SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

November 5, 1920.

President—Dr JOBSON HORNE.

Leontiasis Ossium—Dr LAMBERT LACK.—Female with extensive thickening of cranial and facial bones. The association of antral suppuration with this disease was discussed by several members.

Multiple Polypi of the Deep Pharynx—Dr WM. HILL.—A man, aged 55, suffered from cough and dyspnœa with sensation of lump in throat. The polypi were removed by punch forceps and snare.

Right-sided Recurrent Paralysis with Partial Atrophy of Tongue—Mr W. G. HOWARTH.—Two cases were shown, the cause being a localised bulbar paralysis in the first, and gunshot wound in the second.

Dr WM. HILL said that as true bulbar paralysis was never unilateral and was rapidly fatal, the cause of the first case was probably a tumour in the pontine angle.

Cyst on Vocal Cord—Mr W. M. MOLLISON.—Female, aged 38. A small, white nodule at the junction of anterior and middle third of the right cord. Removed by direct method.

Giant-cell Systems in a Tonsil—Mr W. M. MOLLISON.—Boy, aged 6. Small tonsils were removed on account of enlarged glands in neck. Numerous tuberculous giant-cell systems were found in the sections.

Lympho-sarcoma of Postnasal Space—Mr C. W. M. HOPE.—Patient, aged 34, suffered from nasal obstruction and blood-stained discharge. Postnasal space filled by large bluish-red mass. Glands enlarged on both sides of neck. Successfully treated by radium and X-rays. Postnasal space now free from tumour. Glands in neck smaller.

Carcinoma of the Larynx?—Mr SOMERVILLE HASTINGS.—Woman, aged 52, with loss of voice for two years. The right vocal cord was covered by sprouting granulations. Movement of both cords good. Two Wassermann tests negative. Excision of larynx not performed owing to epileptic fits. Rapid return to normal appearance

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under treatment with potassium iodide. Cell nests were never seen in the microscopic sections.

Lupus treated by Sodium Iodide and Ionisation—Mr DOUGLAS HARMER and Mr T. H. JUST.—The method, used in Copenhagen, consists in the use of single doses of sodium iodide (60 to 120 grs.) followed two hours later by the insertion of needles into the tissue so as to secure ionisation with the positive pole. The liberation of iodine in the tissues destroys the tubercle bacillus. The strength of the current varied from 5 to 30 ma. according to the number of needles used. It was continued for 5 to 20 minutes.

Actinomycosis of Superior Maxilla—Mr DOUGLAS HARMER and Mr T. H. JUST.—The patient was a butcher, aged 59. Treatment by vaccine and potassium iodide is having a good effect.

Large Fibrous Tumour of Cheek—Mr W. LLOYD and Dr WM. HILL.—Duration, twelve years. It was thought to be a fibro-lipoma, but the microscope showed fibrous tissue only.

December 3, 1920.

President, Dr JOBSON HORNE.

Dentigerous Cyst (Follicular Odontome) of Upper Jaw—Dr DOUGLAS GUTHRIE.—The cyst was removed entire from a boy aged 9. There was a history of injury to the upper lip a few weeks previously.

Chronic Superficial Abscess of Left Frontal Sinus—Mr ARCHER RYLAND.—A boy, aged 15, complained of nasal obstruction and frontal headache for several months. Nasal polypi were removed. Two months later a painless, soft, fluctuating swelling appeared on the centre of the forehead. This was found to be an abscess connected with the left frontal sinus.

Laryngocele—Dr FREDERICK SPICER.—Male, aged 68, had been hoarse for twenty-two years, and the appearance of the larynx had never altered during that time. In quiet respiration the right cord is normal; the left is swollen and covered anteriorly by a fold of mucous membrane. The left ventricular band is thickened and corrugated. When the patient says "Ah," a smooth, globular tumour appears, filling the left ventricle and then extending across the opposite cord and blocking the airway.

The majority of members who discussed the case thought that the swelling contained air. There was some difference of opinion as to whether true prolapse of the laryngeal ventricle could ever occur.

Congenital Laryngeal Web—Mr R. A. WORTHINGTON.—A girl, aged 10, whose vocal cords in their anterior half were united

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by a pink, translucent web. She suffered from hoarseness, and dyspnœa on exertion.

