SOCIETIES' PROCEEDINGS

SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY

TWENTY-SECOND MEETING HELD IN THE EAR AND THROAT DEPARTMENT, WESTERN INFIRMARY, GLASGOW

November 21, 1925.

President—Dr W. S. SYME.

A previously undescribed Structure in the Labyrinth of the Bird—Dr ALBERT A. GRAY.—In the labyrinth of birds, an aqueduct passes from the ampulla of the posterior semicircular canal to the recessus perilymphaticus. This aqueduct permits of the perilymph passing backwards and forwards between these two cavities.

The PRESIDENT thanked Dr Gray for his beautiful and artistic demonstration, which was like all his histological work, and was further characterised by a degree of patience which one did not always associate with surgeons.

Dr J. S. FRASER wished to congratulate Dr Gray upon the very beautiful work he had shown. He (the speaker) did not feel competent to speak on the comparative anatomy of the labyrinth, but it struck him that it was difficult to accept Dr Gray's explanation that this hitherto undescribed structure had arisen in response to changes connected with flying, unless it was better developed in flying than in non-flying birds. Further, the birds in which Dr Gray had found this perilymphatic tube so well marked, although they may have flown at one time, certainly did not do so now. He (the speaker) thought it was difficult to say what could be the object of this tube connecting the perilymph space of the posterior canal with the perilymph sac.

Dr GRAY (in reply) said that the aqueduct may be looked upon as a structure that tends to disappear, as birds become more highly specialised. Hence, although it may originally have acted as a means of rapidly accommodating changes of pressure in the labyrinth during the flight of the bird, these changes in pressure may be accommodated in a different way in the more highly specialised birds. Thus the opening from the vestibule into the cochlea may be larger in the latter types of birds, so that the aqueduct described is no longer needed to accommodate the changes of pressure.

A Method of Ligating Vessels in the Tonsillar Fossa—DONALD WATSON, F.R.C.S.

Mr WATSON said that although ligation of vessels in the tonsillar fossa was not required very often, he had found that the easiest instrument with which to catch the vessel was an ordinary pair of straight artery forceps. Occasionally he had found it necessary to use more than one pair of forceps.

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Those now shown were a modified Lane's tissue forceps. He (the speaker) had bought them at Down's as an instrument for grasping the vessels in the tonsillar fossa. The end was bulbous, and as it was not particularly easy to catch vessels in the tonsillar fossa with it, an ordinary pair of artery forceps was used as a guide to enable the ligature to slip over. The reason he had shown this was because he had thought it a much simpler method to use than the instrument he had seen illustrated in a recent number of the *Journal of Laryngology and Otology*.

Dr J. S. FRASER said he would like to ask whether members of the Society often found it necessary to ligate vessels in the tonsillar fossa. Personally, he did not, but he operated on children by the Whillis-Sluder method with the aid of ethyl chloride anæsthesia ; the bleeding lasted thirty to sixty seconds, while the child was turned over into the prone position and cold water poured over the back of the neck. The child could be sat up almost at once ; the nose was blown, and the bleeding stopped very quickly. He (the speaker) examined the throat before the child left the theatre, usually finding an almost dry tonsillar fossa. In adults, on the other hand, he practically always used local anæsthesia, and very often, especially if an interval of ten minutes or more was given after the injection of the anæsthetic, there was practically no loss of blood, either at the time of the operation or afterwards. He (the speaker) would therefore like to know whether members of the Society found it necessary to ligate vessels. He frankly confessed that he had done it on very few occasions and had found it an exceedingly difficult matter.

Dr HOWIE said that he had never ligated tonsillar vessels nor had he had any occasion to do so, because at one period he had had the good fortune to meet Dr Fraser and had discussed this question with him. Dr Fraser had said that one should take a pledget soaked in turpentine and press it on to the tonsillar fossa. He (the speaker) said they had only had to admit to the Wards about four cases during the eighteen years he had been at the Victoria Infirmary. He might have been fortunate, but a little pressure of the turpentine pledget for a few minutes was all that had been required.

Dr DOUGLAS GUTHRIE said that in cases in which there was general oozing with no definite vessel to be seen, he had found that a swab soaked in the dental preparation, carbolised resin, seemed to act as a hæmostatic and also prevented a good deal of the pain which was common after tonsillectomy by dissection.

