SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

President—A. LOGAN TURNER, M.D.

June 5, 1925.

Large Pharyngostomes as an Accident in Laryngectomy: How to avoid them: The Technique of their Closure—Dr A. G. TAPIA (Madrid).—The paper is published in the *Journal of Laryngology and Otology*, No. 12, vol. xl., p. 781, December 1925.

DISCUSSION.

Mr WILFRED TROTTER said the time had passed when it was possible to contemplate the removal of a malignant growth in the pharynx or larynx, leaving the patient to struggle with the necessary mutilation which the mere removal of the tumour inflicted. It had become necessary, before undertaking a radical operation, to consider in what condition the patient would be left, and to calculate whether his life afterwards would be worth living. A radical operation, therefore, must contain some plastic procedure designed to restore to the patient a tolerable existence.

The objective of such plastic procedures was two-fold. First, there was the overwhelmingly important question of function: How was the patient to be allowed to speak after the operation? And, in many cases, how was he to be able to swallow? He (Mr Trotter) did not think that anybody could be contented with the surgery of malignant disease of the pharynx and larynx which did not offer a patient a reasonable chance of maintaining his more or less natural powers of speech and deglutition. There was a second objective, however, when contemplating plastic procedures in these cases, namely, the extreme importance of leaving the patient, immediately after the operation, without any extensive raw surfaces in communication with the pharynx, through which infection might occur with its very serious dangers of cellulitis in the neck and secondary hæmorrhage. There was, therefore, a two-fold object in treatment; (1) restoring the patient to a tolerable existence, and (2) greatly diminishing the danger of the operation, and, incidentally, the length of the convalescence. For instance, in such a condition as post-cricoid carcinoma—a bugbear of surgery—one could, in a reasonably favourable case, ensure that the patient would speak and swallow normally within six weeks of the primary operation, without having undergone any very great risk to life.

Taking the pharynx and larynx as a whole, one might say that, at the present time, there were four regions in which a plastic operation had been proved necessary and was already regarded as practicable. He (the speaker) supposed that the simplest case was the not very common

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carcinoma of the posterior wall of the pharynx. It was a disease occasionally seen in women, and it was exceedingly favourable in the ordinary surgical sense; nevertheless it was, in another respect, unfavourable, because one could not remove the smallest piece of the posterior wall of the pharynx without leaving a gap which presented all the dangers of a raw wound. This was the simplest case for a plastic procedure; one could excise a large section of the posterior wall of the pharynx, and immediately replace it by a flap of skin, closing the subsequent fistula in about three weeks. He (Mr Trotter) thought the method should always be carried out in those comparatively rare cases.

The second situation in which plastic reconstitution was essential was in dealing with a growth in the neighbourhood of the upper opening of the larynx, where it was necessary to remove the party wall between the larynx and the pharynx. If the surgeon did not do a plastic operation here, he left his patient with a funnel, at the bottom of which were the openings of the œsophagus and trachea. It was necessary to reconstruct the wall between the larynx and pharynx by flaps of skin, the peculiarity of the case being that one was compelled to use double flaps, so as to leave a skin surface towards the pharynx and a skin surface for the larynx.

The third situation usually demanding plastic methods was found in connection with tumours of the larynx itself. It was open to controversy—into which he did not propose now to enter—whether the whole larynx should ever be removed. It was a fact that without diminishing the patient's chances of recovery, one could frequently leave half, or one-third, of one cord, or even one arytenoid, removing the rest of the larynx. If one did that, and took the trouble to line the raw surface with skin, surprisingly good results could be obtained as regards voice, and one could greatly diminish the dangers of these almost complete laryngectomies by covering in the raw surface at once.

The fourth situation, already referred to, was the post-cricoid region. One could not usually remove post-cricoid carcinomata without making a complete section of the cervical œsophagus. If this were done and the gullet was not reconstituted, stricture followed and the convalescence was full of danger. If the plastic operation was at once performed, the dangers of the operation were greatly diminished and the patient was left with the capacity for swallowing normally.

In these four regions, no operation for malignant disease should be undertaken without the surgeon being prepared immediately to proceed with a reconstitution of the part which had been mutilated.

There were two rules which should always guide the surgeon in these plastic procedures. One was, that he must know beforehand the kind of tumour with which he had to deal. This raised the question of the exact classification of tumours of the pharynx. There was not sufficient discrimination between the different types of tumour. By examination of the patient, it was possible to recognise the type of tumour and its actual distribution, to plan the operation and the kind of plastic procedure which could be prepared for before commencing the operation.

The second rule was, that in doing plastic work in the pharynx and larynx, the surgeon should secure a reasonable degree of asepsis. Sepsis, more or less, was inevitable in all operations on the pharynx, but it could be

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very greatly diminished. If the patient survived, sepsis involved scarring, and there was nothing more completely upsetting to the results of plastic surgery in the pharynx than much scarring. In his (the speaker's) experience, there was only one means of dealing with what might be called the "normal" sepsis of the pharynx, and that was the care of the teeth. It must be recognised as a fact that good results would be obtained with far greater certainty and safety in the edentulous than in patients who possessed teeth, however healthy.

