# SOCIETIES' PROCEEDINGS

## THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY

THE seventieth meeting of the Society took place on May 14th, 1955, in the Seafield Hospital, Ayr. The President, Dr. J. Fulton Christie, was in the chair.

Cases were shown as follows:

MR. J. SCOTT TOUGH

1-3. Three cases of *carcinoma involving the upper jaw* were presented. In two instances, exenteration of the orbit and excision of the cheek were required. The necessary plastic procedures and prostheses for the resultant deformities were shown and described in detail.

MR. HOWIE congratulated Mr. Tough on the cases presented, which should be a stimulus to the younger otologists. He recommended a general surgical training so that they could undertake these operations. He referred to Ohngren's Monograph on Malignant Disease of the Upper Jaw.

In reply to questions by DR. CHRISTIE and MR. VENTERS, Mr. Tough stated that post-operative prophylactic irradiation was worth while if the tumour were radio-sensitive, even when a wide excision had been carried out.

GENERAL DRUMMOND recalled cases seen with Cade at the Westminster Hospital. Radiation both before and after surgery seemed to give the best results.

5. *"Dish Face" deformity* following an old injury, treated by inlay graft on stent mould, lengthening of nose by forehead flap, construction of columnella from upper lip and provision of acrylic nasal support carried on a denture.

6. *Reconstruction of airway and rhinoplasty in a case of lupus.* The airway was improved by excision of fibrous tissue followed by a free skin graft. A forehead flap was used for the external skin, lining of nostril and columnella.

7. Case illustrating the *Metzenbaum procedure,* excision of 3 mm. of lower end of septum, reduction of columnella skin, and suture of septum in prepared bed in columnella. DR. GIBB pointed out the ease with which these deformities recur. DR. MCKINLAY recommended the Humby knife for making the pocket.

8. *Congenital bifid nose* in child aged 13 years with hypertelorism. A vertical ellipse of skin was removed from the forehead and midline of nose. Excess septal fibro-cartilage was removed and the nasal bones infractured.

9. *Correction of long hump nose* by endonasal removal of hump and shortening of nose.

MR. T. GIBSON and DR. FORBES M. WALKER

10. *Suppurative frontal sinusitis* with sequestrum formation in a man aged 36 who had had two previous attacks of acute sinusitis. X-rays showed a definite sequestrum of the anterior plate of the left frontal sinus. An



https://doi.org/10.1017/S0022215100051215 Published online by Cambridge University Press

osteoplastic flap was turned down, toilet of both sinuses carried out and the sequestrum removed.

11. *Osteoma of Frontal Sinus.* Osteoplastic flap operation carried out. Tumour arose from broad attachment on the posterior wall and was removed piecemeal.

12. *Osteoma of Frontal Sinus.* Osteoplastic approach to expose tumour attached to the root of nose. Tumour was removed in one piece.

DR. SMITH asked why the osteoplastic flap operation was employed in the case of suppurative frontal sinusitis instead of the Howarth operation which was the recognized procedure for septic conditions. DR. WALKER pointed out that the sequestrum was well above the line of the eyebrow, and it was easier to avoid visible scarring. The fronto-nasal duct was not touched.

13. *Deep Invasive Mixed Salivary Tumour of Ear.* A boy, aged 14 years, had a swelling below the right ear removed two years previously. This proved to be a salivary adenoma, and X-ray therapy was prescribed. Recurrence took place below and behind the lobe, and also bulged the posterior wall of the external canal. The tumour was found at operation to have infiltrated deeply the mastoid and the mandibular condyle. Removal was carried out in two stages. The mastoid process, styloid process and condyle were removed. The facial nerve was resected and later grafted. Tube pedical grafts were used to repair the defect left by the extensive excision of tissue.

MR. T. GIBSON

14. *Low Grade Salivary Adenocarcinoma of Palate.* Male, aged 60. In 1915, patient received shrapnel wound of left side of face. Pieces of shrapnel were removed from left maxilla in 1940. In 1949 swelling recurred in left side of palate, and in 1952 a low grade salivary adenocarcinoma with imbedded metallic foreign body was excised. Recurrence again in 1953, when the whole muco-periosteum was excised from the left half of the hard palate. Bony defect in palate found. The left half of the hard palate and upper alveolus were excised.

