SOCIETIES' MEETINGS.

THE AMERICAN LARYNGOLOGICAL ASSOCIATION.

Twenty-second Annual Meeting, held at Washington, D. C., May 1, 2, *and* 3, 1900.

SAMUEL JOHNSTON, M.D., *of Baltimore, President, in the chair.*

Opening Session, May 1.

PRESIDENT'S ADDRESS.

AFTER returning thanks to the members of the Association for the honour conferred upon him, the President spoke of the future policy of the Association. He believed that new members should be elected by a two-thirds affirmative vote of the entire membership. Old members should be encouraged to continue in active work. Scientific and clinical work should go hand-in-hand. One should avail one's self of all possible advances in diagnostic ability —as, for instance, the determination of leucocytosis as an initial feature of malignant disease. More attention should be paid, in teaching students in rhinology and laryngology, to operative work on the cadaver. Members of the Association were looked to as teachers, and consequently great care should be taken in the selection of new candidates. The aim should be not mere numerical strength, but skill in attainment. In the programmes of the future it might be well to limit the number of papers, but more attention should be given to discussion. The former should be grouped in two general classes, scientific and clinical. No opinion should go out from the meetings as official unless it was founded on facts. Mild measures, especially as concerned the use of the cautery, saw, and trephine, should be strenuously urged. A committee of censors, to be elected annually, should be established which should pass all matter to be published in the annual Transactions. In conclusion, a feeling tribute was paid to the memory of two active Fellows who had died during the year— Dr. Max Thorner, of Cincinnati, and Dr. Joseph C. Mulhall, of St. Louis.

Fractures of the Nose. This paper was read by Dr. T. A. DE BLOIS, of Boston.

He said that "broken" noses, so called, were not, as a rule, really fractured. They were rather cases of bony displacement

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and dislocation. They might be classified according to the degree of injury and also according to the relation of the parts involved. There might be a dislocation (not fracture) of the nasal bones—*i.e.*, a solution of bony continuity—or there might be a fracture of the nasal process of the superior maxilla or of the zygoma. Injuries might also result during parturition or from nursing or sleeping, from the constant impact of the nose, delicate at this period, against the mammæ or the pillow. Then, again, there were the cases occurring from falls, blows, and collisions. In the "upper-cut" blow of the boxer there was injury to the septum, followed by swelling, possible abscess, and detachment from the subjacent parts. The "side" blow gave a double dislocation of the nasal bones, while in the direct "front" blow the internal nasal border was driven downward and outward. Treatment consisted in the reduction of the dislocation, which might require a general anæsthetic. These flat noses might be properly manipulated so as to dispense with external apparatus. For an internal splint, a bit of stiff rubber tubing inserted by means of a closed pair of scissors (well greased so as to facilitate their withdrawal) might be of service. The elastic recoil of the rubber slowly acting will often force a dislocated nose into place, though some few days might be required to produce the full effect. Plaster-of-Paris bandage made an excellent external splint. Illustrative clinical cases were then described.

Dr. De Blois also exhibited an illustration of an abnormality of the uvula, which was double, one mass seeming to come from the anterior and the other from the posterior faucial arch. The former was amputated, leaving the latter appearing as a perfectly normal organ.

Dr. Emil Mayer, of New York, inquired of Dr. De Blois if he had not found the rubber internal splint irritating to the nasal mucosa. He himself preferred to use gutta-percha, which could be accurately moulded to fit each individual case, and was less collapsible. Elongated forceps could be used for the replacement of recent cases.

Dr. De Blois replied that the rubber was to be retained only temporarily, until perfect reduction had been secured.

Dr. W. E. Casselberry, of Chicago, recommended the use of a general anæsthetic for perfect diagnosis and reduction. Deeper injuries were very painful, and in children, without an anæsthetic, proper examination was impossible. He commended the external plaster-of-Paris dressing. The objection to all forms of special apparatus was that they were rarely at hand when wanted, and

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were difficult to keep in position. Plaster could be moulded over the nose, carried back to the line of the ears, being made thinner posteriorly, and secured by tapes passing above and below the ears behind the head. Such splints had to be worn ten days, and were, of course, a disfigurement. For internal splinting nosophen gauze applied under cocaine acted admirably. For fractures low down in the nose the ordinary vulcanized tube answered very well.