Dr SOUPER thought the discussion was wandering from the original subject. He said no one had yet mentioned the occasion when it became really necessary to ligate a vessel, namely, when a severe hæmorrhage occurred from one or more points after removal of the tonsil. In the last four years he had had four such cases. In one child, where a large vessel spouted violently in the tonsillar fossa, it had to be caught at once. It proved to be a matter of considerable difficulty, and he thought the technique which Mr Watson had to-day put before them would be of considerable help. In the other three cases, hæmorrhage began within twenty-four or forty-eight hours after operation, and in them he was unfortunate enough not to be called in until the patient was in a fairly collapsed state. In two, the patient was not considered fit to stand any

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further anæsthesia, and the minimum manipulation had to be undertaken so as not to distress the patient. He had found great difficulty in seizing the bleeding point and afterwards in passing the ligature over the forceps in such a way that it would hold. In the first of these cases, he adopted the method of passing a fine suture underneath the point of the forceps on the vessel, so that the ligature was anchored. He had always found this extremely useful and he now took a small-handled needle with him. He thought that these reactionary hæmorrhages were worse to deal with than the primary ones, because in the latter one had the patient under a general or local anæsthetic, and could deal with the matter at once. Mr Watson's method should be of considerable help.

Dr ADAM said that in the case of children he used Beck's snare, but in adults he dissected under a local anæsthetic and hæmorrhage was apt to occur. He (the speaker) found it much simpler to use a Reverdin needle and stitch the pillars. He had never found it fail. He did not pack.

The PRESIDENT said he had always been surprised at the reports of bleeding from tonsils that he had received from the Americans. A very large number of tonsil enucleations were performed, but one rarely had to ligature, and he certainly thought he had not packed or stitched the pillars together more than three or four times. As a rule he applied forceps, leaving them on for a minute or two. It was only in a very small proportion of cases, not more than 1 per cent., where he had thought it necessary to put on a ligature. He thought Mr Watson's method was a very simple one.

Patients with Atrophic Rhinitis, two years after the Operation of Displacement of the Antro-Nasal Wall—Dr W. S. SYME.

Dr SYME said that unfortunately only one of the six or seven patients summoned had come to the meeting. They were the first of the series upon whom he had operated by this method. Although he had previously stated that displacement of the antro-nasal wall in atrophic rhinitis was the best method of treatment that he knew, and while the results, within six months or a year, seemed to be so satisfactory, he was not so sure that after two years or longer they would be so satisfactory. In some which had not reported to-day, there was retraction of the antro-nasal wall and the cavity had again become roomy. He had never cauterised the inferior turbinals and the adjacent portion of the septum, as some did. He had always hesitated to destroy the mucous membrane in these cases. He intended to continue with this method of treatment. He thought that as the result of experience, it was quite possible that further cases would show greater success, but he was bound to say that he was not so favourably impressed after two years as after six months, or even a year. Further prolonged experience was necessary before forming definite conclusions.

Dr HOWIE said the patient shown had told him she had been douching her nose twice a day during the whole time.

Dr SOUPER thought the case shown was an extremely good result. It was a very clean nose, but the left side was again becoming wide. He asked if this particular patient was still receiving any form of treatment.

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The PRESIDENT said that in all these cases, morning and evening, a formalin spray was used. This girl was a particularly good result, because she had no sense of smell before the operation, but now she had the best sense of smell of all the family.

Dr ADAM said that if this was an average result, it was much better than he obtained from putting in grafts of cartilage or fat. He asked if there had been trouble with the lacrymal duct and if the antral wall had been found to be thickened. He thought these cases were an end stage of hyperplastic rhinitis, as the same kind of thickening resulted from chronic suppuration in the mastoid. He would like to know in how many cases the maxillary sinus was involved.

The PRESIDENT said he had already reported on the last point raised by Dr Adam. It had been his (the speaker's) impression that in these cases there was thickening of the bone. The bone of the antro-nasal wall in many cases was sclerosed and in quite a large proportion there was antral disease ; one of the advantages of this method of operating was that there was an opportunity to examine the antrum and to deal with the antral disease. He had never had any trouble with the lacrymal duct.

Notochordoma of the Cervical Region—Dr W. S. SYME and Dr D. CAPPELL. The paper will be published in the *Journal of Laryngology and Otology*.

Septic Thrombosis of the Lateral Sinus; Operation; Recovery—Dr W. S. SYME.—Man, aged 60, was operated on by surgical diathermy early in June 1925, for malignant disease of the mouth. At the same time he suffered from chronic middle-ear suppuration on the left side of long standing. Subsequent to operation he developed pyæmic abscesses in various parts of the body, due, it was thought, to infection from the mouth. After a protracted illness, and contrary to expectation, he recovered. Early in October he returned. The mouth was in a satisfactory condition, but he had a swelling over the upper part of his left mastoid region. There was no rise of temperature. On operating, the mastoid was found to be large and cellular and full of septic granulations and purulent material. There was superficial destruction of bone. The bone over the lateral sinus was very soft and on its removal an abscess was evacuated. After cleaning up this cavity it was found that the lateral sinus at this part was completely destroyed. Further down and further back it was firmly occluded. The question naturally suggests itself, was the previous pyæmic condition due to septic sinus thrombosis which, untreated, had undergone some measure of spontaneous cure?

