SOCIETIES' PROCEEDINGS

THE SCOTTISH OTOLARYNGOLOGICAL SOCIETY

THE seventy-second meeting of the Society was held in the Royal Infirmary, Edinburgh, on Saturday, May 19th, 1956, with the President, Dr. A. Brownlie Smith in the Chair.

Cases were shown as follows:

DR. I. SIMSON HALL

1 and 2. *"Closed Fenestration" Method.* Incision and bone work is similar to the Schwartze operation. Bone removal is carried forward to expose the horizontal canal and attic. Sufficient posterior meatal wall is removed to give a good view. The incus is removed, but the malleus is not touched. Fenestra is made in the usual way, and covered with a very thin skin graft taken from the post-auricular region and floated over the fenestra. The wound is closed with a small drain which is removed in three days. The advantages are the short convalescence and absence of a troublesome cavity. The hearing gain is possibly not so great as with the "open fenestration" method. In Case 1, the right ear was fenestrated by the open method. The left stapes was mobilized, and four months later the left ear was fenestrated by the closed method. In Case 2 the right ear was fenestrated by the open, and the left by the closed method.

3 and 4. *Mobilization of Stapes.* This operation has a definite place in the treatment of otosclerosis. The stay in hospital was only two days, and in some cases the hearing could be returned practically to normal. The fact that a mobilized stapes did not immediately become fixed again, supported the Edinburgh theory that otosclerosis involved a healing process and not a spreading disease. If the bridge of bone at the oval window were broken, the movement of the stapes would prevent re-union. *Drs. Lumsden, Venters* and *McDowall* referred to their experiences with this operation.

DR. A. BROWNLIE SMITH

5. *Otosclerosis Treated by Stapes Mobilization.* The patient, aged 36, had a loss of 50-60 decibels over the lower notes, the right ear being the worse. Immediately after operation he heard a conversation voice across the theatre, audiograms taken about six weeks later showed a gain of 20 decibels in the right ear.

DR. I. SIMSON HALL

6. *Repair of Sub-total Perforation of Tympanic Membrane,* by "swinging door" flap from posterior wall, hinged on tympanic ring. The outer surface of this flap was covered by a free graft from the post-auricular region. Replying

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to a question by *Dr. Hutchison* as to the effect on hearing, Dr. Hall said that there was usually a slight improvement, but that this was a secondary consideration in most cases. Children with large tympanic perforation were debarred from swimming, for instance, and repeated infection of the ear was common. In reply to *Dr. Christie*, he said that infections had complicated and ruined several cases.

Dr. Birrell asked if local anæsthesia had been used. *Dr. Hall* pointed out that most cases were young children, and a general anæsthetic was necessary. Unfortunately this aggravated bleeding at operation, and obstructed fitting of the graft.

DR. A. BROWNLIE SMITH

7-10. *Four Cases of Radical Mastoid Operation with Free Whole-skin Graft* (Pietrantoni). The grafts were cut from the post-auricular area, and placed over the attic on completion of the operation. At Dr. Smith's request, Dr. Gristwood gave results of this method. In a series of 24 cases, the graft had failed to take in 12. In the remaining cases, the hearing loss on the operated side was about 30 decibels, which was quite good for a radical operation. *Mr. Howie* reported considerable success with split skin grafts in radical mastoidectomy cavities.

11. *Healed Tuberculous Otitis Media.* A woman, aged 31, had what appeared to be a congenital atresia of the right external auditory meatus, which was sealed off in its deeper part by a dense plate covered squamous epithelium. She had a right facial palsy which had been present since the age of 5 months, and there were glandular scars in the right side of the neck. A loud shout could be heard in the right ear. Audiograms showed a little hearing in the upper register. Cold caloric test produced slight nystagmus and giddiness. X-rays of the temporal bone revealed no obvious abnormality. While the appearances suggest a congenital defect, the history is very suggestive of a healed tuberculous otitis media.