Dr. JONATHAN WRIGHT, of Brooklyn, called attention to the statements found in the writings of the fathers of medicine respecting the treatment of nasal injuries. The fingers of a child, thongs attached to plugs on the concave side of the injury, etc., had all been advocated. In a recent case one authority had inserted a plug made from the lung of a sheep. All the ancients objected to the use of absorbent material as rapidly tending to become foul.

Dr. JOHN O. ROE, of Rochester, commended the use of a thin metal splint externally with an internal dressing. An anæsthetic should be given when the injury was at all severe. Adhesive plaster was an admirable retaining material.

Dr. H. L. SWAIN, of New Haven, Conn., called attention to the mechanics of the nasal arch, saying that if one could bring the two nasal bones into proper approximation they would support each other. If the patient could be seen frequently he would dispense with all apparatus.

Dr. F. C. COBB, of Boston, had had as good results without as with apparatus. The behaviour of the nose during the first two days after the receipt of injury would determine whether or not apparatus might be safely dispensed with.

Dr. W. K. SIMPSON, of New York, advocated the use of the Bernays sponge specially shaped to fit the inside of the nose. It offered ideal requisites for this purpose, being easy of introduction and hæmostatic by the equable pressure it exerted.

Dr. W. F. CHAPPELL, of New York, had used the sponges, attaching them by iodoform collodion to a thin plate of gutta-percha, a device which had, in his hands, proved of great value.

Atrophic Rhinitis. Dr. J. E. LOGAN, of Kansas City, Mo., read this paper.

He reviewed the various theories of the pathology of this condition, condemning the introduction of the very large number of clinical terms which had been used to describe it. Four theories as to causation seemed worthy of special consideration: (1) Hypertrophy, cutting off the blood-supply by pressure, thus inducing atrophy; (2) suppurative rhinitis in children; (3) bacterial causa-

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tion; (4) sinus disease. For himself, he was inclined to attach importance, on the basis of his own experience, to the last-named theory. He narrated the histories of several cases in which opening and curetting of the ethmoid cells cured the atrophic rhinitis. One unexplained fact in these cases was the real source of the immense amount of secretion.

Dr. COBB had observed in his own ethmoid cases marked atrophy on the side of the sinus disease. In persistent sinus discharge he had noted a steadily increasing atrophy of the intranasal structures.

Dr. WRIGHT stated that post-mortem examination did not show that close connection between atrophic rhinitis and sinus disease that had been claimed by Grünwald and others. In his own personal experience, the inferior, and not the middle, turbinate was the structure primarily attacked. The etiology of atrophy here was hard to determine. There was no analogous process in any other part of the body. He was inclined to attach much importance to the recent views of Cholerva and Cordes, who looked upon the process as the result of a rarefying osteitis, commencing with a bony hypertrophy, the little canals in the bone containing an artery and vein becoming occluded by the bony growth. As a result, the blood-supply to the mucosa was shut off. How this process actually began was a matter of much less importance. Recent anthropometric investigations had confirmed Hopman's view as to the causative relation of a short antero-posterior nerve dimension, and still more strongly Fraenkel's contention as to the special occurrence of the affection in the brachycephalic type of skull. This latter observation, however, might be referable only to certain geographical areas, especially in Germany and Switzerland, and not applicable to American patients. No one cause was alone applicable in every case. In his own experience, 75 per cent. of the cases had occurred in women, and the sexual life might be an important factor.

Dr. SWAIN called attention to the fact that the rarefying osteitis had been marked as the cause of intranasal œdema and polyp formation, but he realized that intranasal conditions might differ in different types of skulls. The brachycephalic type of naris might cleanse itself with more difficulty than would other types.

Dr. J. E. BOYLAN, of Cincinnati, inquired if Dr. Wright had ever seen patients spontaneously recover after the menopause.

Dr. WRIGHT answered that he had noted a cessation of symptoms, while the objective atrophy remained.

Dr. CASSELBERRY declared that we must not overlook the

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associated atrophy of adjacent parts; there was also an atrophy of the lymphoid structures, a non-sensitiveness of the parts, and either a lack of development or an early shrinkage of physiologically associated tissues. The bony walls of the sinuses were especially thin in these cases. All of these lesions strongly suggested to him the theory of a tropho-neurosis.

Dr. SIMPSON had seen cases persisting beyond the menopause with as much virulence as before.

Recurring Membranous Faucitis due to the Bacillus of Friedlander, with Report of a Case. This paper was read by Dr. EMIL MAYER, of New York.

