with the exception of the case where epithelium of the stratified type was found. This case was treated by the nasal route and was still uncured. The results encouraged one to proceed further, but he did not think that they had as yet any definite data to act upon.

BRITISH MEDICAL ASSOCIATION.

Meeting at Sheffield, Wednesday, July 29, 1908.

Oto-Laryngological Section.

Abstract of Proceedings by Dr. Dan McKenzie.

President, Dr. Wilkinson, *Sheffield.*

After extending a welcome of the members of the Section, Dr. Wilkinson adverted to the compulsory medical inspection of school-children, an act which would much increase the responsibility of medical men, particularly of specialists interested in this section of the work. He alluded to Cheatle and Murray's investigations on the hearing of school-children, which showed that the percentage of children suffering from diseases of the ear and upper respiratory passages was very high.

Discussion on Chronic Inflammation of the Pharynx and Naso-Pharynx.

Dr. Peter McBride, in introducing the discussion, mentioned first of all chronic and inflammatory tonsillitis, and asked at what stage interference should be deemed necessary. In the case of hypertrophy with no symptoms in a person with a healthy chest interference was, in his opinion, unnecessary. He had found iodine or other pigments, and occasionally the electric cautery to the whole surface of the tonsil, of service. Occasionally crypts could be incised with a small knife, and so the tonsil broken up into segments which could be punched out. Where the orifices of the crypts were small and difficult of access the electric cautery gave good results, and although it had been said that this treatment only sealed up the crypts and enabled secretion to collect underneath, the speaker himself had never seen this happen. Where crypts contained plugs of secretion and the supra-tonsillar fossa was well marked he preferred the knife and the punch. In cases

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in which there were enlarged glands in the neck the tonsil when removed sometimes showed tubercle bacilli, and then he preferred to enucleate. In children he always used the guillotine. Escat limited the guillotine to children under eight. Dr. McBride did not find the use of the bistoury and scissors satisfactory in an ordinary way. A hot or cold snare was occasionally employed, and there were other methods known to all.

Chevalier Jackson had stated that, in the usual method of operating by the guillotine, cicatricial tissue covered the tonsillar stump, and the condition of the patient after operation was worse than before. With this opinion the speaker disagreed. Enucleation should not be regarded as the routine procedure, because it is possible that in the tonsillar tissue we may have a defender of the organism against bacteria. Bleeding was a rare sequel to the operation of tonsillotomy, but occasionally it proved troublesome. He had found that after removal under local anæsthesia it was a good plan to make the patient stand up. He was surprised that the recumbent position was still advocated both in epistaxis and in bleeding from the tonsil, and yet we all knew that syncope was a reliable hæmostatic, and for this reason the standing position was of utility. Other methods of stopping hæmorrhage that might be mentioned were the cautery, pressure, suture of the pillars, Michel's clamps, and the tying of the external carotid artery. Chevalier Jackson had found that, after the clot was removed from what seemed to be a mere oozing, a spouting vessel could generally be found.

Reverting to other inflammatory diseases of the tonsil, he said it was questionable whether keratosis could be included under this heading. This condition seldom required treatment, but if it caused discomfort the clumps could be destroyed with forceps. As a rule the tonsils were the parts most implicated in the disease. Germicides were of little use, with the possible exception of salicylic acid in solution. Left alone the patches of keratosis tended to disappear spontaneously.

Ulcers of the tonsil, excluding syphilitic conditions, were uncommon. He mentioned forms of tonsillar ulceration described by Moure, *amygdalite ulcéreuse aigue*, in which there were few constitutional symptoms, and the floor of the ulcer was occupied by a slough. The disease seemed to be commoner in France than it appeared to be in England. The prognosis was favourable, and the chief interest centred in the diagnosis, since these ulcers resembled mucous patches.

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Turning to chronic pharyngitis, he said that in pharyngitis sicca the treatment was simply palliative.