Dr. Brown Kelly said that he had shown a similar case to the Society in November, 1954. A girl, aged 7 years, had been deaf since birth, but had sufficient hearing to learn to speak. The auricles were well developed, but each external canal ended in a cul-de-sac at a short distance from the entrance. He was convinced that the condition was congenital, especially as it was bilateral. *Dr. Simson Hall* considered that in a unilateral case, it might well be an infection, and not a congenital condition. He asked if there were any signs of canals.

DR. J. F. BIRRELL

12. *Case of Deafness Associated with Congenital Hypoparathyroidism.* The child, aged 9, gave a history of congenital laryngeal stridor, polycystic kidney removed in 1950, and chronic idiopathic hypoparathyroidism treated by calciferol 40,000 units daily and calcium lactate, from age of 3 years. Mother was hyperparathyroid, and part of her hypertrophic gland was excised and implanted into patient in rectus abdominis and upper end of tibia. Temporary

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improvement resulted. Later, Vitamin D was re-instituted, and then replaced by Sterogyl. Deafness has persisted. Hearing aid and speech therapy instituted.

Dr. Christie suggested that lip-reading lessons should be given. In reply to *Dr. Seex*, he said that children deaf enough to require a hearing aid should also have instruction in lip-reading.

DR. I. SIMSON HALL

13. *Case for Diagnosis.* A boy, aged 10 years, was referred on account of attacks of horizontal vertigo of sudden onset, with nausea and vomiting. He had been diagnosed elsewhere as "abdominal epilepsy", and treated with phenobarbitone. Cochlear and audiometric tests showed complete deafness in left ear. There was no response to the differential Caloric test in either ear, but on continued stimulation, a response was obtained in both, although delayed on the left side. X-rays of petrous bones were negative. Recently, attacks had become more frequent. He had been admitted to the ward for observation and nicotinic acid therapy. The most likely diagnosis was "Ménière's disease".

Dr. Gibson mentioned a patient aged 7 years with similar attacks. Dr. Hall had destroyed his labyrinth with complete success. *Dr. Christie* said that the youngest child he could recall with similar symptoms was aged 4 years. He had been deaf for one or two years before becoming giddy. The appearances were very suggestive of an acoustic neuroma.

DR. R. B. LUMSDEN

14. *Ulceration of Mouth and Pharynx.* Case for diagnosis. A woman, aged 42, had recurring ulcers in the mouth and throat for several years. Examination showed large superficial ulcers on right lower lip, tip of tongue, right anterior faucial pillar, and palate. The larynx showed nibbled appearance of the epiglottis but no ulceration. Throat swabs, Wassermann and Kahn tests were negative. X-rays of chest and nasal sinuses showed no abnormality. Biopsy report was "subacute inflammatory reaction with no specific features". Response to a course of Cortisone injections was doubtful.

Mr. Howie recalled a similar case which he had shown to the Society last year. In this instance the response to cortisone had been good. *Dr. Brownlie Smith* said that one of his colleagues had suffered from mouth ulcers due to taking sleeping tablets.

15. *Hæmangioma of Tongue. Diathermy.* A woman, aged 21, had a diathermy wedge excision of tongue root by a general surgeon in 1945, and again in 1948. When seen in 1952, had discomfort in throat and thick speech. A vascular tumour mass on the right of the dorsum extended into right tonsil fossa and down into right vallecula, pushing epiglottis backwards. Diathermy was applied by direct laryngoscopy in four stages, between July, 1952, and February, 1954. In November, 1955, there was distortion of epiglottis, and persistent œdema of right vallecula. No evidence of tumour remained. A tender, fibrous thickening of the right dorsum showed keloid on section.

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DR. I. M. FARQUHARSON

16-20. *Five Cases of Reticulum Cell Sarcoma of Nasopharynx.* Two men and three women were shown. In three, there was a history of deafness, in two, the chief complaint was enlarged cervical glands. All were being treated by radio-therapy. Their ages ranged from 52 to 83.

Dr. Gavin Young said that these cases of nasopharyngeal tumour were often missed, being treated for "nasopharyngeal catarrh" or for tinnitus. The Specialty should be impressed with the tremendous importance of scrupulous care in examining the nasopharynx in every case.