Œdema of Upper Aperture of the Larynx, for Diagnosis—Sir JAMES DUNDAS-GRANT.—Man, aged 57, had hoarseness for two years and swelling over larynx for three weeks. The swelling was opened by a surgeon, but its contents were not examined. Although physical signs in the chest are extremely indefinite and no tubercle bacilli have been found, the diagnosis of tuberculosis is the most probable. Wassermann negative; urine normal.

Fixation of Arytenoids in Osteoarthritis — Dr A. J. HUTCHISON.—A lady, aged 48, crippled by arthritis. Stridor and hoarseness for eighteen months. Arytenoids fixed close together, leaving only a narrow slit between the cords on respiration. Improvement after extraction of teeth, which were affected by pyorrhœa. The stridor has disappeared.

Bilateral Abductor Paralysis: Division (?) of both Recurrent Laryngeal Nerves—Dr DAN M'KENZIE.—Woman, aged 44, right thyroid lobe removed when 14, the left lobe when 40 years of age. Both vocal cords are in the position of adduction.

Paralysis of Right Recurrent Laryngeal Nerve after Thyroidectomy—Mr T. B. LAYTON.—Female, aged 45.

The discussion upon these two cases brought out the fact that the nerve injury occurred pretty frequently in operations on the thyroid gland. The opinion was expressed that the injury was caused by the surgeon's knife, and did not arise from post-operative cicatrisation.

February 4, 1921.

President—Dr W. JOBSON HORNE.

Tumours of the Ventricles and of the Ventricular Bands—commonly called the False Cords—of the Larynx: An Epidiascopic Demonstration—Dr W. JOBSON HORNE.—The demonstration was restricted to innocent tumours and granulomata, and to cases and specimens forming part of original work by the author.

The term ventricle was used to include the sacculus laryngis, or such part as may be left of that vestigial structure of anthropoid and other apes.

(1) *Eversion, prolapse,* or *hernia* of the mucous membrane of the ventricle. A specimen was demonstrated in which the left ala of the thyroid cartilage was involved in a gummatous necrosis, and this had led to the detachment, prolapse, and eversion of the mucous membrane lining the ventricle. The specimen demonstrated that prolapse of the ventricle was not merely a traditional theory but an entity. (2) *Solid*

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pedunculated tumours springing from the vault of the ventricle might present at the mouth of the ventricle as a solid tumour. (3) *Pseudo-cystic tumours* springing from the vault of the ventricle may emerge from the mouth of the ventricle. (4) *True cystoma of the ventricle*, congenital in origin, but rare. Dr F. Spicer's case brought to the December meeting was probably an example.

Granulomata.—Syphilis and tuberculosis *per se* are not specifically conducive to prolapse of the mucous membrane of the ventricle, or to the development of growths within the ventricle. A well-developed gumma limited to the ventricular band may cause confusion in the differentiation of the parts and in the diagnosis.

Lipomatosis.—An enlargement or tumefaction of the ventricular band, due to a remarkable and circumscribed proliferation of fat cells amounting to a lipomatosis or fatty degeneration of the structure.

Epidiascopic Demonstration of Two Authenticated Specimens of Eversion of the Sacculus Laryngis—Dr Irwin Moore. —(1) *From the Museum of Guy's Hospital*—recorded by Walter Moxon as eversion of the sacculus laryngis. (2) *From the Museum of the Hospital for Diseases of the Throat, Golden Square*—recorded by Morell Mackenzie as eversion of the ventricle.

(1) In Moxon's case a pendulous tumour, semi-elliptical in shape, is seen protruding from the anterior half of the ventricular orifice and lying on the vocal cord. Moxon stated that the tumour could easily be replaced into the normal position of the sacculus laryngis, *i.e.* it could be inverted and returned behind the false vocal cord to again easily fall out of its position and reappear in the larynx as now seen. On these grounds he surmised that the tumour was the everted sacculus laryngis. Recent resection of a portion of the left thyroid ala by Professor Shattock has proved that Moxon was correct.