In granular pharyngitis, granules were to be seen on the posterior wall of the pharynx, and the lateral folds were congested and swollen, and proved a source of great irritation in many cases. There were two types of granular pharyngitis: One in which the pharynx appeared pale and anæmic. In these cases the symptoms complained of were paræsthesia and weakness of voice. They were cured by iodine pigment and the internal administration of iron, arsenic, or strychnine. The granules could be destroyed by the cautery, but he thought the effect of this treatment was as much mental as physical. In cases characterised by huskiness of the voice and discomfort in the throat the ridges behind the pillars might be incised. In the second group, congestion and irritability were salient characteristics. There were coughing and retching, especially in the morning, and the uvula was generally found to be enlarged. These patients were, as a rule, men who "did themselves well," indulging somewhat too freely in alcohol, tobacco, highly-spiced foods, etc., and the pharynx generally yielded to the results of careful dieting and regimen. Pigments and the electric cautery might be resorted to. He preferred the pipe or cigar to cigarettes. These patients frequently objected to strict rules at home, and benefit might be obtained by sending them to watering-places. In plethoric cases purgative waters were of service, and without using the word "gouty," he found that condition was benefited by the use of colchicum and iodide of potassium.

In chronic pharyngitis, nasal stenosis if present might require treatment. In the milder cases breathing exercises should be recommended. These exercises should not be limited to the respiratory muscles only, for exercises of the limbs and body generally were of the utmost importance. There were some cases in which there were complaints of constantly catching cold, and, which upon examination presented no signs of trouble in the nose, pharynx, or larynx. In such cases nasal stenosis should be rectified, but the speaker considered that it was wise to warn the patient that this treatment would not eradicate the tendency to catch cold. Among the commoner forms of nasal stenosis, alar collapse might be numbered, and for this there were many remedies, operative or other. With regard to the tendency to catch cold he referred to the work of Moritz Schmidt. This author advised cold-water sponging followed by dry friction, and in cases in which this proved too rigorous a method of treatment bathing might be per-

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formed with warm, and then by degrees with colder water, or hot baths might be followed by cold baths. Sea-bathing was of great advantage. Along with these rules he prescribed regulations regarding the clothing, which in the speaker's opinion were truly Spartan. Schmidt dwelt upon the noxious effects of hot rooms. His principles were to accustom the skin to different temperatures by exposure to cold water, etc., aided by gymnastics and exercises. It was important before prescribing physical exercises to make sure that the heart was sound. The speaker thought that Schmidt did not sufficiently emphasise the details of the exercises. In this country the use of the morning bath with friction, and the life with open windows were uniform practices. Most people said they took exercise, but it would be generally found that their exercise was ill-regulated, and that on the days when they went golfing or hunting they ate and drank proportionately more than was necessary. He would lay it down as a rule that when exercise was required it should be prescribed and the details gone into. Regular exercise enabled the patient to avoid all types of chronic pharyngitis, but if under these circumstances he still was found to suffer from the disease it would be discovered on investigation that he smoked or drank too much. To practise respiration through the nose was specially useful in alar insufficiency, and benefited the general health. No doubt too much had been expected from the use of breathing-exercises by some people. Medicinal exercises should vary with each individual, and in all cases should amount to what might be termed "modified athletic training." The heart, the age, and the patient's strength, of course, ought to be considered. In exercising the body all the muscles should participate. The result of a properly regulated form of exercise was to give rise to an increased feeling of warmth. Excess, straining, and fatigue must be avoided. After exercising, a cold sponge, and friction with a rough towel were advisable, and the exercise should be taken twenty or thirty minutes before the mid-day or evening meal. In those forms of regulated exercise which went by the name of "physical culture" he considered that the breathing was badly timed, sufficient provision not being made for increase of respiration, consequently, after each individual exercise a few minutes should be given in which rapid breathing might be performed. Time and trouble were necessary.

Dr. Barry Ball (London), dealing with chronic inflammation of the naso-pharynx, said that this trouble was usually secondary either to rhinitis or pharyngitis of the lower pharynx. The