DR. I. SIMSON HALL

21. *Carcinoma of Epiglottis.* The growth had been treated by radio-therapy unsuccessfully. A growth remained on the left side of the epiglottis. Excision was carried out by right trans-hyoid pharyngotomy. The case was shown for contrast with a case of epiglottidectomy previously shown to the Society, and operated on by the midline route. Dr. Hall thought the latter route healed better.

DR. BROWNLIE SMITH

22. *Carcinoma of Larynx.* J.M., aged 72, was shown at previous meetings of the Society. First seen in March, 1946, with carcinoma of right cord. Laryngo-fissure was performed. Keratosis of right reformed cord noted in 1948. Biopsy in 1953 showed squamous carcinoma. Laryngo-fissure in September, 1953, with removal of reformed right cord, and small part anterior end left cord. In April, 1956, larynx appears distorted, but no sign of growth. In reply to a question by *Dr. Simson Hall, Dr. Smith* stated that no cartilage was removed at either operation.

DR. R. B. LUMSDEN

23. *Laryngeal Injury.* James P., aged 11, ran into a lorry while riding his bicycle. There was stridor, dyspnœa, hæmoptysis and slight cyanosis. Surgical emphysema of face, neck and upper chest. X-rays showed right apical pneumo-thorax, and surgical emphysema in superior mediastinum. The voice was husky two weeks later, and laryngoscopy showed the right side of the larynx to be swollen and the cord immobile. Two months after the accident, the right half of the larynx was still swollen and indurated. The right cord was fixed in the midline, and the arytenoid could not be displaced.

Dr. Brownlie Smith mentioned the case of a doctor, injured in a car accident. At first stridor was severe, but in four hours diminished, and a tracheotomy was not required.

Dr. Land mentioned the danger of air obstruction from emphysema, and recalled a case which he treated by tracheotomy with good result. *Dr. Gavin Young* mentioned a hæmophiliac who had an intra-laryngeal hæmorrhage. Cyanosis was relieved by the passage of an intra-tracheal catheter. This was tolerated for 48 hours.

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24. *Subglottic Stenosis. Excision and Skin Graft.* Mrs. C., aged 65, developed subglottic stenosis following intra-tracheal anæsthesia for hysterectomy. Tracheotomy was required 60 hours after operation. Biopsy ten days later showed subacute inflammatory tissue. Operation one month later through laryngo-fissure approach. Fibrous tissue at level cricoid excised, and Thiersch graft applied on rubber tube, transfixed with tantalum wire. Rubber tube and tracheotomy tube removed about a month later.

DR. G. D. MCDOWALL

26. *Para-œsophageal Abscess and Mediastinitis.* Mr. R.B., aged 56, complained of lump in throat following the swallowing of a mutton bone five days previously. No foreign body was found, but a scratch noted on the posterior œsophageal wall, just below the crico-pharyngeus. Two days later rigors occurred, with severe dysphagia and surgical emphysema of neck. X-rays showed a fluid level at C6. The abscess was exposed through an incision along the anterior border of the sternomastoid. On passing an œsophageal speculum, a free flow of pus occurred through a small puncture on the posterior œsophageal wall. The external wound was drained and a nasal feeding tube passed. One week later the wound had to be re-opened, and a large amount of pus released (*Dr. Ironside*). Bacteriological report: *proteus vulgaris*, sensitive to streptomycin. With anti-biotic treatment, the condition gradually resolved.

Dr. McDowall thought that it had been a mistake to pass the œsophageal speculum on the second occasion, as it had resulted in the abscess discharging through a small hole which had closed again. *Dr. Gavin Young* said that many of these cases could be treated by passing a sucker into the cavity on several occasions, and giving penicillin. *Dr. Brown Kelly* mentioned the case of a patient on whom a practitioner had passed an umbrella probang for suspected foreign body. A strip of mucosa had been removed from the gullet wall, and an abscess developed in the neck. Although this was in the pre-anti-biotic era, the patient recovered after the abscess had discharged into the œsophagus.