(2) Morell Mackenzie removed a portion of the thyroid ala and found that the sacculus laryngis was absent on the left side, and that the protruded sac seen in the lumen of the larynx could be inverted and replaced in its normal position. He states that the "left ventricle of Morgagni" was entirely everted and the right sacculus protruded from the ventricular orifice. Recent examination of this specimen shows, however, that there is no prolapse of the ventricle, and that the tumour consists of the everted sacculus laryngis.

It is necessary to discriminate between eversion of the sacculus laryngis and eversion of the ventricle, and I hope to show proof that there is no such condition as prolapse of the ventricle of Morgagni; that the only way in which eversion of the ventricle can occur is either by a tumour occurring behind or in the wall of the ventricle, pushing it or dragging it inwards into the cavity of the larynx, or as a secondary or final stage of eversion of the laryngeal sacculus.

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Adhesions between the Back of the Tongue and the Posterior Pharyngeal Wall—Mr NORMAN PATTERSON, F.R.C.S.—Male, aged 22. Since nine years of age had been treated for lupus. Dyspnœa on exertion. Dysphagia with hard foods. Numerous bands of scar tissue extending from the pharyngeal wall, border of soft palate and posterior pillars of the fauces, down to the base of the tongue, with small communications between the buccal cavity and the hypopharynx. Wassermann negative.

Opinions were solicited as to treatment. It was pointed out that the improvement under treatment was usually of a temporary character, stenosis tending to recur.

Report of Two Cases of Fatal Tonsillectomy—Dr A. L. MACLEOD.—CASE 1. Girl, aged 10. Enlarged tonsils and adenoids. Operation at 9.15 A.M. Anæsthetic, C_1E_2. Seen at 12 and 2.30, quite well, no bleeding. Seen at 4.30, vomiting bright blood. Seen at 6, still vomiting. Under ether, stitched faucial pillars, plugged nasopharynx, and injected $\frac{1}{6}$ gr. of morphia. At 10 o'clock child better, conscious, talking, and asking for food. At 3 A.M. sudden death. Total bleeding following the operation not excessive. No post-mortem. Certificate signed "pulmonary embolism."

CASE 2. Girl, aged 6. Enlarged tonsils and adenoids. Operation at 10.30. Anæsthetic, C_1E_2. Seen 12.30, hæmorrhage, vomiting. 1 P.M., second anæsthetic given. Clot in the left tonsillar fossa; left tonsillar pillars stitched; nasopharynx plugged. Patient did not recover consciousness, sudden death at 5 P.M. There had been no further bleeding. On post-mortem examination the tissues were blanched but not excessively. No clot in stomach. Thymus very slightly enlarged. A few enlarged mesenteric glands. Other organs normal. Verdict returned; death from hæmorrhage and shock.

The opinion of the members of the Section was desired on the following points: Was death caused by the anæsthetic, by embolism, or by laryngeal spasm? What part did the hæmorrhage play? In the discussion very little light was thrown on these points.

Large Angeioma of the Nasal Septum—Mr HERBERT TILLEY, F.R.C.S.—Female, aged 42, with large fungating, foul-smelling mass projecting from right nostril, and semi-fluctuating swelling over right side of nose. Growth was found to be attached to septal cartilage by pedicle, the size of an ordinary lead pencil, with extension upwards and backwards to ethmoidal region.

Pathologists were in doubt as to whether the growth was an angeioma or melanotic sarcoma, but rather favoured the first named.

Tumour of the Larynx—a Soft Fibroma—Dr W. H. JEWELL, O.B.E.—Male, aged 57. Husky six months; five months

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ago coughed up piece of "flesh," size of hazel-nut, giving relief for three weeks, but since then huskiness. Cough and impairment of breathing have been progressive. On tilting the head backwards, a smooth, succulent, and somewhat globular tumour nearly the size of half a walnut is seen passing backwards from beneath the epiglottis and covering the whole of the glottis with the exception of a narrow space at the posterior extremity of the vocal cords.

Foreign Body (Centipede) discharged from the Nose—Mr CYRIL HORSFORD, F.R.C.S. — Patient suffers from chronic suppuration of the maxillary antrum, and has been twice operated upon. There is a good intranasal opening through which the antrum is regularly washed out, but discharge still continues. Following a few days' pain and irritation, the foreign body now shown, which looks like a caterpillar, was blown out alive (**Lithobius melanops**). Seventeen cases have been reported in which such animals have been found in nasal cavities.