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presence of morbid secretions in the naso-pharynx was a fruitful source of inflammation in that region, and the proximity of the Eustachian orifices rendered such cases dangerous. Chronic naso-pharyngitis, or, as it was usually termed, post-nasal catarrh, was a disease of adult life. In children the same symptoms if present were due to adenoids. All morbid secretions from the nose, etc., which obtained access to the naso-pharynx were retained there because of the difficulty of expelling them; particles of dust also lodged in these regions. In adults the remains of adenoids were frequently the seat of catarrhal changes with plentiful mucous secretion. In other cases the catarrh of the naso-pharynx was dry and there might be some atrophy. Chronic rhinitis was frequently associated with hypertrophic form of catarrh in the naso-pharynx. Under these circumstances the space was reduced in size and the pharyngeal tonsil, if not completely atrophied, might be the seat of a chronic lacunar tonsillitis. Occasionally the disease affected the central bursa of this region and the secretion dried in shape of a triangular crust on the posterior wall. With regard to treatment it was necessary to consider the conditions upon which the disease depended. The nose, if blocked, should be made free, otherwise cleansing of the naso-pharynx was a difficult task, and the persistency of the disease in many cases arose from this fact. If chronic rhinitis was neglected the disease in the naso-pharynx would not get well. The consumption of alcohol and the use of tobacco should be carefully regulated. The secretion in the naso-pharynx should be removed by washes through the anterior nares. He used for this purpose a small rubber ball syringe of the capacity of one ounce, preferring it to douches and irrigators. A post-nasal syringe was difficult to use. Regarding washes, it would be found that alkaline or saline solutions agreed best when isotonic to the blood; soda bicarbonate in the strength of 6 grains to the ounce and common salt in the strength of 3 grains to the ounce fulfilled this requirement. He doubted the efficacy of antiseptic washes, but in dry cases, after cleansing, a spray of vaseline oil containing menthol would be found serviceable. The treatment should be persevered in or relapse might be expected. Iodine and glycerine in increasing strength was useful not only in dry, but in all cases. The benefit derived from nitrate of silver was doubtful, and the electric cautery should never be used in the naso-pharynx. If the disease was in the pharyngeal bursa or tonsil these should be treated, the former by being opened and the latter by removal.

In the treatment of adenoids he was sure that no medical treat-

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ment was of the slightest value. The inflammation which frequently attacked adenoids and which intensified all the symptoms might be treated medically, but nothing short of surgical operation could be recommended for the growths themselves. No one nowadays believed that breathing exercises alone were sufficient to cause retrogression of the adenoid tissue. Between fourteen and twenty natural retrogression took place no doubt, but it took place whether the patient had breathing exercises or not. Adenoids should be removed only when they caused symptoms, but there were certain cases in which a large mass of adenoids was present without symptoms where operation might be recommended as a prophylactic measure. For the operation a general anæsthetic was necessary. He had no rules to give regarding anæsthesia since he preferred to leave these details to the anæsthetists. All he stipulated for was sufficient time to complete the operation, and nitrous oxide gas did not fulfil these requirements. Gas and ether, or chloroform were preferable. Concerning recurrence, he was of opinion that it took place exceptionally when the operation was performed in a child under three years of age, but in older children recurrence after an operation properly performed was never found. Regarding those cases in which it was said the operation was performed three and four times all he could say was that it was inefficiently done. After operation, nasal respiration was spontaneously restored in most cases, but it could not be denied that occasionally the ultimate result of restored nasal breathing was not obtained even with the greatest care and expense. It would be interesting to know how much benefit had accrued to the community since the removal of adenoids had been so widely practised; at the same time it could not be denied that all the benefits expected by the earlier operators were not always obtained. Nasal breathing was sometimes not re-established; deafness sometimes persisted; chronic suppuration of the middle ear did not always get well; and for this reason one had to be careful before performing an operation not to promise too much.

Mr. Mark Hovell (London) was surprised at one omission in the last speaker's remarks regarding the cause of the persistence of adenoid symptoms after operation. In the speaker's opinion persistent symptoms were always due to the enlargement of the posterior ends of the inferior turbinals. For this reason the removal of these posterior ends should be practised as part and parcel of the operation in all cases. It was no rare occurrence to find symptoms persisting after the ordinary operation, but since he had begun to remove the posterior ends he had never seen a failure. He had often operated by removing the posterior extremities in cases where the adenoids had already been removed by other men. This addition to the ordinary operation did not increase the bleeding, and

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in nearly all cases the posterior ends could be successfully removed by Mackenzie's snare.

Dr. Scanes Spicer (London) was struck with the note of dissatisfaction in the remarks of the introducers of the discussion with regard to the results in adenoid operations. When the symptoms persisted the possibility of nasal stenosis should be kept in mind, and should be dealt with when present. Regarding physical culture, the speaker observed that forced inspiration through the nose in cases where the passages were blocked aggravated the morbid condition by increasing congestion and engorgement of the intra-nasal structures. In those cases one could see that the chest was sucked in at the sides, and children after the exercises were often worse than before. Scientific physical culture postulated the perfect balance of the whole body. The nose must be opened up before the culture was started. He had recently become aware of a teacher of breathing exercises in London who had succeeded in many cases where other people had failed.