DR. I. SIMSON HALL

26. *Parapharyngeal Abscess* (under care of *Dr. W. M. S. Ironside*). Mrs. A.L., aged 61, choked on a mutton bone. X-rays showed an opacity at lower border 6th cervical vertebra. No foreign body found on œsophagoscopy, but a tear noted immediately below the crico-pharyngeus. Within twelve hours, rigors developed, followed by surgical emphysema of neck. Foreign body still visible on X-rays. Through an incision along the anterior border of the sternomastoid muscle, a large abscess was opened and drained. At the same time, œsophagoscopy revealed the bone lying behind the lower edge of the transverse tear. On anti-biotic therapy, recovery ensued.

DR. I. M. FARQUHARSON

27. *Case of Dysphagia.* Mrs. M. S., aged 46, complained of slight discomfort in the throat and mild dysphagia. Examination of nose, nasopharynx, pharynx and larynx revealed no gross abnormality. X-rays with barium swallow showed

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a large calcified mass lying behind and to the right of the œsophagus just below level of the aortic arch. It appeared to be causing compression and displacement of the gullet, and thick barium showed delay in passing this region. The mass is most likely confluent, calcified, tuberculous glands. In the right lower lobe, an old calcified tuberculous focus was visible.

28. *Achalasia of Œsophagus.* A girl of 13 years complained of food sticking in the throat and vomiting. Onset was sudden, about seven months ago. X-rays showed achalasia of cardia with gross œsophageal dilatation. Œsophagoscopy showed a pouch in the dilated part of the gullet, with excoriated walls. The stricture at the cardia was dilated. This manœuvre had to be repeated nearly two years later, and in January, 1956, a Heller's operation was performed. She can now eat ordinary food. The advisability of operation before fibrous stenosis occurs is stressed.

DR. A. BROWNLIE SMITH

29. *Facial Pain.* G.T., aged 31, complained of pain in the right side of the face and around right eye. No cause could be found on examination. Treated by plaster of Paris collar, which was left on for four weeks. Pain was completely relieved.

DR. J. F. BIRRELL

30. *Multiple Papillomata of Antrum.* Miss B.D., aged 69, had a long history of nasal obstruction, discharge and antral pain. Lately, blood-stained post-nasal discharge had appeared. Examination showed that far back, below the right inferior turbinate, was a pale pink, fleshy growth, and biopsy revealed an actively proliferating epithelial papilloma. Right Caldwell-Luc operation was performed, and the antrum found to be full of tumour tissue which had ruptured into the inferior meatus. The tumour was easily shelled out, but one year later recurred. The pathologist regarded the tumour as potentially malignant. The antrum was re-opened, the growth removed, and radium inserted. X-ray therapy was also given.

DR. I. SIMSON HALL (original examinations by *Dr. W. M. S. Ironside*)

31. *Fibrous Dysplasia of Bone.* R.M., aged 9, was seen in November, 1953, with bilateral catarrhal deafness. In 1955 a hard, bony swelling of the right side of the face was noted. Biopsy from the antero-lateral wall of the right antrum showed "fibrous dysplasia of bone". There is no orbital displacement, and the condition seems to have remained stationary.

Exhibits

DR. I. SIMSON HALL

1. Examples of Lendrum's chromotrope 2 R stain for eosinophilia (prepared by Dr. R. Gristwood).

2. Slides of Papanicolaou staining (prepared by Dr. W. M. S. Ironside).

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Dr. A. Brownlie Smith

3. Radiographs of congenital parotid gland calculi (case notes accompany).

Dr. J. F. Birrell

4. Microscopic slides of Hodgkin's Disease of the Tonsil (case notes accompany).

Dr. I. M. Seex

5. Photographic illustrations of a case of traumatic facial palsy in an achondroplasiac. Plastic operation employing strips of temporal muscle and fascia lata. (Case notes accompany.)

6. Photographs and X-rays of a case of marked unilateral proptosis of the eye associated with chronic sinusitis and an eosinophilia of 40 per cent. (case notes accompany).

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