MR. T. O. HOWIE and DR. FORBES M. WALKER

15. *Salivary Tumour of Larynx* in a man aged 55. Laryngoscopy showed fullness in region of right false cord, and œdema of upper surface of right true cord. Biopsy showed pure salivary gland tissue. Laryngofissure was carried out and swelling of cord excised, revealing a laryngocele occupying the right ventricle. This was shelled out. Pathological report on excised tissue was: ectopic salivary adenosis. Periodic review shows satisfactory progress. DR. MILNE commented on the fact that these tumours are of low grade malignancy, but some recur even after radical excision. The exact genesis is uncertain. DR. MORRISON suggested that these tumours were suitable for "prophylactic" irradiation.

MR. T. GIBSON and DR. FORBES M. WALKER

16. *Salivary Tumour of Nasopharynx.* The patient, a woman aged 32, had nasal obstruction for 18 months. Examination showed a large soft tissue



https://doi.org/10.1017/S0022215100051215 Published online by Cambridge University Press

swelling in the nasopharynx. Biopsy proved this to be infiltration of sub-epithelial tissues by a mixed salivary tumour of cribriform type. Operation consisted in a transverse incision in the palatal vault, and removal of the posterior part of the hard palate. The soft palate was split in the midline and the tumour removed by diathermy. The soft palate was sutured, but the defect in the hard palate was maintained by packing to obtain a permanent opening. A prosthesis was fitted.

DR. FORBES M. WALKER

17-22 (excluding 20). Five cases of *Malignant Disease of the Nasopharynx* were presented. Enlarged cervical glands were seen in all cases. Deafness occurred in two instances, and epistaxis was a chief symptom in two. There were two squamous celled carcinomas, one reticular sarcoma, one lympho-epithelioma and an epidermoid carcinoma. Treatment was by X-ray therapy. DR. CHRISTIE pointed out that many of these tumours occur without a break in the mucosa. He recalled a case in which the first biopsy was reported as a reticulosarcoma of Hodgkin type, whereas another specimen was reported as a granulomatous lesion—tuberculous sarcoid type. DR. SMITH congratulated DR. WALKER on seeing all these cases which dated from 1950. Some cases with severe pain required resection of the frontal tracts. GENERAL DRUMMOND mentioned the great frequency of nasopharyngeal cancer in Hong Kong and Malaya. Very little could be done for them as they lacked sufficient radiation facilities. DR. WALKER, referring to the racial incidence, mentioned the frequency of cases in the Chinese quarter in New York.

23. *Pneumonectomy following Implantation of Radon Seeds.* A man, aged 64, developed an obstructive lesion of the right lower bronchus which proved to be a poorly differentiated epidermoid carcinoma. Radon seeds were inserted, and his general condition improved considerably. Pneumonectomy was carried out by Mr. Barclay about six weeks later. DR. BOYD thought that every such case should have a thoracotomy. Seeding may make some cases relatively comfortable, but this treatment does not always succeed. Mr. HOWIE mentioned having used Negus's radon container many years ago and found it relieved some cases temporarily. Deep therapy usually made these patients very ill and might cause a breakdown of the blood.

DR. C. A. P. DONALDSON

24. *Sub-glottic Fibroma.* A girl, aged 8 years, had severe "asthmatic attacks". The larynx was normal on direct examination, but there was a large swelling below the left cord. Biopsy showed a highly cellular fibroma. Should a laryngo-fissure be done or should X-ray therapy be done first? DR. MILNE did not think the tumour malignant, but that it would kill the patient owing to its site unless something were done. DR. BIRRELL thought a laryngofissure should be done at once. DR. MORRISON did not think that the tumour was radio-sensitive.

26. *Multiple Laryngeal Polypi* in a man aged 61 affected both cords. Removal was carried out on several occasions. Pathologist reported that the



https://doi.org/10.1017/S0022215100051215 Published online by Cambridge University Press

polyps had pre-malignant possibilities. On the advice of Dr. Morrison he was given X-ray therapy.

27. *Ozaena Treated with Vit. A.* These five cases were all females, two of whom had active sinus disease. Dosage was about 50,000 units given daily five times a week, in some instances supplemented by 300,000 units Vit. A. on the other two days by intramuscular injection. Biopsy reports were given. Although clinical improvement occurred, this was not always confirmed by the pathological report. In reply to a question by DR. GIBB, DR. DONALDSON stated that his reasons for giving Vit. A. therapy were based on the work of Fell and Mellanby, who found that, *in vitro*, embryonic chick ectoderm differentiated into mucous, sometimes ciliated, epithelium (similar to normal nasal mucosa) when the medium contained excess Vit. A.



https://doi.org/10.1017/S0022215100051215 Published online by Cambridge University Press