acid had been applied, and the attacks had ceased absolutely. The fourth case was so recent that the result was not yet known. The operative treatment of cases of non-suppurative labyrinthine vertigo had been suggested many years ago by Mr Cheatle, and carried out by Mr Lake, Mr Jenkins, Mr Hugh E. Jones, Mr Sydney Scott, and others.

The difficulty consisted in selecting cases in which operation was indicated, and in excluding extra-labyrinthine causes for the vertigo.

Sequestra removed from the Region of the Eustachian Tube during a Radical Mastoid Operation—T. H. JUST, F.R.C.S.—Female, aged 23, had suffered from suppuration in the right ear since childhood. For six weeks before being seen by exhibitor she had had a right-side facial palsy. She died suddenly five days after a radical mastoid operation. An autopsy showed extensive osteitis, practically the whole of the petrous portion of the temporal bone being involved.

Section of Ependymal Glioma growing from the Floor of the Fourth Ventricle, simulating a Cerebellar Abscess, in a case of Bilateral Chronic Suppurative Otitis Media—T. H. JUST, F.R.C.S.—Male, aged 26, complained of double otorrhœa of long standing, and of symptoms indicating that the left cerebellar fossa was involved. On exploration, the cerebellum bulged under pressure, but no abscess was found. The patient became worse, and a more thorough exploration was made, but the result was negative. The patient suddenly died of respiratory failure two days later. On post-mortem, an ependymal glioma was discovered, arising from the floor of the fourth ventricle. The tumour would have been absolutely irremovable.

THE SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY

SEVENTEENTH MEETING, HELD IN THE ROYAL INFIRMARY, EDINBURGH

June 9, 1923

President—Dr R. P. MATHERS.

A Case of Adeno-Carcinoma of the Kidney with Secondary Metastatic Growth in the Larynx—Dr A. LOGAN TURNER.—(The case will be published *in extenso* in the *Journal of Laryngology*.)—Male, aged 70, suffering from hoarseness for three months, was seen in January 1922. The mobility of the right vocal cord was impaired by a smooth, pale, non-ulcerated sub-glottic swelling. The rest of the larynx appeared normal. A firm, painless swelling, the size of

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a small orange, involved the left deltoid muscle. A section made from the latter revealed a tumour, the structure of which resembled a hypernephroma. The laryngeal tumour was regarded as being a similar metastatic growth.

Post-mortem examination, in August 1922, disclosed the primary tumour in the right kidney.

Dr ALEXANDER said he had nothing to add except from the point of view of the pathology of hypernephroma. Most authorities believe that suprarenal "rests" do occur in kidneys, and, from such "rests," tumours may develop which are called hypernephromata; it is recognised now that many primary renal neoplasms, which have been regarded as arising from suprarenal inclusions, are, in reality, adeno-carcinomata of the kidney itself, which have acquired a superficial resemblance to suprarenal cortex from their very complex papillary structure. In the case under discussion, parts of the primary tumour showed definitely that the condition was really a papillary adeno-carcinoma of the kidney, whereas the deltoid metastasis was not unlike the zona fasciculata of the suprarenal cortex.

Dr GRAY desired to ask Dr Alexander with regard to the spread of cancer. Dr Sampson Handley of London held the opinion that cancer never spreads by the blood-vessels, but always by the lymphatics. He (the speaker) did not altogether agree; and in this case the tumour appeared certainly to have spread by the blood-vessels.

Dr ALEXANDER replied that Dr Sampson Handley's belief that cancer spread, in the vast majority of cases, by permeation of lymphatic channels was now, he thought, universally accepted, but that cancer also disseminates, not infrequently, by the blood-stream could not be doubted at all.

Cases of Lupus and Malignant Disease of the Fauces and Pharynx treated with Diathermy—Dr A. LOGAN TURNER.