Friedlander's bacillus, first described in 1882, has been found in local manifestations in stomatitis, ozæna, rhinoscleroma, acute suppurative rhinitis, in pus in the antrum of Highmore, in membranous bronchitis, in suppurating dacryocystitis, and in ulcers of the cornea. In manifestations by extension it has been found in parotiditis, otitis, broncho-pneumonia, purulent pleurisy, pericarditis, pyelo-nephritis and meningitis. Generally it has been found in pyæmia and septicæmia.

The first mention of its occurrence in connection with pharyngeal affections was made by Max Stoss in 1895, who described one case.

In 1897 Nicolle and Hebert described five others. Pakes has brief notes of five more cases in 1898, and Billet reports two in 1899. To these recorded cases the writer adds another.

Regarding the frequency of the occurrence of this bacillus, Hebert reports that, in 1600 examinations of cultures taken from diseased throats, it was found present eight times, while Pakes found it 5 times in 500. The brief histories of the recorded cases are given, and all are in accord that the distress occasioned is very slight, often in no proportion to the extent of the affection. The patients complain of but little or no discomfort; the exudate, which occurs most frequently on the tonsils and on the pharyngeal wall, remains persistent for a long time, until it eventually disappears. There is no glandular swelling and no fever. The membrane is pearly white, is very adherent and difficult to remove with forceps, and leaving a bleeding surface when forcibly detached.

The case cited by the author was referred to him by Dr. J. C. McReynolds, of Dallas, Texas. A young lady of nineteen had been under the care of the latter for eighteen months. During all this time a membrane formed either over the entire pharynx and soft palate, or over the latter alone. This membrane formed, and subsequently exfoliated on the third day, an interval of entire

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freedom then existed, when it re-formed. After exfoliation the throat appeared normal. If it was prematurely removed, a raw surface bleeding on manipulation was present. When it exfoliated large pieces were removed, which were pearly white with numerous pinhole perforations. Constitutional manifestations were very slight and mild in comparison with the local involvement.

At no time during the past year and a half had she been free from the membrane more than fourteen days.

The growth of the membrane was carefully watched by the writer and described as being opaque-looking at first; then a very thin adherent membrane appears, and is exceedingly tenacious. In a few hours it becomes thick and is pearly white. Twelve hours later exfoliation occurs, and large pieces may be removed without pain, the underlying mucous membrane being reddened but not bleeding. The membrane is all thrown off, and nothing can be noted of any pre-existing affection from its appearance. Two days later the process was repeated.

These conditions remained for the month that she was under the writer's observation. Her general condition was otherwise good.

Cultures sent to the Local Health Department resulted in the report of "No Klebs-Loeffler bacillus."

Examinations of the membrane by George S. Dixon and Eugene Hodenpyl showed it to consist of squamous epithelium, arranged in layers of from three to six cells in thickness. On the surface of the membrane, between the cells, as well as within them, are very numerous bacteria, in the form principally of short bacilli. There is no fibrin present, neither can leucocytes, bloodvessels, nor connective tissue be detected.

Bacteriological examination by A. J. Lartigan showed Friedlander's bacilli in pure culture. A guinea-pig was inoculated, and the bacillus of Friedlander was found in the spleen.

These reports are all given in minute detail, and a coloured drawing of the diseased state accompanied the paper. The similarity of the cases found in the literature and the one presented by the writer is striking, there being the same rounded character to the edges, the same pearly points strewn through the membrane, the same adhesiveness in the early stages, and the same bacillus in pure culture. There were some points of difference in them, though. In but one other case was the entire soft palate covered. In none of the recorded cases was there any exfoliation. But the chronicity, the absence of any constitutional signs, the membrane formation, and the bacillus, always present in pure culture, makes the diagnosis positive.

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The question of the possibility of malingering was gone into thoroughly and emphatically negatived.

As far as treatment was concerned, the disease seemed to be limiting itself by very slow process indeed, orthoform in alcohol always rendering her comfortable.

The author concludes thus:

1. That anginas due to the bacillus of Friedlander may exist in a subacute or chronic form.

2. They occasion no distress, except, perhaps, in the beginning of the membranous deposit.

3. They may appear in membranous form, exfoliating and recurring.

4. In the chronic form treatment seems to be of no avail, the bacilli eventually becoming much less active, and the conditions cease by limitation.

5. They are probably much more frequent than the few recorded cases seem to indicate.

At the close of the session Dr. Boylan exhibited a hypodermic syringe for the application of cocaine to the pharyngeal vault for adenoid operations.