Mr LIONEL COLLEDGE said he wished to recount a case which illustrated Mr Trotter's last remark on the importance of removing the teeth. The patient was a man aged 61, who had had a laryngo-fissure done in Scotland in 1920, by an operator now dead. Three years later the patient had consulted Dr Brown Kelly, who had found a recurrence in the anterior part of the larynx. The patient had then been sent to Sir St Clair Thomson, and had eventually come to him (Mr Colledge) to have the larynx excised. He (the speaker) had advised the patient to have all his teeth extracted, but after the dentist had removed seven, the patient had refused to have any more touched. In conjunction with Sir St Clair Thomson, he (Mr Colledge) had then excised the larynx. On the fourth day after the operation the wound had become foul and had begun to give way. On the eighth day, it had completely broken down and a severe septic bronchitis had set in. On the eighteenth day the patient was apparently moribund; but there had been a gradual improvement and the chest condition had cleared up. An attempt at closure had then been made, but the wound broke down again. The patient returned three months afterwards. He had then had two more teeth removed and he (Mr Colledge) had operated again, but with the same result. After that, the patient had placed himself entirely in his (the speaker's) hands, and the remaining twelve teeth were removed. He had then done another plastic operation, and nine days afterwards he had closed the wound. After the last operation, the patient had remained well.

A case illustrating the difficulty of closing the pharynx was seen in a man aged 55, who never took exercise and who drank half a bottle of whisky daily, consequently he was a poor subject. He had not consulted his doctor until his condition had become so serious that he suffered from stridor even when sitting down quietly. The larynx was removed and was found to be choked with a growth; there was a second tumour in the pharynx, so that a large part of the pharynx had also to be removed. Microscopically, both were identical epitheliomata, but there was more than an inch of quite healthy mucous membrane separating the two tumours. A large gap was necessarily left in the pharynx. The patient had progressed very well for a month, and then had suddenly died.

Sir ST CLAIR THOMSON said that the question of closing the stomata was one which was often omitted from the text-books. To judge from text-books, one might think that after laryngectomy, or similar operation, it was only necessary to stitch the wound and healing resulted. His colleagues had asked him (Sir St Clair) if that was the case, and he had had to reply that it frequently was not. Before the war, when less had been known about plastic surgery, one had to wait and pack, and watch

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healing progress slowly, and he (the speaker) had known the closure of a wound to take three months.

The case referred to by Mr Colledge, with which he (Sir St Clair) had been associated, was very interesting, because when the wound was dressed every morning, pus was noticed and they had not known from where it came; the area had not appeared to be purulent. One day they packed the wound with extreme care, and, when they returned next morning, pus was found on the top of the dressing, not in the wound where it had previously been seen; it had come down from the teeth.

Sir JAMES DUNDAS-GRANT asked whether any who had operated on these cases had been tempted to allow the wounds to heal by the open or the partially open method. He (Sir James) had been greatly interested, when seeing Mr Wilfred Trotter perform lateral pharyngotomy, to note that while he stitched the deeper parts, he only partially stitched up the superficial parts, thus leaving a space for the escape of secretions and for packing. The result had been perfectly satisfactory. In the few laryngectomies which he (the speaker) himself had performed, he felt that they might as well have been done by the open method, because the wounds had broken down and had finally healed by packing. The first case described by Mr Colledge was absolutely convincing as to the necessity for removing the teeth.

Dr TAPIA (in reply) said that he had spoken in his paper of the preparatory care of the mouth and nose. He never operated nowadays until carious teeth had been extracted and other similar precautions taken.

With regard to the tonsils, owing to the age of the patients in these cases, the tonsils rarely gave trouble. Naturally, if he (Dr Tapia) found them to be infected, he would remove them.

Methods of Caring for Diseases of the Pharynx, Larynx, and Mouth—Dr CHARLES H. MAYO (Rochester, Minnesota).—The paper is published in the *Journal of Laryngology and Otology*, No 11, vol. xl., p. 697, November 1925.

Speech without a Larynx—Professor H. BURGER (Amsterdam). —Abstract of paper is published in the *Journal of Laryngology and Otology*, No. 12, vol. xl., p. 789, December 1925.

McKenty-Western Artificial Larynx—Mr LIONEL COLLEDGE, F.R.C.S.—Two patients making use of this apparatus were exhibited.

An Artificial Larynx—Dr R. GRAHAM BROWN (Brisbane).—The communication is published in the *Journal of Laryngology and Otology*, No. 12, vol. xl., p. 793, December 1925.

DISCUSSION.

