by a large firm swelling. The patient is evidently suffering from a growth which started in the nasopharynx, and has passed out through the pterygo-maxillary fissure into the zygomatic fossa and then upwards into the temporal fossa.

I propose to treat the case by radium passed into the substance of the tumour and X rays applied over the side of the face. Before treatment a portion will be removed for microscopic examination.

Endothelioma of the Post-nasal Space.—W. H. Jewell.—A girl, aged thirteen, first noticed something amiss four months ago on account of speaking through her nose; lumps (glands) in throat three months; intermittent headache and earache two months. The growth is attached

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to the left lateral and posterior wall of the nasopharynx, bulging the soft palate forward; it is fairly firm, extends as high as the left choana, and bleeds readily on digital examination. The lymphatic glands of the left side of the neck are enlarged and extend nearly as low as the clavicle; in places they are firm and discrete.[1]

Salivary Calculus.—Irwin Moore.—Patient, a male, aged fifty-six, attended hospital on November 16, 1917, complaining of a swelling on the right side of the neck under the angle of the jaw for one year, together with a swelling under the tongue, from which a month previously some watery fluid stained with blood had been discharged, followed by considerable diminution in the size of the neck swelling. A number of septic teeth had been recently removed from the neighbourhood of the swelling.

On examination: The right submaxillary gland was found to be enlarged, hard, but mobile. On the right-hand side of the floor of the mouth, about midway, in the position of Wharton's duct, an irregular, hard swelling was observed from which pus exuded in small quantity. A piece was removed for microscopic examination.

Report on Section.—"Sections of this tissue show considerable thickening of squamous epithelium with œdema and inflammation of the underlying tissues. There is certainly considerable hypertrophy of the epithelial processes, which dip into the submucosa, but in my opinion the condition is inflammatory, probably the result of local irritation, and not malignant. It is only fair to state, however, that in consultation the opinion has been expressed that this is an incipient squamous epithelioma" (Dr. Eastes' Laboratory).

Mr. Tilley: I remember a similar case of salivary calculus where there was a swelling under the jaw, and when the calculus moved into the duct there was considerable pain, especially during meals. If the calculus ulcerates through the duct the condition becomes septic, and the induration with granulations produce an appearance like malignant disease. I suggest that the hardness towards the median line is due to a few crystals of the calculus blocking the opening of the duct.

Dr. Irwin Moore (in reply): When I first saw the case my diagnosis was salivary calculus, but, as Sir StClair Thomson has just pointed out, we are all somewhat inclined to assign too much importance to the pathologist's report. In this case Dr. Fletcher had expressed his opinion that the piece removed from the floor of the mouth was not malignant. Yet in consultation with others it was considered to be early squamous epithelioma. However, since sending in the notes for the agenda Dr. Ironside Bruce made a film skiagram, which shows a large calculus embedded in the sub-maxillary gland. There is a fistula in Wharton's duct which is discharging freely, and accounts for the swelling of the gland having subsided since I saw the case a week ago. Professor Shattock reports that the section of the growth examined by him is not malignant.

Postscript.—On December 11, under an anæsthetic, the calculus was located in Wharton's duct, close to the submaxillary gland, and was removed by incision. It measured 10 by 7 mm.

[1] Shortly after this child was shown she developed cerebral vomiting, followed by blindness of the left eye, then of the right, and ending in coma and death two months later.

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Malignant Disease of the Larynx.—Irwin Moore.—Patient, a female, aged fifty-eight, when first seen on October 4, 1917, complained of hoarseness of the voice for one year following a severe cold, accompanied the last six months by cough, and for three months by blood-stained sputum. There has been some difficulty in breathing for four months. On admission to hospital on October 13 considerable inspiratory stridor was present, which necessitated tracheotomy, and this was performed by Mr. Macnaughton-Jones. There is no history of tuberculosis nor of syphilis. The Wassermann reaction is negative. A few enlarged glands are present on both sides of the neck. There is no difficulty in swallowing, but patient has wasted considerably, her former weight having been 10 st. Examination of the larynx shows marked stenosis caused by infiltration and fixation of the soft parts on the right side. The entire larynx is distinctly congested. The arytænoids are not enlarged.

Examination of the lungs by Dr. Halls Dally on November 24 showed that the percussion note was impaired above the left clavicle in front, and in the left supraspinous fossa behind, accompanied by moist sounds, which, however, were difficult to differentiate from the sounds caused by the presence of the tracheotomy tube. There is considerable difficulty in coming to any definite conclusion as to the condition of the lungs. Examination of sputum is negative.