Dr. J. H. Bryan, of Washington, showed an aseptic syringe for nose and ear work and improved drainage-tubes for the frontal sinus; Dr. R. P. Lincoln, of New York, a wax model of a recurrent tonsillar tumour, with illustrative plates; Dr. Mayer, a hollow intubation-tube introducer for use in laryngeal stenosis, the intubation-tube itself being retained by an arm screwed in through the tracheotomy incision.

Dr. T. R. French, of Brooklyn, exhibited photographs of a chair to be used in the employment of the upright position in ether operations on the nose and throat.

Second Day—Wednesday, May 2, 1900.

Samuel Johnston, M.D., *of Baltimore, President, in the Chair.*

Discussion.

The Early Diagnosis and Treatment of Laryngeal Cancer. The discussion was opened by Dr. J. N. Mackenzie, of Baltimore, who spoke on "Methods of Diagnosis and General Principles of Treatment."

The speaker said he would confine his remarks to certain phases of the question which were at the present time more pressing and of immediate importance. Omitting the matter of a possible cancer

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bacillus, there were three methods of arriving at a diagnosis: (1) The naked-eye appearances combined with the clinical history; (2) thyrotomy, as affording a more complete inspection of the parts; (3) microscopical examination of a removed fragment. The second method was frequently a part of the first. The latter was the most practical of all, though we had unfortunately relegated it to a subordinate place. The removal of a fragment for examination generally so stimulated the malignant growth that it marked the beginning of the end. As to the clinical history, no one solitary symptom was of unequivocal value. Many cases might be positively diagnosticated by this first method. He asked whether, when reasonable doubt existed, a piece should be removed for microscopical examination. In the view of the speaker, he should answer absolutely in the negative. Under the term "thyrotomy" we might include even a more extensive division of the cervical tissues than the mere laryngo-fissure. This was allowable in cases of reasonable doubt, or when there was failure to define the exact territory occupied by the disease. Even here it might be impossible to map out the whole of the affected area. There might be a diffuse infiltration difficult, if not impossible, to recognise fully. As to removal of a piece for microscopical investigation, it must be said that the patients were at once exposed to the danger of auto-infection or of metastasis. There was also the danger of stimulation of rapid increase of the neoplastic area. The method was unsatisfactory, inconclusive, misleading, and often impossible. As to the nature of the infectious element in cancer, we were still in the dark. It might be a bacillus or inhere in some peculiar vital characteristic of the cancer cell. As to treatment, the time would probably come when the treatment of cancer would not be surgical, but medical. An antitoxin would probably be discovered. At the present time the only safe procedure was the total extirpation through healthy tissue of the cancerous mass, together with complete ablation of the neighbouring glands and lymph channels. Surgical methods in the past had been incomplete, and eradication had been only partial. It was, indeed, often difficult to determine the limits of disease, and the microscope would show infiltration in areas which to the eye appeared normal. There was often a diffuse infiltration, or there might be a deep-seated epitheliomatous mass which only slowly approached the surface. If the disease approached the middle line, removal of tissue should be early and complete. Such operations should be undertaken only by surgeons of skill, and there should be the proper ethical relation between surgeon and patient, so that the latter should authorize the former

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to do whatever seemed most advisable. Under these circumstances the laryngologist must come to the aid of the general surgeon. The removal of the lymph structures in the area under consideration was one of the easiest dissections of major surgery. A low tracheotomy should be done. The chief danger was the recurrence of the disease in the cervical lymphatics. In cases seen very early, in which the growth was small and papillomatous in appearance, circumscribed, not in the median line, and not especially malignant-looking, we might remove one half of the larynx. Sometimes growths which seemed pathologically malignant were clinically benign. If there was no evidence of malignant infiltration in the pedicle, we might possibly be justified in removing simply the growth as it appeared, without the more formidable operation. But even here there was doubt as to whether we had completely removed all the malignant deposit. As to removal of one half of the larynx, the remainder was not of especial service so far as voice production was concerned. Intralaryngeal operations in cases of extensive disease were to be condemned. Simple thyrotomy with curettage was not up-to-date surgery, and was a reversion of procedure to the status of fifty years ago. No operation could be assumed as correct which did not include the removal of the lymphatics. Success by partial removal might be explained by a mistake in diagnosis. Many adenomata had mistakenly been classified as true carcinoma.