Dr TAPIA (Madrid) said that Professor Burger's case was an exceptional one; he (the speaker) had had two or three patients who spoke quite as well as this gentleman. The method required a good deal of intelligence and perseverance, and the working-man patient was not likely to succeed

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with it. He (Dr Tapia) did not encourage the method, because, if patients got accustomed to it, they could not use the instrument which he recommended. He claimed that his own instrument was physiological; it could be tuned by means of screws. Among his patients was a barrister, who went into Court and talked for hours with the help of this apparatus, and with remarkable absence of fatigue. There were many modifications of the instrument. One man disguised it, so that he appeared to be merely smoking a pipe. He (the speaker) was working on another model.

Sir JAMES DUNDAS-GRANT presented to the meeting a patient whose larynx he had removed two years previously, and although she had no voice, she had such wonderful articulation that she did her own shopping by word of mouth, and was readily understood.

Professor BURGER (in reply) said there were three kinds of speech, and the oldest was illustrated by Sir James Dundas-Grant's patient and by Mr Colledge's first patient, namely, speech without intonation and independent of respiration. The patient made speech with the muscles of the mouth and tongue; there was only a very small quantity of air, and with it speech could be produced. The second was by means of instruments. The third type was that exhibited by himself (Professor Burger), consisting of a vicarious glottis formed anywhere in the pharynx or œsophagus. The case which he showed was not so exceptional as Dr Tapia had thought, and the speech mechanism was the same as that in the normal man.

Tracheotomy in Tuberculous Laryngitis—Dr T. RITCHIE RODGER.—Paper published in the *Journal of Laryngology and Otology*, No. 10, vol. xl., p. 639, October 1925.

DISCUSSION.

Sir JAMES DUNDAS-GRANT said he thought that Dr Ritchie Rodger was justified in performing tracheotomy in these cases. To carry it out in cases in which there was no stridor or obstruction would require consideration, and would depend to a great extent on the condition of the lungs. If the larynx was affected and the lungs only to a slight degree, it might be done. Dr Ritchie Rodger had not described the lung condition in his patients. With regard to procuring rest, Sir Felix Semon had said that only in a small proportion of cases one could see the respiratory movements as described in physiological works, and that the natural position of the vocal cords in quiet respiration was due to the shape of the cartilages when they fell into the intermediate position. He (the speaker) had had to do tracheotomy in very few cases, but one of these had confirmed Dr Ritchie Rodger's opinion as to the beneficial effect of the operation. A girl, suffering from tuberculosis of the larynx, had been sent to a home for the dying. Stridor developed, and the surgeon-in-charge had said that she was too ill for tracheotomy to be attempted. She had, however, insisted on being brought back to Brompton Hospital, where he (Sir James) had performed tracheotomy at once. The patient was still alive and able to do without her tracheotomy tube.

He (the speaker) wondered whether any member had experience of the German method of attempting to paralyse the recurrent laryngeal nerve by

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cutting or freezing it, or by injecting alcohol into its neighbourhood. If, as has been suggested, gastrostomy was also performed in order to neutralise the movements of deglutition, it seemed to him that too much would then be attempted. He did not think those drastic measures would be adopted here, while we obtained such good results from silence.

Mr E. D. DAVIS said that at the Mount Vernon Hospital there were many cases of advanced laryngeal tuberculosis, and during a period of two years, tracheotomy for urgent dyspnœa was only done twice. Tracheotomy should be avoided for two reasons: (1) The wound became very septic; there was a mixed infection, and the patient did not improve. (2) As a result of the tracheotomy, the cough was much increased and caused considerable damage to the larynx. Arrest of the cough was as important as silence.

Sir ST CLAIR THOMSON said he thought tracheotomy, as a curative method, was seldom called for in cases of tuberculosis. Out of 450 cases of tubercle of the larynx at Midhurst Sanatorium, he had had to do tracheotomy only two or three times on account of dyspnœa, *i.e.*, in order to save the patient's life. In two or three other cases in which he would have liked to perform it, the patients had declined the operation. One was a doctor, who at no time during his illness had had tubercle bacilli in his sputum. He refused to have tracheotomy performed, and said he would try the alternative, which was to keep silent and remain in bed. As in most cases, respiration was restored, but the patient had to have tracheotomy done at a later stage, and he died.

He (Sir St Clair) asked in how many of Dr Rodger's cases there were tubercle bacilli. Patients could die of tuberculosis without having had bacilli discovered in their sputum. In those cases with laryngeal symptoms, but in which no tubercle bacilli could be found in the sputum, tracheotomy, as a therapeutic measure, was most promising.

Dr P. WATSON-WILLIAMS said that tracheotomy afforded immense relief in some cases of tuberculosis in which there was dyspnœa, and it prolonged life for a short time, but he (the speaker) had never seen a case in which tracheotomy had saved the patient's life and led to a cure. The disadvantages to which Dr Ritchie Rodger had alluded seemed to outweigh such advantanges as could be attributed to the operation as a curative method. Complete rest could not be obtained without paralysing the musculature, but that would, of course, place the patient in still greater difficulties.