Dr. Dundas Grant (London) said that in dealing with enlarged tonsils in adults he had not obtained good results from simple discission. In tonsils with deep crypts he preferred punching the tonsillar tissue, a method which, as it were, converted the flask into a basin. He alluded to massage of the tonsil from the outside, and had found that the "*Mandelquetscher*" of Hartmann was useful in causing the extrusion of the caseous masses from the tonsillar follicles. The punch he employed was that known as "Ruaults," and he reserved the wire écraseur for favourable cases. The electric snare he did not advise on account of the eschar left. When the tonsil was covered or hooded by a large *plica triangularis* he incised this fold and so obtained access to the tonsil. It should be pointed out to patients in whom uvolotomy was performed that their cough might not be immediately relieved. Too much attention, he thought, had been paid to the granules in granular pharyngitis, and he agreed with Dr. McBride when he stated that the electric cautery in such cases gave relief which was mental rather than actual. The neurotic factor was often the most important, and for paræthesia he advised the application of menthol in olive oil. Physical exercises should be frequently changed, because a continuance of the same exercises day after day was a dismal and uninteresting proceeding. He had found many hints in a book published by Spalding, entitled 'Ten Minutes' Exercise for Busy Men.' Regarding post-nasal catarrh, most benefit could be obtained in cases in which a small adenoid mass was present by scraping the mass away. In children bronchitis and symptoms which simulated phthisis were frequently due to adenoids. For cleansing purposes he preferred an inspiratory or snuffing nasal douche to any form of syringe as offering less danger of the fluid being driven up into the Eustachian tubes. This might advantageously be followed by sprays of liquid vaseline. Violent inspiratory exercises with nasal obstruction were calculated to be injurious to the heart and the thoracic organs generally.

Dr. Watson Williams (Bristol) said that surely Mr. Mark Hovell's experience regarding the posterior ends of the inferior turbinals was unusual. He did not think that it was shared by the other members of the Section. Pharyngitis due to dyspepsia was analogous to the pharyngitis produced by toxic materials, such as atropin, muscarin, etc. Similar results were produced in dyspepsia. Frequently the cause of chronic pharyngitis was obscure. He occasionally came across cases in which general pains were associated with sore throat, and pharyngitis might thus be a local manifestation of a general dyscrasia.

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Mr. Atwood Thorne (London) was distinctly of opinion that tobacco had little or no effect on the pharynx. The paper published by Lack some years ago had, he thought, effectually disposed of this supposition. Naso-pharyngitis was always secondary to some other condition. Unlike Mr. Mark Hovell he did not approve of the removal of the posterior ends in all cases, but only in a few.

Mr. S. Knowles Renshaw said that the exciting cause of granular pharyngitis was mouth-breathing. He recommended that in place of the sprays the medicinal agent should be mixed with soft paraffin in ointment form, because that substance adhered to the surfaces longer than a watery solution.

Mr. S. Ouston found that hypertrophy of the posterior ends was present in almost all cases.

Dr. Andrew Wylie (London) wished to draw attention to a cause of pharyngitis which seemed to have escaped the notice of the introducers. This was paresis of the soft palate such as was found in gumma, peritonsillar abscess, etc. After any of those complaints paresis was a frequent occurrence, and food collected above the soft palate and thus led to the disease. In other cases deficiency of teeth and hepatic disease were exciting causes, and he occasionally found it after the removal of adenoids and tonsils in children. He was in the habit of advising that the patient during breathing exercises should lie on a hard table with arms extended.

Dr. Haring advised that local conditions should receive attention in order that sources of irritation may be removed. He recommended that patients suffering from the complaint should go to high altitudes. Among drugs, bromides and sulphur were useful in reducing congestion, and he had found calcium sulphide of great service. Douching was the method *par excellence* in atrophic rhinitis. He also objected to Mr. Mark Hovell's sweeping remarks. He alluded to the occurrence of what had been termed "false adenoidism" where all the symptoms of adenoids were present but no vegetations were to be found on examination.

Dr. Jobson Horne (London) said he was grateful that he had passed his early life in the pre-adenoid days, because had he as a child been directed to practise the various methods of breathing exercises described by the members he would have revolted. He was grateful also that he had never been operated upon because the adenoid tissue in the tonsils and elsewhere was perhaps an important defence to the organism of which they knew too little. In cases which showed enlarged tubercular glands in the neck, the tonsils and adenoids did not give any evidence of the presence of tubercle bacilli in the tissue removed, and thus it might be that these structures either destroyed or rendered the organisms inert. It was bad surgery to remove these structures if no mechanical disturbance was present, and there was undoubtedly a tendency to operate unnecessarily. He agreed with most of the speakers that it was unnecessary to remove the posterior ends, especially in children, in whom the enlargement was more apparent than real. Children required no intranasal surgery. They would remember the saying of Juvenal that "Bacchus and Venus were the cause of throat troubles."