Methods of Treatment and the Statistical Results. This aspect of the question was discussed by Dr. D. Bryson Delavan, of New York, who exhibited elaborate statistical tables not included here.

The speaker had made, seven years ago, an earnest plea for the full reporting of all cases, not only those which were successful, but those which were not. The tables presented were a careful compilation of 163 cases occurring in the practice of some eight Continental surgeons. No one had been included who had not had at least ten personal cases. This excluded all American operators. The current statistics on the subject were faulty, because they were too promiscuous. The cases were confused, and there was a resulting repetition. In some instances the patient had undergone more than one operation, and so appeared in more than one category. Finally, in the published statistics there was no sharp line of demarcation between thyrotomy and partial resection. Out of the entire number of cases studied there had been only 6 per cent. of recoveries; that is, the patients were alive three years after operation.

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The Surgical Procedures. Dr. J. Solis-Cohen, of Philadelphia, said that before undertaking operation permission should be secured from the patient to do whatever seemed necessary. If the mass was of such a shape that a section could be punched out through the whole thickness, thus allowing examination of the cut surface, this procedure was permissible. If the growth affected the vocal band, a thyrotomy might be done, and a knife be employed to remove the circumscribed diseased area. Partial extirpation was not reliable. In the performance of laryngectomy he would call attention to the following points: (1) In order to prevent the entrance of septic matter into the lungs, we should operate with the head of the patient in a semi-inverted position. Some material might be aspirated into the lungs; but this happened with a tracheal tampon, for absolute protection with the latter device is impossible. (2) Preliminary tracheotomy should be done, otherwise we may be troubled by the descent of the trachea. (3) The epiglottis should be retained if possible. (4) We should shut off all communication of the mouth with the air-passages. In attaching the upper part of the trachea to the skin, the tube should be slit longitudinally for a short distance. (5) All dressings should be avoided. No packing should be allowed, as it caused a constant desire to swallow. Feeding by enema should be done, and no tube be used per os. (6) The larynx should be removed from below upward, and after operation the foot of the bed should be elevated. For the proper attitude toward the practical problems of these operations a combination of the laryngological and surgical minds was needed.

Dr. C. C. Rice, of New York, expressed the conviction that the laryngologist should not turn over these cases to the general surgeon until the diagnosis was positively established. It was difficult to make an early diagnosis. He believed in giving the iodides and carefully watching the progress of the case before advising operation.

Dr. Emil Mayer, of New York, called attention to the fact that cases often diagnosticated as laryngeal cancer showed the origin of the growth to be in the œsophagus. He thought that there was a very decided limit to the extent of applicability of endolaryngeal methods.

Dr. W. K. Simpson, of New York, could not advise total extirpation without a microscopical examination of a fragment removed for this purpose. No one could always made a diagnosis from appearances alone. If the case came to us early and showed an isolated deposit, we might use endolaryngeal methods. In one of his own cases thus treated the man was alive four years after

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operation. In view of his personal experience, he could not advise total extirpation.

Third Day—Thursday, May 3, 1900.

Secondary Hæmorrhage after the Use of Suprarenal Extract. This paper was read by Dr. F. E. HOPKINS, of Springfield, Mass.

He gave the histories of three cases of posterior exostoses of the septum in which the extract had been used, and in which secondary hæmorrhage resulted. The object of the paper was to give the opinions of various clinicians to whom the author had written as to the liability of hæmorrhage under the conditions named. Almost all agreed that there was considerable danger, and that safety required the use of intranasal packing after the extract had been employed. In regard to the remedy causing coryza after being sprayed into the nose, there seemed to be an idiosyncrasy in this respect, and it could not be determined beforehand just who would and who would not be benefited by this procedure.

Dr. H. L. SWAIN stated that he had had more hæmorrhage with cocaine and the extract combined than with either alone. It should be remembered that the latter acted on the muscular fibre of the arterioles, and did not lead to the formation of any coagulum. Consequently, when the vessel relaxed there was liability of bleeding.

Dr. J. W. FARLOW, of Boston, had had no hæmorrhage with the extract, and had seen some remarkable cures of coryza follow its use. Yet it might benefit a patient at one time and cause him much discomfort at another. This experience had recently been met with in one of his patients. He had succeeded in removing headaches from intranasal conditions, sometimes in a very remarkable way. The question arose in such cases, how long it was judicious or safe to continue the use of the remedy.