Sir Felix Semon had pointed out that the position of the vocal cords when at rest, as distinguished from the cadaveric position, was due to the persistent tonus of the abductors of the cords (posticus muscles) whereby in the position of rest, a wider aperture of the glottis was maintained than in complete paralysis or in the cadaver.

It was often very difficult in cases of laryngeal tuberculosis to determine how far the lung was involved, as the physical signs of the pulmonary disease frequently became much obscured owing to the condition of the larynx. In such cases there might be an absence of physical signs and yet, in them, post-mortem examination would show lung involvement far beyond what had been expected.

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Dr DOUGLAS GUTHRIE said that ten days previously he had had occasion to perform tracheotomy on a lady with extensive tuberculosis of the lungs and larynx. She was well advanced in labour at the time, and her child was born four hours after the operation. The progress of the labour did not seem to have been influenced by the tracheotomy, though it was as yet too soon to speak of the probable later effect. In the second case mentioned by Dr Ritchie Rodger, was the iodide which was administered the cause of the œdema of the larynx?

Dr RITCHIE RODGER (in reply) said that in the first case there had been no appreciable lung disease, and this was largely true of the second, although the sputum had on one occasion contained tubercle bacilli. In the third case there had never been any obvious lung lesion; in fact, the tuberculosis officer considered the glandular condition to be due to lymphadenoma. Removal and examination of the glands, however, had settled the point to his (the speaker's) satisfaction; further, the complete recovery of the patient in four months, with sanatorium treatment only, seemed to confirm the tuberculous view. In the fourth case the lung condition had been the dominant feature, and in the fifth case there had been a definite lung lesion, which, however, had improved before he (the speaker) had seen the patient. Tubercle bacilli were found in the sputum in three out of the five cases, and in the two cases in which the search had proved negative, the patients had made the most dramatic recovery in the matter of time.

With regard to the effect of the iodide, there was an impression that it was wrong to use iodide in inflammatory conditions of the larynx. The subsequent history of the second case showed that there had been an abscess developing in connection with the peri-chondritis: this had burst three weeks after the tracheotomy, so that the iodide could be exonerated from blame.

Furuncle of the Nasal Vestibule: Cavernous Sinus Thrombosis: Leptomeningitis: Death: Autopsy—Dr A. LOGAN TURNER and Dr F. E. REYNOLDS.—The paper will be published *in extenso* in a future number of the *Journal of Laryngology and Otology*.

Restoration of Movement in the Vocal Cord after Nerve Anastomosis: Kinematograph Demonstration—Sir CHARLES BALLANCE and Mr LIONEL COLLEDGE.

Intranasal Dacryocystostomy—Dr J. S. FRASER.—The paper is published in the *Journal of Laryngology and Otology*, No. 11, vol. xl., p. 725, November 1925.

Mr LAWSON WHALE said that three years ago he had shown about twenty cases at the Annual Meeting of the Section; in all of them West's operation had been performed.

With regard to technique; if the nasal septum required to be resected, this should be done beforehand and not when the tear sac was being treated. If there was any difficulty in displacing the bone medially into the

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nose after using the gouge, he (the speaker) did not think this should be effected by pressing with the finger on the inner canthus ; it was better to use a large-sized probe.

When working with small gouges or chisels, one was working at an acute angle and at a disadvantage, for it was difficult to prevent the instruments from slipping. He had therefore devised a gouge which he called the "mashie," as it was like a golf mashie, but turned the other way. It enabled one to take a good grip. Dr Fraser had not indicated his criteria of cure or improvement. His (the speaker's) own arbitrary criteria were as follows: If the eye never watered, even in a strong wind, the operation had been a complete success ; if it watered only in a strong wind, that indicated a modified success ; if it watered even indoors, the operation had been a failure.

Mr A. J. M. WRIGHT said that he felt it was submitting the patient to an unnecessary repetition of operation to do the septal resection at another sitting.

Mr J. W. HARRISON said that two points in technique were of considerable importance. (1) In removing the bone, care should be taken to do so in thin flakes. If it was removed in thick pieces, there was a risk of splitting and splintering the surrounding bone and thus increasing the trauma and the amount of granulation tissue formed, factors which in turn increased the tendency of the opening to close. (2) In making the opening, care should be taken to make it large, not only from above downwards, but from before backwards ; otherwise it would probably close and the result would be disappointing. He thought that it was safe to operate in the case of a suppurating sac with phlegmon, when the acute symptoms were subsiding. He had himself done so in several cases, with satisfactory results.

Mr E. D. DAVIS said that a number of these cases had been sent to his clinic from the Royal Westminster Ophthalmic Hospital and the results had not been very satisfactory. Cases of suppuration and dilatation of the sac were more suitable for intranasal dacryocystostomy than were the chronic cases of lachrymal obstruction, in which all other methods of treatment had been tried, and which were sent on to the nasal surgeon as a last resort. The fistula made in the bone always had a tendency to close, and the operation had to be repeated.