Dr W. S. SYME said that the problem of these cases was becoming almost an economic one. He had, at the present time, five in his wards, all requiring a great deal of the nursing staff's attention in keeping them clean. When the slough commenced to separate, the mouth must be kept clean by swabbing with H_2O_2, and it meant a great tax upon the nursing staff. He thought that diathermy was a tremendous aid in the treatment of these cases, whether operable by the knife or regarded as inoperable. He showed a case to the Society in December. It was sent as inoperable, with a very large mass in the palate, side of the fauces and tongue, and extending into the pharynx, with a mass of glands in the neck. A year previously, he had removed the growth completely by diathermy, leaving the glands in the neck. The patient remained without any recurrence, but the interesting point about him was in the change that took place in the glands. He had left the glands in the neck at the time, but removed them, several months after, from the anterior triangle. They had gone down very much, and one hard gland about the size of his thumb remained. He removed it, and found that it had undergone changes which seemed to be towards cure. The mass had been converted into very firm fibrous tissue in which were a few islets of malignant tissue. Was it possible that in the

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process of coagulation of the tissue in these cases, there was some chemical change by which something was formed that had an effect on cancer cells carried to a distance? It was not the action of the heat, because the glands were at a distance. In treating an intralaryngeal condition, such as lupus, by this method, he thought it safer to perform a preliminary tracheotomy.

Dr MATHERS asked if the tubercular cases thus treated were of the nature of lupus. He had treated two cases of lupus of the soft palate with, so far, excellent results—better than he had ever seen with acid nitrate of mercury or anything else.

Dr LOGAN TURNER said that he had been treating lupus by diathermy, and where the nasal and pharyngeal condition had been combined with lupus of the larynx, tuberculin had been used. The danger in operating upon the larynx lay in the production of stenosis.

Case of Temporo-Sphenoidal Abscess—Drs A. LOGAN TURNER and G. EWART MARTIN.—Male, aged 46, a case of left-sided temporo-sphenoidal abscess, was operated on in 1920 by Dr Turner. He developed signs of intracranial pressure with Jacksonian fits two years later. A decompression operation with separation of adhesions over the old affected area was performed in January 1923 by Dr Martin. No intracranial symptoms had developed since, and improvement in memory had taken place.

Two Cases of Left Temporo-Sphenoidal Abscess in Females, aged respectively 13 and 15: Operation: Recovery—Dr J. D. LITHGOW.

Left Temporo-Sphenoidal Abscess following Chronic Suppuration: Operation: Recovery—Dr W. T. GARDINER.—Male, aged 16, had headache and vomiting for two weeks. He became comatose on the fifteenth day, and was sent into hospital as an encephalitis lethargica. On examination he could not be roused. The left pupil was larger than the right. Both meatuses contained foul-smelling pus. It was ascertained from the relatives that there had been an attack of pain in the left ear two weeks previously. At operation (2/4/23) 1½ ounces of foul pus were evacuated. On one occasion, four days after operation, there was slight drowsiness and aphasia owing to re-collection of pus. Further course was uneventful.

Right Temporo-Sphenoidal Abscess following Chronic Suppuration: Operation: Recovery—Dr W. T. GARDINER.—Female, aged 16, for sixteen days previous to admission had pain in the right ear with intermittent vomiting of the projectile type. She had had a radical operation on the left ear in 1920. Oculist

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reported double optic neuritis of some considerable standing. Operation on right ear: lateral sinus far forward; tegmen antri removed and small extradural collection of pus was found. Dura mater was covered with granulations to the extent of a shilling-piece. Bone removed and dura mater incised to extent of one inch. Dressing forceps passed into brain in an upward and forward direction without result: finally in a backward direction, when a large quantity of very foul-smelling pus was evacuated to the amount of about two ounces. After treatment gave considerable trouble with drainage, but eventually dressing twice daily proved successful.