Dr. A. W. WATSON, of Philadelphia, had seen more hæmorrhage with the use of the extract than without. He thought that after its use patients should be kept in the office for half an hour or so. Then, if any dangerous degree of vascular relaxation occurred, they would be under direct control. He had seen acute coryza follow the intranasal use of the extract, and in his own person had had under these conditions what he believed to be a general acute sinusitis lasting ten days. He had thought that in the latter instance the solution might have become infected.

Dr. SWAIN said that if the fresh glands could be obtained it was possible to make a solution of their active principles in acetic acid, and that this solution might be put up in glass tubes and kept indefinitely.

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A Case of Ozæna of probable Sphenoidal Origin. This paper was read by Dr. J. W. FARLOW, of Boston.

His patient was a girl, aged twenty-one years, with a crusty, odorous discharge from the left naris. There was considerable atrophy of the intranasal structures, but the discharge seemed to come definitely from the posterior portion of the naris. The probe seemed to pass into a cavity which was regarded as the sphenoidal sinus. Syringing with peroxide of hydrogen and an alkaline antiseptic, and later curetting, practically relieved all the symptoms.

Dr. S. W. LANGMAID, of Boston, remarked that the recent epidemic of influenza would probably cause much sinus disease. That it did produce much acute trouble was in accord with his own experience, for he had recently seen five acute cases in two weeks. If the influenza attack passed off quickly, trouble in the sinuses would not result; but if for any reason the latter became obstructed, inflammation would be very probable.

Dr. A. W. WATSON believed that ozæna could occur independently of atrophy, or there might be crusts without ozæna. He was inclined to regard true ozæna as due to sphenoid and posterior ethmoid disease. He preferred a very weak formalin solution for the irrigation of these upper and posterior regions.

Dr. FARLOW, in closing the discussion, said that it was always advisable in looking at these cases to have the patient wait after the nose had been thoroughly cleared out, for then it would be possible to ascertain the exact site of discharge.

Bullous Middle Turbinates. Dr. J. PAYSON CLARK, of Boston, read this paper.

He reported two cases, both in women, the prominent symptom being headache. The large turbinates were removed without incident by the cold snare, with complete relief to symptoms.

Cyst of the Larynx. Dr. CLARK also read this paper.

The mass was situated on the middle of the right vocal cord, and from its hardness suggested a fibroma. The forceps slipped from its surface at the first attempt at removal, but it was cut with a laryngeal knife, when a fluid escaped showing degenerated epithelial cells and leucocytes. The firmness was probably due to the deep situation of the cyst in the substance of the cord.

Dr. JONATHAN WRIGHT, regarding the first paper of Dr. Clark, said that he was inclined to doubt the statement which had been made that these bullous conditions were the result of development from fœtal conditions, and presented no inflammatory evidences. He had examined several of these masses, and had found on the

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convex surface what appeared to be osteoblasts, and on the concave what appeared to be osteoclasts. The former produced bone, while the latter absorbed it. The conditions met with might be due to the unequal activity of the two classes of cells beneath the embryonal layer of mucosa. It was a striking fact that most of these cases occurred in women, and after the establishment of puberty.

Fibroma of the Larynx. This paper was read by Dr. A. B. THRASHER, of Cincinnati.

The patient was a woman aged fifty-six years, who had complained of dyspnœa and hoarseness. Her family history was negative. The posterior and lateral walls of the larynx seemed to be the seat of some deposit, so that the true cords appeared pushed in, and were defective in abductor movement. A fragment of the mass was taken for examination. The report was fibroma. Iodide of potassium was given in increasing doses, but in a week the patient was seen again, and was much worse. After a preliminary tracheotomy with the head dependent and gauze packing, the larynx was split, and it was seen that there was a submucous hypertrophy extending down to the cartilage. It appeared to be simply connective tissue. It was removed with forceps, and the patient made a good recovery. The voice was now rough and hoarse, but audible. Two similar cases were described. The rarity of the case consisted in the extensive connective-tissue deposit.

Singular Exhibitions of Partial Paralysis of the Vocal Cords due to Overuse of the Telephone. Dr. C. C. RICE, of New York, read this paper.