Mr GRAHAM BROWN said that he had had experience of dacryocystitis both as an ophthalmologist and as a nasal surgeon, and he felt no compunction about doing the external operation. In attempting to do an internal operation, one encountered considerable difficulties. His (the speaker's) operation was a combination of the internal and the external, and its advantage was that it afforded a good view of the sac. One could take away as much of the internal wall as one wished, and this was done under a local anæsthetic. The scar was negligible even when severe suppuration followed the operation.

Dr FRASER (in reply) said that he had used local anæsthesia in his first seventy cases, but many of the patients had felt considerable pain when the bone was being removed, especially if the bone was thick. For this reason

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he operated more recently with the aid of general anæsthesia. He had seen no evidence of infection of the ethmoid in his cases, but it was seldom that one opened the ethmoid cell when exposing the tear sac. He agreed with Mr Whale's criteria as to cure. The cases he (Dr Fraser) regarded as "cures" were those in which there was no trouble from lacrymation, either in the wind or out of it. Those which he regarded as modified successes were cases which in a strong wind still caused some trouble with lacrymation.

He agreed with Mr Harrison about removing small pieces of bone; if large pieces were loosened, there was sometimes difficulty in removing them from the nose. In one case he (the speaker) had operated soon after an acute attack of "perisac" abscess, and in that case trouble had been caused by excessive bleeding, which gravely interfered with the operation. He had had no experience of chronic cases not doing well. The case with which he liked to deal was one in which there was a large sac, not one in which there was watering of the eyes without an empyema of the sac. He had had no experience of the combined external and internal operation.

The Condition of the Accessory Sinuses in Encephalitis Lethargica—Dr A. LOWNDES YATES.—The paper is published in the *Journal of Laryngology and Otology*, No. 10, vol. xl., p. 646, October 1925.

The PRESIDENT said that this was a new subject of investigation, and he hoped that Dr Lowndes Yates would continue his observations.

Dr P. WATSON-WILLIAMS, while congratulating the author on this pioneer work in connection with encephalitis lethargica, said he thought Dr Yates would himself admit that it was necessary to make further observations before the ground was secure, and one must hope that he would have further opportunities for such investigations. Members would recall the work of Dr Peters in connection with the finding of the meningococcus in the sphenoidal and other sinuses, results which seemed very definite, but were not always corroborated by the investigations of others.

A difficulty in connection with cases of encephalitis lay in the correctness of the diagnosis. At the last meeting of the Section he (the speaker) had brought forward two examples of sphenoidal sinus infection with ocular defects, and one of these was a case in which there was a definite enlargement of the blind spot, and with a definite infection of one particular sinus; yet that case had been set down by a previous attendant as an overlooked case of encephalitis lethargica. He (Dr Watson-Williams) was convinced, however, that it was an instance of ocular manifestations due to simple sinus infection. He would like to hear more definite criteria on which the diagnosis of encephalitis in the cases investigated by Dr Yates had been arrived at.

CLINICAL CASES.

Tuberculoma of the Tonsil—DOUGLAS GUTHRIE, M.D.—Male, aged 30, who now shows merely a scar in the right tonsillar region, awoke one morning in December 1924, with a sensation as of a foreign body in the throat and a constant desire to swallow. He examined

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his throat, and noticed a swelling on the right tonsil. The symptoms continued until he was seen by exhibitor on 6th February 1925. The swelling was quite painless, and only caused a feeling of discomfort.

On examination, the right tonsillar fossa was seen to be occupied by a smooth hard mass, pale and waxy in appearance, and the faucial pillars, especially the posterior, presented the same appearance. The left tonsillar fossa was empty, there being no tonsil apparent on naked-eye examination. The patient was a healthy man who had never suffered from tonsillitis, and he had no chest symptoms. No enlarged glands were palpable in the neck. Wassermann reaction was negative.

On 14th February 1925, the tonsillar mass was dissected out under general anæsthesia with the diathermy knife. Apparently the tumour was limited by the capsule of the tonsil, and was the size of a large walnut. Microscopic examination showed chronic fibrosis with numerous tuberculous deposits of typical appearance.

Dr J. S. FRASER said that he had seen the patient before Dr Guthrie operated. He (the speaker) did not feel sure of the diagnosis, but the appearance of the tonsils was very similar to that of the uvula and palate in a case published by Dr Logan Turner in the *Journal of Laryngology and Otology*, in 1916, under the title "A peculiar form of Hyperplasia of the Mucous Membrane of the Upper Respiratory Tract." In both cases the part affected had a yellowish-pink, waxy appearance. Possibly the President's case had been a form of chronic tuberculosis involving the palate. The microscopic section shown in the present case did not, however, convince him (the speaker) that it was one of tuberculosis of the tonsil.

Dr GUTHRIE (in reply) said that the diagnosis had been confirmed by two competent experts in microscopic pathology. He had not found a similar case in literature.