Dr LOGAN TURNER said that it would be interesting to learn from observations upon a large series of cases operated upon for temporo-sphenoidal abscess, as to the proportion of cases which suffered from Jacksonian fits.

Dr GRAY wished to ask Drs Turner and Martin, with regard to the loss of memory in their case, if any distinction had been made as to the kind of loss of memory.

Dr DOUGLAS GUTHRIE inquired if the reporters of those interesting cases had any experience of the method of dealing with cerebral abscess as suggested by Lemaître. The latter introduced at first a fine capillary tube, and then used a larger tube at each dressing until free drainage was secured. By this means he claims to eliminate the dangers of meningitis and cerebral hernia.

Dr MARTIN (in reply to Dr Gray) said it was a case of loss of word memory. Drainage had been the difficulty in every one of his cases of brain abscess, and he found that if the means used were changed from time to time—now rubber tubes or gauze alone, now gauze and rubber dam—the best results seemed to be obtained. His patient was admitted practically unconscious. He had watched him for some time and had warned him of possibilities. When digging in the garden the patient suddenly began to develop a tremor on one side and fell down. His wife said that the tremor started in the right hand and then affected the right leg and then the whole body. In the region of the old abscess there was a large blood-clot which showed some signs of organisation, and, round this, there were a great many adhesions, which were freed. Decompression had been done on other cases which had had either a temporo-sphenoidal or a cerebellar abscess where there were adhesions in the region of the abscess.

Dr LITHGOW said that, with regard to the younger girl, her memory for naming objects returned within twelve hours of opening the abscess. The other case did not have loss of memory.

Dr W. T. GARDINER said that his first case was admitted comatose. He could not therefore be tested for aphasia; the morning after operation the temperature and pulse were normal, but, four days after operation, when drainage was interfered with, aphasia was present until the pressure was relieved.

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Society of Otology and Laryngology

A Series of Cases of Ozæna treated by Vaccines—Dr ROBERT ROBERTSON (introduced by Dr W. T. Gardiner).

Dr MATHERS said that the Society was indebted to Dr Robertson for his report on the treatment of this rather troublesome and difficult condition.

Dr LOGAN TURNER said that the results obtained by vaccines in his hands had not been encouraging. In pre-war days a number of cases were so treated and closely observed, and the results were not considered satisfactory. He did not wish to prejudice the Society against the use of vaccines in ozæna, but he did not think that the results in Dr Robertson's series of cases were encouraging.

Dr WHITEHOUSE asked Dr Robertson what was the average duration of the treatment by vaccine in the ozæna cases and how often it was administered.

Dr GAVIN YOUNG said that certain investigators had associated syphilis and tuberculosis with this condition. He would like to ask Dr Robertson if he had taken any cognisance of this in preparing his vaccine.

Dr BROWN KELLY said that before the war, with the assistance of Dr J. F. Smith, he had treated a series of cases of ozæna with a vaccine of Perez bacillus. Watery secretion was increased and crusting was diminished, but the patients were not cured. Rhinologists should feel indebted to Dr Robertson for his efforts to benefit subjects of ozæna because they were very helpless in the treatment of this disease. He (the speaker) would not, however, regard the cases shown to-day as cures.

Dr ROBERTSON (in reply) said that all the patients expressed themselves as feeling distinctly the better of the treatment, more so than when under treatment by douching. He (replying to Dr Whitehouse) considered that a period of two years was necessary to effect a cure.

Sarcoma of the Tonsil*—Dr DOUGLAS GUTHRIE.—Female, aged 22, had suffered for four months from a sensation of swelling in the throat, difficulty of swallowing, and "thickness" of speech. A swelling, the size of a pigeon's egg, of firm consistence and bright crimson in colour, occupied the right tonsillar region. There were no enlarged cervical glands. On 9th October 1922, the tumour was easily and almost bloodlessly dissected out under general anæsthesia, and was found to be limited by the capsule of the tonsil. Dr James Dawson reported that the microscopic characters were those of endothelial sarcoma.