He said that he would make its title a query, for he desired to obtain the consensus of opinion as to the possible effect of overuse of the telephone on the voice. He had had two cases. The first was a nervous man, aged forty-five years, who had been accustomed to use a desk-transmitter, with his head in a cramped position. The cords showed evidence of fatigue of the thyro-arytenoid muscles, and there was a loss of sustaining power in the other outer muscles, for the cords trembled and the arytenoid cartilages separated immediately after approximating for phonation. The man was directed to take a rest from business, and to use the telephone with head erect, so as to afford perfect freedom of the cervical muscles. Recovery had been only partial. The other case was that of a man who was stout and not at all nervous. On the right side of the larynx there was fair adduction. The edge was straight, but there was a lack of tension, with an incomplete view of the cord, which

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was obscured by the overhanging and congested parts. By rest and the assuming of a proper attitude while using the telephone, this patient completely recovered.

Dr. T. A. De Blois opened the discussion by relating the case of a man whose head was violently bent forward as the result of a fall. As a result, a sudden strain was put upon the muscles of the neck, and he became hoarse from inability to approximate the cords.

Dr. W. E. Casselberry mentioned the case of a clergyman who was accustomed to become very much excited in his pulpit work, and gradually developed a similar condition to that seen in the cases mentioned by Dr. Rice. Rest and the formation of the habit of more quiet speech greatly improved the condition.

A Case of a Pin in the Larynx for Two Years; Removal by Endolaryngeal Methods. This paper was read by Dr. A. W. de Roaldes, of New Orleans.

The patient was a young girl in whose larynx a pin was found situated on the posterior portion, having pierced the apex of the right arytenoid at its inner side. Its head was embedded more deeply on the right side just above the false cord. Forceps were applied, the left index-finger being placed behind the larynx to steady it. The forceps slipped, but the finger caught the pin, which was thrown out of the mouth. In such cases, when the head of the pin was below, it might at first have passed some way down the trachea, and then have been coughed upward so that the point engaged. Moreover, the head of the pin impeded its migration so that it did not move about in the tissues as a needle would. The Rontgen rays might often locate the pin when it was impossible to make out its exact position by the mirror. Another point of interest in this case was a hard swelling in the neck which was probably due to infection which had stopped short of suppuration.

A Peculiar Case of Migratory Foreign Body with X-ray Illustrations. Dr. D. Braden Kyle, of Philadelphia, read this paper.

The patient was a woman, who constantly complained of a feeling as if a foreign body was moving about under the scalp. She suffered from intense neuralgias, which at times seemed to focus in the mastoid, and at other times in the ethmoid or antral regions. In one of these latter attacks there had been a discharge of purulent material from the naris, and in the discharge was a piece of a needle. The symptoms continuing, it was concluded that still another piece was somewhere in the tissues, and an X-ray picture was made, showing a dark line in the neighbourhood of the antrum, though it was impossible to tell whether the body was actually in

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the antrum or on the bone corresponding to one of its walls. The antrum was opened and its cavity illuminated, but nothing was found. In a short time a gum-boil formed, which discharged, giving escape to another piece of the needle. From this time all symptoms disappeared.

Dr. S. W. LANGMAID called attention to the fact that attempts at swallowing often caused great changes in the location of foreign bodies in the upper air tract.

Dr. W. K. SIMPSON commended the trial of forceps and other instruments upon material similar to the foreign body before actually attempting the removal of the latter. He found sharp forceps better than merely roughened blades.

Dr. KYLE closed the discussion. He stated that the patient had suffered from an X-ray burn, and remarked that the time of the exposure causing the burn was not so long as the exposure on previous occasions when no burn had resulted.

Tracheal Injections in the Treatment of Pulmonary Tuberculosis. This paper was read by Dr. T. MORRIS MURRAY, of Washington.

He gave a short history of the development of this procedure, and then mentioned his personal experience with thirteen cases of pulmonary tuberculosis. In all there was at first a slight explosive cough, but in all the general effect on the cough had been good. No spasm had been noted. The solution used consisted of thyme and eucalyptus oils in olive-oil. His experience had been that cough and expectoration had both been lessened, while the temperature had fallen and the general condition had been improved.

Dr. W. E. CASSELBERRY believed that the benefit from this plan of treatment was confined entirely to the bronchitic element of the disease. He had no confidence in its alleged effect upon the general course of the tuberculosis. It did, however, benefit some of the symptoms attributable to the mixed infection which pulmonary tuberculosis presented.

Dr. J. SOLIS-COHEN observed that this was not a new plan of treatment, as it had been practised forty years ago. Its greatest benefit was seen in cases of bronchiectasis.

Correction of Deviations of the Nasal Septum. Dr. JOHN O. ROE, of Rochester, read this paper.