Two Cases illustrating a Method for the Treatment of the so-called "Dislocated Quadrilateral Cartilage of the Nose"—HAROLD KISCH, F.R.C.S.—An incision is made with a sharp knife along the anterior edge of the dislocated cartilage. The incision is carried down to and includes the crest to which the cartilage is invariably attached. By submucous resection the cartilage and crest are fully exposed and also the greater part of the rest of the cartilage and crest behind. With a chisel the crest is divided from the floor of the nose. The cartilage with the crest is then manipulated, until the cartilage lies in its normal position to form the proper columella of the nose. In some cases the cartilage is too large, and then small portions are removed with punch forceps.

The cartilage should lie in position, without any tendency to move. A cigarette plug is kept in position, on the side of the

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dislocation, for twenty-four hours, and then replaced by another for a further twenty-four hours.

The advantages of the operation are that the columella is restored and the air-way freed, without any risk of deformity. The operation is particularly useful for cases occurring in young children, when it is important that no cartilage be removed.

Dr IRWIN MOORE supported Mr Kisch in this procedure, and stated that he had carried out the method during the past eight years. He considered that if resections of the septum in adults were performed in a similar manner, there would be fewer unsuccessful cases. In children this was an ideal operation, and no ill effects nor alterations in the shape of the growing nose followed.

Mr A. J. M. WRIGHT said it was important that it should be settled whether the last clause in the notes was correct: "The operation is particularly useful for cases occurring in young children, when it is important that no cartilage be removed." He asked whether that was the experience of other members.

Sir JAMES DUNDAS-GRANT said he himself usually did this operation at the same time as he did submucous resection of the septum. The dislocation was generally on the side opposite to the deflection. In slighter cases he pushed the lower end of the projecting cartilage into the opposite nostril, so as to over-dislocate it, and then passed a mattress suture through the dislocated portion of cartilage on the side to which one had dislocated it. This carried it too far to the opposite side, but in healing, it usually settled down at the mid-line.

Dr DOUGLAS GUTHRIE said that he thought the danger of removing a limited area of cartilage in children had been exaggerated; only a small part need be removed, just enough to relieve the obstruction. He had traced nineteen out of twenty-six of his own cases of submucous resection of the septum in children under twelve years of age, and from two to five years after, there was no nasal obstruction and no deformity in any of the patients.

Mr LAWSON WHALE said his results were exactly the opposite of those mentioned; therefore, in a child he always refused to do submucous resection of any kind.

Mr KISCH (in reply) said he was surprised to hear that surgeons could do submucous resection on a dislocated cartilage, with removal of the cartilage, without deformity resulting. He had seen at least six cases with considerable deformity resulting from removing a dislocated anterior end. The girl shown was a case of dislocation of the anterior end of the quadrilateral cartilage, and if that piece of cartilage was removed, deformity resulted; it might be only a slight dropping of the tip of the nose, but in a girl that was a considerable deformity. It was just as important not to have any deformity in the adult as it was in the child, but the feeling existed that submucous resection should not be done in children. Still, if one could do an operation which relieved the obstruction, and no risk of deformity was run, he (the speaker) did not see why it should not be done.

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Royal Society of Medicine

Tonsil Hæmostatic Forceps—R. GRAHAM BROWN (Brisbane, Queensland).—The communication is published in the *Journal of Laryngology and Otology*, No. 10, Vol. xl., p. 650, October 1925.

A Case of Extrinsic Laryngeal Epithelioma: Recovery after Operation by Mr Wilfred Trotter: Specimens and Microscopical Sections.—Sir JAMES DUNDAS-GRANT, K.B.E., M.D. —A male, aged 57, when first seen by me complained of discomfort in the right side of the throat, attributed to the swallowing of a fish-bone six months previously. The laryngoscope revealed a swelling of the right ary-epiglottic fold with an ulcer on the posterior third, the edges of which were slightly everted, justifying the diagnosis of epithelioma, although the mobility of the cords was perfect. The Wassermann reaction was negative; there was some chronic bronchitis, but no sign of pulmonary tuberculosis. Mr Douglas Harmer confirmed the diagnosis and concurred in the opinion that the case was eminently adapted for operative removal by lateral pharyngotomy as formulated by Mr Trotter, who undertook the operation.

A specimen of sputum was examined by Dr Carnegie-Dickson, who detected no tubercle bacilli, but in a little mass of blood-clot there was "a firm little nodular mass, probably also fibrin, but sufficiently suggestive of the possibility of tissue to require examination by section." This was subsequently effected, and two very minute portions of formed tissue were found, which consisted of "little concentric masses or nests of squamous epithelial cells, evidently little crumbs of broken-off warty growth. Though, of course, insufficient for a differential diagnosis of epithelioma, and not showing their relationship to any surrounding tissue, they are extremely suspicious, and might quite well be minute broken-off portions of a squamous epithelioma." In view of the seriousness of the issues at stake, I removed a portion of the growth for microscopical examination and it was found to consist of typical epithelioma.