Removal of Foreign Body Impacted in the Œsophagus.—G. C. Cathcart.—Mrs. S——, aged forty-five. She came to me on October 27 and gave the following history. At lunch she had just taken a piece of duck when someone spoke to her. She hastily gulped it down, found it too big, and tried to bring it back into the mouth, but failed; she felt choked, and tried to drink some water; she then sent for a doctor, who passed a rubber tube. She was apparently relieved for a time, but as the day wore on began to get more and more uncomfortable. When I saw her at 8.30 p.m. she complained of great pain in the centre of the breast-bone, with increasing difficulty of breathing and inability to swallow anything. She was pale and haggard-looking and in a cold sweat, and evidently in great distress. As she was certain there was no bone in the piece she swallowed, I did not have her X-rayed but sent her at once into a nursing home. Under a general anæsthetic I first passed a tube into the larynx and found it clear; then I passed the œsophagoscope, and at a distance of 8 in. a large, dark greenish mass was seen. With the forceps I had I only succeeded in bringing away pieces of the meat. As I did not have a pair of Dr. Irwin Moore's forceps, I asked him to come and bring his. He then passed them and at once brought up a large mass with the bone attached. Fortunately the sharp point of the bone was turned down, otherwise it would have scratched the œsophageal wall as it was coming up, but the patient suffered no ill-effects.

This case shows the advisability of always having an X-ray photograph taken, and also the need of every œsophagoscopist having a pair of Irwin Moore's forceps as an essential part of his armamentarium, as one never knows when they may not be wanted. The bone and a drawing of the pieces of duck are shown. The bone measured 30 mm. ($1\frac{3}{8}$ in. in length) by 13 mm. ($\frac{1}{2}$ in. in breadth), and the weight of the meat attached to it was $\frac{1}{4}$ oz.

Case for Diagnosis.—G. C. Cathcart.—Mr. J. S—— was brought to me on October 27, 1917, by Dr. N. Turner, complaining of persistent

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hoarseness. He is aged sixty-seven. He was staying at Ramsgate in April, 1916, when an explosion took place at an ice factory. He went to assist the firemen, and in a short time had a choking feeling, and had a pain in his throat and chest, owing to the escape of ammonia. The pain continued for a few days after his return to London. In December he had a bad cold and a return of the same pain that he had had when helping after the explosion; this lasted for a few days. Some months later he found he was getting hoarse and had difficulty in speaking. On laryngoscopic examination the whole larynx was seen to be inflamed, and there was a great deal of swelling in the interarytænoid space, over the arytænoids and on the cords, and there was what looked like heaped-up necrotic tissue on both cords and in the arytænoid space. There was evidently some perichondritis of the arytænoid cartilages, as they were partly fixed, and there was only a small space left for breathing, which caused him to have stridor at night.

I removed a piece of the uvula, which was causing him considerable irritation and was very much elongated. Two days later I did a low tracheotomy. The patient has now been wearing the tube for a fortnight, and during that time has not used his voice at all. He has still a great deal of swelling in the interarytænoid space and over the arytænoid cartilages, but no necrotic tissue is to be seen. I have never seen a case quite like this before, and should be very glad to have the opinion of the members in regard to it.

Mr. TILLEY: I think it is a tuberculous gland. There is much œdema of one glosso-epiglottic fossa, and there is much ulceration on the laryngeal aspect of the epiglottis. The laryngeal appearances are in favour of tuberculosis also, although there are no physical signs in his chest. I think there may be an old tubercular focus in the apex of one or both lungs, and that the laryngeal mucous membrane has been infected.

Sir STCLAIR THOMSON: There is no doubt about it being tuberculosis, but it is worthy of notice that laryngeal tuberculosis in the elderly is a very protean affair, and is apt to deceive people—that is to say, it does not follow the routine symptoms. It often simulates syphilis, or malignant disease, and it is commonly found in the elderly in what is regarded as a primary form. It is also apt to be acute and to kill its victims quickly. That seems rather a contradiction, because in middle age tubercle of the larynx is often a mild condition, but tubercle of the larynx in the senile is apt to be very severe.

Tuberculosis of Larynx.—W. Jobson Horne.—Patient, a discharged soldier, aged twenty-two. He joined up in March, 1916, and was in France in December, 1916. He was invalided out in May, 1917. He has had sore throat and dysphagia for several months, but not before the war. There is no family history of tuberculosis. No sputum is available. The thorax has not at present been examined. Larynx: Considerable œdema and infiltration of epiglottis and arytænoid region.

In the first place treatment by scarification is proposed.

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