Tertiary Syphilis of Palate, affecting Husband and Wife—Dr DOUGLAS GUTHRIE.—J. A., aged 42, suffered from "a skin complaint" in 1917, and was treated by injections (? salvarsan). Since then he has suffered from tinnitus and deafness of left ear, and,

* Previous cases are described in exhibitor's paper on "Sarcoma of the Tonsil," *Journal of Laryngology*, November 1918.

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during the past few months, from discomfort in the throat and pain behind the angle of the left jaw. The appearance at first suggested a syphilitic lesion, but is now obviously epithelioma.

Mrs A., aged 40, complained of pain in the palate and throat, also of severe headache several times a week. She has six children, the youngest aged 9 months. The condition of the palate is one of tertiary syphilis. The coincidence of the lesions of the palate in husband and wife appears unusual.

The Operative Treatment of Congenital Enlargement of the Nose: Lantern Demonstration—Dr DOUGLAS GUTHRIE.—

The exhibitor stated that the patient had the misfortune to be born with an unduly large nose, and as she grew older the deformity increased. The deformity was rather aggravated than otherwise, in that, at the age of five, she underwent an operation for harelip. This, of course, narrowed the lip and caused the nose to become more prominent. Apart from the general enlargement of tissue the skin was unaffected. It was a pure and simple hypertrophy. At the age of eighteen she was anxious to have something done. The nose was reduced in size by the removal of a wedge-shaped piece of tissue from each side. The tissue included mucous membrane and cartilage, but not skin. After removal of the wedge of tissue, a malleable copper splint was applied, so that the nose was pressed upon and the edges of the incision within the nose brought together. The external part of the nose was thus reduced to a normal size, but the sides were unduly straight and the nose had a pyramidal shape, the curves of the alae being lost. In order to restore the natural curves of the alae, a second operation was performed ten days later, which consisted in the inward transplantation of each ala.

Dr W. S. SYME hesitated to criticise what was good work, but he thought that Dr Guthrie was asking for trouble. Some day, he will get a worse result than the appearance originally presented by the patient. The incision is made in the most septic part of the nose, just inside the vestibule, and unless the deformity is worse than it appears to have been in this patient, he (Dr Syme) would be inclined to leave it alone.

Mr J. J. M. Shaw was inclined to agree with Dr Syme that the treatment one would have adopted in this case would have been to encourage the girl to believe that her nose was not so abnormally large as to make it noticeable. It was a fairly common type of broadening in association with the condition of harelip from which this patient suffered. The antero-posterior dimension was apparently increased by comparison with the post-operative tightening and retraction of the upper lip. Dr Guthrie saw the patient, and was able to estimate the effect upon her happiness of the supposed disfigurement in a way which was not possible by the inspection of photographs. Once undertaken, the operative result would be considered satisfactory.

Dr DOUGLAS GUTHRIE agreed that these operations should not be indiscriminately performed, and in certain cases he had advised that the

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nose should not be touched. In this case, if either Mr Shaw or Dr Syme had seen the girl, he felt sure they would have been perfectly satisfied that it was wise to try to help her to look a little more presentable.

Cancer in the Roof of the Post-Nasal Space with Secondary Deposit in the Right Carotid Triangle—Dr NEIL MACLAY.—Male, aged 53, seen at end of September 1922, complaining of deafness in the right ear for over a year, and a lump in the neck for two months. The deafness was middle ear in type. In the right carotid triangle there was a small lump, firm but not hard, fairly movable and not tender. The right tonsil contained some septic plugs, and the post-nasal mirror showed what looked like adenoid tissue streaked with mucopus. The tonsil was treated by local measures and a nasal douche employed.