The operation was carried out by Mr Wilfred Trotter on the lines laid down by him in his paper before this Section (June 1920) and in his lecture before the Royal College of Surgeons. When we examined the patient, five months later, we found the parts quite normal in appearance. The patient is at present enjoying active life.

Tracheal Stenosis treated by means of a Dilator formed of fine air-filled Drainage Tubes—HERBERT TILLEY, F.R.C.S.— Patient, aged 20, had diphtheria when fourteen months old; high tracheotomy; cannula worn for six months. In February 1925 had increasing dyspnœa.

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Examination revealed web-like constriction about 1½ in. below glottis. Operation, 26th February. Low tracheotomy and insertion for ten days of fine air-filled rubber tubes; patient can breathe through the larynx (with the cannula corked) for four to five consecutive hours.

Cure of Tuberculous Laryngitis by Galvano-Puncture—HERBERT TILLEY, F.R.C.S.—Female, school teacher, consulted me, in 1908, for chronic hoarseness. The anterior half of the left vocal cord and ventricular band were congested and had a granular appearance. These regions were punctured by the galvano-cautery on seven occasions, and the patient was admitted to Midhurst Sanatorium for the primary lesion in the right apex. She recovered sufficiently to resume her work as a school teacher. She was readmitted in 1923, and Sir St Clair Thomson reported that the larynx was still cured.

I saw her last month and noted a well-marked scar on the left ventricular band and a whitish thickening on the left vocal process.

Dr W. A. KELSON said that twenty years ago he showed a case of what was termed primary tuberculosis of the larynx cured by galvano-cautery. He (Dr Kelson) had seen the patient again five years ago with recurrence of the disease. He had died later from pulmonary tuberculosis He (the speaker) asked what was the criterion of "cure."

Sir JAMES DUNDAS-GRANT said that the best form of local treatment of tuberculosis of the larynx was the galvano-cautery in appropriate cases. He had tried various solutions including trichloracetic acid, but he always returned to the galvano-cautery method, not only for its cauterising and healing power, but also because it took away the painfulness. Many years ago he had asked a Sister in Brompton Hospital which cases made the best progress, and at once she had replied, "Those treated with the galvano-cautery."

Mr H. TILLEY (in reply) said that thirteen years ago he had made a galvano-puncture of the left vocal cord, and the patient afterwards went to Midhurst Sanatorium for her primary lung trouble and her voice recovered; since then it had remained as good as it is to-day. She had to return to Midhurst because of a recurrence of the lung trouble, but this quieted down until a year ago when she had hæmorrhage from the lung. Her general health is now excellent and her voice is normal.

Tuberculous Ulcers in the Œsophagus and Stomach—HERBERT TILLEY, F.R.C.S.—Post-mortem specimen of gullet of a female patient showing a tuberculous gland which had produced left recurrent paralysis. It also shows tuberculous ulcers in the gullet and stomach, which had caused no definite symptoms during life. Patient was under the care of Professor T. R. Elliott, in University College Hospital, who had referred her to me on one occasion because of hoarseness.

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Royal Society of Medicine

Epithelioma of Faucial Pillar removed by Diathermy Dissection—DAN MCKENZIE, M.D.—Male, aged 55, consulted me two years ago with an oval ulcer with an irregular floor and raised edges, about 1.5 cm. in diameter, on the buccal surface of the right anterior faucial pillar, towards the floor of the mouth. It felt hard. A piece removed was regarded by Wyatt Wingrave as epithelioma. On 16th June 1923, after ligature of carotid and removal of glands, the ulcer was excised by the diathermy method. No recurrence to date (15th May 1925).

Mr J. ALDINGTON GIBB asked whether it was the routine practice to ligature the carotid, and if so, which carotid? He had operated on eight of these cases and had never tied the carotid. He had arranged to do his ninth case in two or three days.

Case for Diagnosis—H. LAWSON WHALE, F.R.C.S.—Female, aged 27, for eight years has suffered from a lump on the left side of the neck, which causes pain when she is cold, and swells intermittently to the size of a tennis-ball. Opposite the left great cornu of the hyoid is a round swelling the size of a plover's egg. It is reducible by pressure. It is under the skin, freely movable laterally, and, to a less extent, up and down. It is elastic; no fluctuation, but on bimanual examination an impulse is conveyed to mouth; no pulsation, true or communicated; not attached to carotid sheath. Vocal cords thickened, pink, fleshy; movements good and equal.

Dr IRWIN MOORE said he thought this was probably a case of laryngocele, *i.e.*, a sacculus laryngis which had extended into the neck. It was certainly, in his opinion, an air sac, and its situation externally between the thyroid cartilage and the hyoid was the usual site for these air sacs. The diagnosis appeared to be clear, because on pressure the air could be squeezed out, and the swelling disappeared, while on phonation it immediately refilled and the swelling reappeared.