Dr. McBride, in reply, said that it was difficult to treat the condition known as Thornwaldt's disease. He also disagreed with Mr. Mark Hovell's remarks. Dr. Dundas Grant had mentioned massage. The speaker preferred von Troeltsch's gargling methods. He did not agree with Mr. Atwood Thorne's opinion that tobacco was not the cause of the disease, nor could he admit that paresis of the soft palate was a cause, as Dr. Wylie had said.

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Dr. Barry Ball, in reply, said he preferred the guillotine for the excision of the tonsils. If necessary he freed the tonsil from its surroundings. If the tonsil were well separated from the anterior pillar a clean excision could be obtained. Regarding breathing exercises he was very sceptical of their good effect. In a certain number of cases the persistence of the symptoms might be due to enlarged posterior ends, but there was no necessity to remove them in all cases. They were fairly often enlarged in children, but subsided spontaneously in a year or two after operation. At the same time, when all was said and done there was a residuum of cases in which the results were not quite satisfactory. He also thought, with Dr. McBride, that tobacco might be looked upon as a cause of chronic pharyngitis. Thornwaldt's disease was very rare and might be treated by slitting up the median recess with a small hook-shaped knife.

Cervical Tumours simulating Enlarged Glands associated with Laryngeal Paralysis.

By Dr. Andrew Wylie.

The cases were three of endothelioma and one of lymph-adenoma. In one of the former the common carotid artery had ruptured during convalescence from the operation, causing sudden death. In the others removal was completely effected with no recurrence.

The President said that endotheliomata of the neck were fairly common, and those described in the paper seemed to present the usual characters in that they were present for many years and then suddenly began to increase. It was always difficult to dissect them away from the carotid sheath. It was supposed that these tumours grew from the carotid body.

The Use of Bougies for dilating the Frontal Sinus Infundibulum.

By Dr. Dundas Grant.

These consisted of metal sounds curved like Hartmann's frontal sinus cannulæ. A small bougie was first of all introduced and then larger ones in succession until the duct had sufficiently dilated, and then the sinus was washed out. He described cases in which the duct had been dilated so that the patient could wash the sinus out for himself. The method of treatment was, he thought, worthy of trial before resorting to the radical operation.

Dr. Hunter Tod (London) asked if the bougies tried were soft.

Dr. Dundas Grant, in reply, said he intended to have a more flexible set made on the same principle as Lister's urethral bougies.

Some Points on the Anatomy and Surgery of the Tonsils, Illustrated by Stereo-photographs.

By Mr. James Hardy Neil.

He advocated the enucleation of tonsillar tissue.

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Some Experiences in Direct Examination of the Larynx, Trachea and Œsophagus.

By Dr. Brown Kelly.

The author had found the method distinctly useful, especially in infants. He narrated a case of congenital laryngeal stridor in which the direct method of examination had shown the vibration of the summit of the arytænoids which originated the croaking sound, thus demonstrating the correctness of the views expressed by Sutherland and Lack some years ago.

He had operated by the direct method in removal of papillomata and nodules from the vocal cords, and had found tracheoscopy very useful. He had been successful in removing a haricot bean from the bifurcation of the trachea. The direct method of examination was also useful in those cases in which there was pain in the throat from no very obvious cause, for it was possible in some cases to show that this pain originated in malignant disease of the anterior wall of the œsophagus. He had also found it useful in the diagnosis of diverticula of the œsophagus.

Demonstration of the Methods of Direct Laryngoscopy, Bronchoscopy and Œsophagoscopy.

By Mr. E. B. Waggett.

(*To be continued.*)

AMERICAN LARYNGOLOGICAL ASSOCIATION.

Thirtieth Annual Meeting held at Montreal, May 11, 12, *and* 13, 1908.

(By courtesy of the *Medical Record.*)

Dr. Herbert S. Birkett, *of Montreal, President.*

(*Continued from p.* 452.)

Hyperplasia Lateralis Linguæ; Papillitis Atrophicans Bilateralis Linguæ.

Dr. Henry L. Wagner, of San Francisco, reported these two cases. The first was that of a man, aged forty, an inveterate cigarette smoker, with some dental defects and a narrowed lateral diameter of the lower jaw. There was a hyperplasia of the super-

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