On 12th October 1922, the gland mass seemed to be in the same condition: post-nasal space was cleaner, and it was possible to see on the right border of the adenoid growth a very small irregular area which was regarded as an ulcer. After some delay, owing to patient's objection to operation treatment, the gland mass was removed and the post-nasal space curetted on the 9th of November. The former was the size of a walnut, and the other tissue, which was removed in one piece, looked like adenoid tissue which had become fibrous in parts.

Histological examination showed both tissues to be carcinoma of spheroidal cell type. Radium was placed in the post-nasal space and X-ray radiation by deep method of Erlangen employed.

Dr GAVIN YOUNG said there was a good deal of pus under the middle turbinal on the affected side. He thought that possibly there might be some extension forward of the original condition into the antrum, or there might be merely antral suppuration.

Dr LOGAN TURNER thought the nasopharynx was in a very satisfactory condition. He agreed with Dr Young that there was pus in the middle meatus on the right side. There was some scar tissue in the site of the old tumour, and a little rough area as one passed towards the left side. He suggested to Dr Maclay that he might apply the diathermy button in that situation.

A Short Note concerning a Case in which Endoscopic Search for a Fish Bone in the Gullet was followed by Cellulitis in the Neck and Abscess Formation in the Chest Wall under the Ribs—Dr NEIL MACLAY.—(Published in the *Journal of Laryngology and Otology*, October 1923, p. 518.)

DISCUSSION.

Dr W. T. GARDINER did not agree that the œsophagus was previously inflamed before the passage of the fish bone. He thought that the fish bone had stayed there and then passed through the wall of the œsophagus.

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He asked why general anæsthesia had been used for the ordinary examination for a foreign body by the direct method. He (Dr Gardiner) had removed nine or ten fish bones within the last year from the œsophagus, and he thought that as soon as the œsophagoscope was introduced, difficulty in getting down arose because there was œdema of the œsophageal wall above the foreign body. He had found in three or four cases that the bone was half-way through the gullet wall with half an inch projecting into the œsophagus. He thought that in this case the fish bone had probably passed through.

Dr CAMPBELL MACGREGOR had had a somewhat similar case—a man who complained of severe dysphagia and pain behind the manubrium sterni, having swallowed a haddock bone three days before. The œsophagoscope was passed, and, 10 in. from the teeth, the mucosa was found very pale and œdematous with the upper end of the fish bone fixed in both lateral walls. The bone was grasped and withdrawn without difficulty. It was a gill bone, $1\frac{3}{4}$ in. in length and half an inch in breadth at the upper end, where there were two sharp points which had been impacted in the œsophageal wall. The patient was obviously ill and had the abdominal type of face, a subnormal temperature, and a rapid pulse. He was admitted to the ward, and though his temperature rose and the pulse rate remained high, he had less pain. His condition became much worse. Pericarditis and pleurisy were diagnosed on the second day, and he died early on the fourth day after admission. At post-mortem there was a double perforation of the œsophagus, acute mediastinitis, with mediastinal abscess (two pints of pus), pleurisy, and septic pericarditis. He thought it possible that the fish bone in Dr Maclay's case was still in position or had passed through the œsophageal wall into the soft tissues, and that there was no local inflammation prior to that. He (the speaker) might add that his patient had a very septic mouth (pyorrhœa and bad teeth), and had been trying to force the bone down with food during the three days before he reported.

Dr MARTIN said that Dr Maclay's short note raised one interesting point. Was the œsophagoscope to be passed in every case when a patient complained of swallowing a fish bone, when nothing could be found by the indirect method, the assumption being that the fish bone may have passed into and remained in the gullet, and be liable to cause a mediastinal abscess? He had had a somewhat similar case about a month ago. A man reported that he had swallowed a fish bone. In the examination he (Dr Martin) could find nothing except thickening in the lateral hypopharynx. Two or three days afterwards, the patient developed signs of abscess in the side of the neck and an X-ray showed definite gas formation in that region. Mr George Chiene opened it and found foul-smelling pus. The condition advanced to mediastinitis and death. No post-mortem was made, but in this case no fish bone was found.