It was an exposition of the plan of operation previously presented by the writer, whereby the septum was fractured by a fenestrated comminuting forceps. Of all deviations 5 per cent. involved the posterior part of the bony septum, 25 per cent. the anterior cartilaginous part, and from 65 to 70 per cent. the osseo-

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cartilaginous junction. Other descriptive terms simply referred to varieties, and not to location. For anterior deviations he advocated a horizontal incision and an oblique bevelled incision, forming more or less of an angle with the first. By this device the flaps would more easily slide by each other.

Surgery of the Turbinal Bodies, with a New Method of Operating. This paper was read by Dr. J. E. BOYLAN, of Cincinnati.

He advocated the removal of large portions of the turbinates when the obstruction had resulted from hyperplastic changes. The obstruction was more apt to be located at either end of the turbinate. Posterior obstruction was rarely of a hyperplastic nature. For instruments he used the saw, snare, and scissors, especially the snare. In this way he obtained better results than from the cautery.

Dr. W. E. CASSELBERRY used the cautery, but was careful to make deep linear incisions, and in this way had had no septic or other trouble. He urged caution in its use on the middle turbinate, care being taken to confine its action to the lower dependent portion of the bone, which he never cauterized on its upper surface.

Hæmorrhage from a Peritonsillar Abscess. Dr. W. F. CHAPPELL, of New York, related this case.

His patient was a young man aged twenty-seven years, who had had several quinsies, the most recent of which had been opened by an incision through the posterior pillar. Half an ounce of pus was evacuated. Five days later there was a severe bleeding. The urine showed albumin and casts. The bleeding recurred, and the abscess cavity appeared filled with clots. An incision was made through the anterior pillar, and the cavity washed out and packed daily for ten days, at which time the patient was well. Later a rheumatic attack came on without cardiac lesions. The condition of the kidney had continued up to the time of latest observation. When the cavity was opened for washing out, the ascending pharyngeal artery could be seen, but there were no evidences of ulceration. Dr. Chappell had been able to find the records of ten similar cases. All had occurred in patients in whom the quinsy had burst spontaneously. In no case had there been immediate hæmorrhage. Of ten cases, eight had been fatal. In the two recoveries the carotid had been tied. The lesson from these figures was to open early.

During the different sessions of the association the following papers were read by title: "Laryngeal Irritation a Cause of Asth-

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matic Paroxysms," by Dr. W. L. Glasgow, of St. Louis; "Severe Hæmorrhage after Operations on the Throat and Nose: Report of Five Cases," by Dr. A. A. Bliss, of Philadelphia; "Angioma Cysticum of the Nose: Histological Analysis and Physiologico-Chemical Research of its Contents," by Dr. H. L. Wagner, of San Francisco; "Dermoid Cysts of the Nose," by Dr. H. S. Birkett, of Montreal.

Officers Elected.—Officers for the coming year were elected as follows: President, Dr. H. L. Swain, of New Haven, Conn.; First Vice-President, Dr. H. L. Wagner, of San Francisco; Second Vice-President, Dr. A. A. Bliss, of Philadelphia; Secretary and Treasurer, Dr. James E. Newcomb, of New York; Librarian, Dr. J. H. Bryan, of Washington; Member of the Council, Dr. Samuel Johnson, of Baltimore.

The next meeting will be held at New Haven in the spring of 1901.

THE OTOLOGICAL SOCIETY OF THE UNITED KINGDOM.

Third Ordinary Meeting, May 7, 1900.

Sir William Dalby, *President, in the Chair.*

The President announced that Professor Politzer of Vienna had been elected an honorary member by the Council.

Mr. Charles Ballance showed a case of epithelial grafting of the labyrinth after removal of the semicircular canals. A woman aged fifty-four years had had discharge from the left ear since childhood. On May 7, 1898, she was admitted into St. Thomas's Hospital with a large masto-squamous abscess, foul otorrhœa, and extreme vertigo. The old mastoid operation was performed, but discharge from the ear and vertigo still persisted, and deafness was absolute. On February 6, 1900, Mr. Ballance found a sinus leading into the petrous portion. The semicircular canals were in part removed and the vestibule opened, the remaining cavity being repeatedly swabbed out with absolute phenol. For several days the patient was very sick and giddy. On February 17 the cavity was grafted. No giddiness or sickness occurred after the grafting. On removing the plug on February 22, the patient at once said she could hear well. When shown at the meeting, the wound was soundly healed, the hearing was good, and the patient could run, being free from giddiness and also from tinnitus.

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