A Case of Atrophic Rhinitis treated by the Insertion of Rib Cartilage into the Floor of the Nose—W. M. MOLLISON. M.Ch.—Boy, aged 12, with typical atrophic rhinitis and much crusting; laryngitis due to nasal condition; vigorous douching for a year; no improvement. In March 1925, operation by Mr E. H. Richards; insertion of pieces of rib cartilage into the floor of the nose through an incision under the upper lip. No douching since operation; no crusts now.

Epithelioma of the Vocal Cord treated by Excision—F. F. MUECKE, C.B.E., F.R.C.S.—Female, aged 52, was admitted on 21st May 1922, with history of gradual hoarseness for one year; no pain on examination. Ulcerative growth involving whole of the left cord, which was fixed.

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General anæsthetic; low tracheotomy; window removed from thyroid ala with whole of left cord. Tube removed four days later. She left hospital in fourteen days. Sections showed polygonal squamous and horny-celled carcinoma.

Sir JAMES DUNDAS-GRANT said he considered the case most successful as regards the eradication of the disease. He asked why the window operation should be adopted when the other seemed simpler.

Mr E. D. DAVIS said that he did not agree with Sir James Dundas-Grant that the operation in which the growth was dissected off the thyroid ala was as simple as removing the ala of the thyroid cartilage with the growth. A much better exposure was obtained by the latter operation, and the bleeding points could be more easily secured.

Mr MUECKE (in reply) said that this operation was quicker than the other; in this case it had not occupied twenty minutes. The possibility of broncho-pneumonia following long anæsthesia was a very important point. One could not do laryngo-fissure so quickly.

Carcinoma of Tonsil, etc.—F. F. MUECKE, C.B.E., F.R.C.S.—Male, aged 51, complained of six months' pain about the throat and three months' dysphagia. On examination, a large ulcerative growth involved the tonsil, soft palate, side of pharynx, and alveolus. Diathermy, 14th November 1924. No glands had as yet developed.

Extensive Cut-Throat with Stenosis—F. F. MUECKE, C.B.E., F.R.C.S.—Female, aged 23, in November 1924, had an extensive self-inflicted cut-throat passing through thyroid cartilage. Tracheotomy tube was placed in the original cut. She was admitted 19th February 1925; with urgent dyspnœa. Low tracheotomy was done under local anæsthesia.

Almost complete occlusion of larynx was seen one-eighth inch below cords. Small sharp hook passed through tiny orifice which was enlarged by pulling hook upwards. Constricting membrane cut away and large bougies passed. Patient now feels no inconvenience whatsoever.

Sir JAMES DUNDAS-GRANT said this case illustrated what was taught in medical jurisprudence, that the cut made in murder attempts was much lower down than that in a case of suicide; in the former case it was below the cricoid cartilage.

? Laryngocele—F. F. MUECKE, C.B.E., F.R.C.S.—Male, aged 48, had two years ago a violent retching attack. Subsequently he developed a sense of suffocation when sleeping on the right side. He noticed that he could produce a lump in his throat by making efforts as if to expel saliva.

On examination, there was a thin-walled, cystic-looking swelling projecting upwards just in front of the uvula, difficult to feel as it

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subsided as soon as patient breathed. Slight thickening of left pyriform fossa was seen. Tumour was painted with methylene blue, and blue was seen in the pyriform fossa.

Under local anæsthesia, tumour was grasped by forceps and when extended and forcibly held up, another forceps was placed round the pedicle in the pyriform fossa and the pedicle ligatured. Unfortunately, the intensely thin wall burst and some fluid escaped with definite air bubbles.

Dr IRWIN MOORE said he believed this was a case of intrinsic laryngocele. The late Professor Shattock divided these air-sacs into pneumatoceles and hernias, and clinically he advised that the term laryngocele should be employed for those sacs which extended outside the larynx, and the term hernia for the intrinsic ones. He (the speaker) had found that the seat of election for intrinsic hernias of the sacculus laryngis was a weak area situated between the ventricular muscles, similar to that found in the deep pharynx in the case of diverticula.

ABSTRACTS

THE EAR.

Ocular Pain—an Indication for the Radical Mastoid Operation in Acute Middle-Ear Suppuration. By ANDRÉ MOULONGUET. (*Annales des Maladies de l'Orielle, du Larynx, etc.*, July 1925.)

Although first noticed by Ostmann in 1897, and later by other observers, sufficient importance has not been attached to ocular pain in this connection.

Four cases are described. In all of them, during the course of an acute otitis media, in the majority of which paracentesis had been practised two or three times—and in one case an antrotomy—a severe burning pain was complained of in the eye of the same side. There was no paralysis of orbital muscles and no abnormality detected in the fundus of any of the cases.

Two patients died, one probably from cerebral abscess, the other from meningitis; post-mortem examination was not possible. In the other two, radical operation on the mastoid gave rapid relief to the pain and was succeeded by recovery.

The symptom cannot be satisfactorily explained, but the author is convinced of its significance, as indicating urgent need for radical operation in those cases in which antrotomy has failed to give relief.

J. B. CAVENAGH.

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