Dr W. S. SYME asked what was the usual attitude of members towards the question of swallowed fish bones? Did they always pass an œsophagoscope and look for the fish bone? Many patients came complaining of having swallowed a fish bone, and when no sign of anything could be found, they were sent away.

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Dr BROWN KELLY said that he had had the same difficulty in deciding what to do. He did not care to pass the œsophagoscope without general anæsthesia, especially when looking for a fish bone. One was liable to push the bone deeper into the tissues if the patient retched. In the case of a private patient, careful consideration was desirable before sending him into a home and giving him general anæsthesia, otherwise, in many instances, the search might reveal the presence of no foreign body, and the trouble and expense incurred by the patient would have been in vain. If there was pronounced pain and complete inability to swallow, an examination should be made at once, but, if these signs were moderate or slight, he was inclined to wait a day and then find how the patient was; if somewhat better, another day might be allowed to pass. If at any time, however, there was the apparent probability of a bone being impacted, an œsophagoscopic examination should be made without delay.

Dr MACLAY (in reply) said he was glad that the case had excited some comment and interest. He joined issue with Dr Gardiner, and agreed with Dr Brown Kelly with regard to anæsthesia. He (the speaker) had removed many fish bones, but he had always used general anæsthesia and found it more convenient to do so. He did not always pass the endoscope when a patient told him he had swallowed something, but if it was a question of a fish bone, and there was a definite point of localised tenderness, he thought that one ought to do something to settle the question. With regard to the suggestion that the fish bone remained *in situ* and went through the gullet wall in his case, he thought the chances were that it would have been seen at the external operation or during subsequent dressings. Moreover, had it been overlooked as suggested, and allowed to remain embedded in the tissue, he did not think the external wound would have healed and remained healed for so long a period. The amount of inflammatory disturbance which he saw in the gullet was quite different to what he had hitherto experienced, and he did not see how it could all have taken place in twenty-four hours. He was disposed to think that some definite pathological change had taken place in the gullet prior to the time at which the fish bone was said to have been swallowed.

Three Cases of Nasal Tuberculosis—Dr G. EWART MARTIN.—(*a*) Female, aged 52, with a history of nasal obstruction for nine months: blow on the nose thirteen months ago: no pain: no previous trouble.

Seen 28/4/23. Right side of septum showed a lobulated, pale tumour, congested towards the anterior nares, hard to touch, situated at about half an inch from the front of the nose, on a level with the lower anterior part of the middle turbinal and inferior turbinal: nasopharynx clear: the tissue consists of numerous tubercles.

(*b*) Female, aged 67, with a history of nasal polypi: frequent cauterisation by her doctor. She began to notice her nose becoming sore on cold days.

Seen 9/6/22. Redness and swelling of left nostril with a small ulcer: nose blocked far back by pinkish swelling covered with

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some pus in the region of the inferior turbinal. Nothing to note on posterior rhinoscopy. Larynx normal. Wassermann negative. Small portion removed and reported on as suspicious of sarcoma; second portion showed appearances characteristic of tuberculous infection. After the removal of a portion, the disease spread to vestibule and on to the septum. With the diathermy knife all infected parts were cut out.

9/1/23. Still some granulations: treated with acid nitrate of mercury. This case is evidently on the border line between lupus and tuberculosis. Had apparently started far back in the nose in the region which had been frequently cauterised, spread forward to the skin margin, and had not shown any of the discrete, apple-jelly-like nodules so common in lupus.

(*c*) Girl, aged 13. Examined 5/4/23. Child's mother noticed a growth in the right nostril seven days previously. Patient had always spoken thickly, and was deaf for some time previously. There was a small, lobulated swelling (painless) on the right side of the septum: no extension on to skin margin: no post-nasal discharge: very slight adenoids: the tonsils enlarged and rather fibrous looking. Small portion of growth shows well-marked tuberculous infection. Beyond slight blepharitis and some corneal changes, the child is healthy. No signs of any lung trouble. She has always been healthy, and is the eldest of seven. Family history is good.