Bilateral Adductor Paralysis—Mr PHILIP FRANKLIN, F.R.C.S. —Male, aged 65, complains of hoarse voice, occasional paroxysms of coughing while eating or drinking. First noticed five years ago. No other symptom; negative Wassermann. Report of post-nasal swab: *Staphylococcus aureus and Micrococcus catarrhalis.* Both vocal cords are bowed on expiration, with approximation of vocal processes and arytænoids. He suggested that a nasopharyngeal infection might probably be the cause.

A Laryngeal Growth (?) with Abductor Paralysis—ELEANOR LOWRY, M.B.—Patient, a woman, aged 44, with hoarseness. loss of weight, and occasional choking attacks at night during the last twelve months. Weight, 6 st. 11 oz. Considerable pulmonary tuberculosis, both lungs. No tubercle bacilli. Thickening and granulations on right vocal process extending over posterior third of cord. Double abductor paresis.

SECTION OF OTOLOGY

January 21, 1921.

President—Sir CHARLES BALLANCE.

Cavernous Sinus Thrombosis—Mr T. RITCHIE RODGER.—Published in *Journal of Laryngology*, April 1921.

Tympanic Exostoses—Mr W. M. MOLLISON.—Girl, aged 20, had suffered from otorrhœa. Examination showed exostoses springing from the tympanic ring, and on one side almost touching the short process of the malleus. There was a second exostosis actually in the drumhead.

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Royal Society of Medicine

Tinnitus associated with a Rhinolith—Mr LIONEL COLLEDGE.—A woman, aged 59, complained of tinnitus, also of discharge from the right nostril and obstruction. No deafness. Right ear normal. Suppuration in the right maxillary antrum and polypi. With a probe the stone could be felt. A radical Caldwell-Luc operation was performed and the stone removed from the nasal fossa. A carious bicuspid tooth was also extracted. Symptoms greatly relieved.

Pyorrhœa Alveolaris affecting the Ears—Mr ARTHUR J. HUTCHISON.—CASE I. Female, aged 18. Increasing deafness and tinnitus in both ears. Membranes normal. Rinne positive; bone conduction shortened. Pyorrhœa alveolaris discovered; five teeth extracted. Tinnitus ceased and hearing improved.

CASE II. Male, October 1919, discharge from right ear; treated by antiseptic drops, syringing, vaccines, ionisation. In 1920 pain in right elbow, later in knee and neck. October 1920, pyorrhœa discovered; teeth extracted; within two weeks ear became perfectly dry; pains in joints disappeared.

Gunshot Wound of the Ear—Mr HAROLD A. KISCH.—Private J., admitted January 1916, suffering from extreme rheumatoid arthritis. He was morose. Profuse offensive discharge from left ear, with mastoid tenderness. At operation the base of a bullet could be seen just below the promontory. With some difficulty a complete rifle bullet was extracted, the point of which must have been in close relation with the carotid artery. No sign of fracture of the external meatus. Next morning he said: "There, I always told them it was there, but no one would believe me." His mentality immediately changed for the better. He stated that he was in a wood near Ypres, in October 1914, when he felt a "clack" in his ear. He fell down and then went back with his comrades. As there was some bleeding from the ear he was X-rayed, but nothing was seen. His ear started to discharge and his joints commenced to be affected. Uninterrupted recovery: joints also improved.

Foreign Body in Mastoid Antrum—Mr JEFFERSON FAULDER.—Boy, aged 8, admitted with a foreign body (blue bead) in the left ear. Healed scar in the post-aural groove. Attempts to extract the bead (*a*) *per vias naturales* failed; (*b*) post-aural incision. The foreign body was found to have disappeared. No normal structures could be made out in the tympanum. Two days later post-aural wound reopened. Depression found on the surface of the mastoid process, rather below the level of the spine. This was deepened until the antrum was opened, exposing the bead lying amongst granulations. It appeared to have arrived there by way of a much enlarged aditus. The radical mastoid operation was completed.

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