Dr BROWN KELLY said that as in these three cases growths had formed, they might therefore be termed tuberculomas. This affection was by no means common. There were differences of opinion as to whether it should be associated with lupus. A typical tuberculoma appeared as a growth with a lobulated, smooth, unbroken surface. If the surface ulcerated, an appearance might be produced similar to that of hypertrophic lupus in which the granulations were crowded together and there was a discharge of pus. The diagnosis depended upon the microscope which revealed tubercles, but bacilli were usually found only after a long search and in the deepest part of the growth. He asked the members whether they agreed with the view often expressed by writers, that patients with nasal tuberculosis developed pulmonary tuberculosis. He had a number of cases that were still evidently free from involvement of the lungs, although they had had nasal tuberculosis for many years.

Dr PETERKIN asked to what size these tuberculomata usually attained. He had a case of a woman about 30, who had evidently suffered from congenital syphilis. She had a flattened nose, perforation of her hard palate, and her nasal septum was almost completely destroyed. She was sent on account of nasal obstruction, and the nasal cavities were found occupied by a greyish, opaque-looking mass, which extended into the nasopharynx. A portion was removed and reported as being histologically tubercular. The mass was removed and in some months it recurred, and

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the patient reported again with the nose and nasopharynx filled with it, and the soft palate bulging. She was having difficulty in swallowing. He took a piece from the nasopharynx and submitted it to the pathologist, thinking that there must be something more than tubercle. He found it was sarcoma and removed the mass again pretty thoroughly, partly from the nasopharynx and partly through the hole in the palate, and submitted the whole mass again. He found histological tubercle and, upon staining, tubercle bacilli. The Wassermann was negative.

Dr MARTIN (in reply to Dr Brown Kelly) said that none of these cases showed any signs of a tubercular focus elsewhere. The lungs showed nothing. In each of the cases the Wassermann was definitely negative.

Case of Rhabdomyoma of the Posterior Aspect of the Soft Palate—Dr EWART MARTIN.—Girl, aged 6, with a history of discharge from nose and snoring at night. Lately the child had been inclined to be peevish and crying and disinclined for food: family history negative. She is the first child of the second marriage, and both parents have been previously married.

Seen 4/11/22. Tonsils large: post-nasal discharge. Examination of nasopharynx under an anæsthetic, when it was found to be filled with hard, polypoidal tissue, growing from the upper posterior part of the soft palate and the shelf at the lower border of the posterior nares. Tissue was examined by Dr F. E. Reynolds, who reported a rhabdomyoma.

5/3/23. Chloroform anæsthesia: the whole of posterior part of soft palate scraped: no signs of adenoids, and no appearance of new growth anywhere else in the nasopharynx.

15/3/23. Child now able to breathe through the nose. Nasopharynx clear, but a small roughness on posterior wall of soft palate, evidently a small portion which had not been thoroughly scraped.

Dr ALEXANDER reminded members that tumours of muscle were of two kinds, those arising from striped muscle and those arising from unstriped muscle. The latter, leio-myomata, were in the nature of the uterine "fibroid," perhaps the commonest of all tumours. The former, rhabdomyomata, were extremely rare. He had seen examples in the kidney and œsophagus. The tumours of striped muscle were usually simple in character, but many appeared to be potentially malignant, and this one was obviously very malignant and might be termed a rhabdomyosarcoma.

Dr MARTIN said that he had been unable to find another case of rhabdomyoma of the nasopharynx reported in literature. The tumour was usually found in the heart or in the kidney or bladder, and there were two cases reported in the œsophagus. The tumour itself looked rather like a mass of very hard, small polypi. Recurrence had taken place in the soft palate and the cervical glands were enlarged.

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