Massive Deposits of Calcareous Salts in the Site of an old Othæmatoma of both Ears—Dr A. A. GRAY.

Dr GRAY said that twenty years ago the patient had othæmatoma. The blood-clot, instead of being absorbed, had become organised and ultimately the seat of large deposits of calcareous salts.

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Small Papillomatous Formations at the Entrance to the External Auditory Meatus—Dr A. A. GRAY.

Dr GRAY said that the patient was a young man who had suffered from slight eczema of the external meatus. As soon as this was cured, a crop of papillomatous growths appeared at the entrance to the canal.

Cicatricial Stenosis of the Larynx—Dr A. BROWN KELLY.—Female, aged 18, fell downstairs nine years ago and fractured the thyroid cartilage. Increasing dyspnœa necessitated tracheotomy four weeks after the accident. Later, thyrotomy was performed and the local condition explored. The lumen of the larynx afterwards slowly diminished until it was reduced to a small oval aperture. This was opened up and dilated in September 1925, and the patient has since worn an intubation tube.

The PRESIDENT said that these cases were very difficult to treat. He thought they were probably more difficult than cicatricial stenosis of the trachea, and the method adopted by Dr Brown Kelly seemed to be giving a good result.

Fixation of the Left Vocal Cord—Dr JAMES ADAM.—A steelworker, aged 36, had had recurrent cough since boyhood; occasional purulent spit; shortness of breath on exertion and sweating. He was not aware of the slight roughness in his voice, but admits he never could sing.

Sepsis of teeth, gums, and soft palate observed; hard palate of adenoid type. X-ray of chest shows fibrosis about roots of lungs and calcareous gland near root of left lung. Left vocal cord fixed near mid-line; thickening of left arytenoid especially toward base. Wassermann reaction negative; no tubercle bacilli. No history of diphtheria, scarlet fever or rheumatism.

The PRESIDENT said that the case appeared to him to be one of abductor paralysis. It was sometimes difficult to determine whether fixation was due to paralysis or to an inflammatory condition round the arytenoid.

Four Cases of Tracheal Tumour—Dr JAMES ADAM.—The Paper is published in the *Journal of Laryngology and Otology*, vol. xli., p. 174, March 1926.

DISCUSSION.

Dr J. S. FRASER wondered, in view of this case, whether it would not be well to press for a tracheoscopy or bronchoscopy on patients who are sent by a physician for the discovery of a bleeding spot in the throat. These cases were sent with a history of coughing up blood and the physician reported he could find no evidence of phthisis in the chest. The nose, pharynx, and larynx were examined, and one found no evidence of any bleeding point there and reported to this effect. He (the speaker) thought it might be well to suggest in these cases that a bronchoscopy should be carried out in order to make sure that no growth was present in the trachea or bronchi.

The PRESIDENT said the same thing had occurred to him, and with this additional method of diagnosis in their hands, they should use it more

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frequently and in those cases where there had been spitting of blood for which no cause could be found. The bleeding in some of these cases was ascribed to varicose veins on the tongue.

Chondroma of Larynx—Dr CHARLES MACARTNEY.—Female, complained of huskiness and weak voice since April 1925; no pain; no loss of weight. Swelling on left side of neck was first seen by patient about the end of July. This, according to her, has not altered in size. Up till April voice was natural.

Laryngeal examination shows a round swelling occluding the whole of the left side and posterior part of the right side of larynx. A portion was removed and no malignancy found. Wassermann result pending. Provisional diagnosis — chondroma. Since August the size of the growth has not altered materially.

Dr LOGAN TURNER was inclined to agree with the diagnosis of enchondroma which had been made. He had used a laryngeal probe, and there was no doubt, from the hardness of the growth, that it was probably a tumour of this nature.

Dr Connal said he supported the diagnosis. He had had the opportunity of suspending the patient, and on touching the growth it was smooth, hard, and evidently attached to the underlying cartilage.

Case for Diagnosis—Dr JOHN W. LEITCH.—Male, aged 25, was seen for the first time on 23/10/25, owing to presence of chronic middle-ear suppuration (right ear) with polypi in the middle ear. The following notes are taken from the Medical Ward Journal: Admitted 4/10/25 with ophthalmoplegia and violent headache. The latter began fourteen days ago and was followed a few days later by inability to raise his right eyelid. About a week ago, vomited two or three times daily for a few days, but not since. Sent into hospital on account of severe exacerbation of the headache late on the evening of 3rd inst. 9/10/25: Wassermann reaction negative. 20/10/25: Attack of "explosive" vomiting last night.

The ophthalmologist reported—Complete ophthalmoplegia externa and interna. Disc perhaps a little pale, but nothing else of note. (Dated 8/10/25.)

On transfer to Ear Department, condition was as follows: Slight discharge from right ear; depths of auditory canal filled with polypoid granulations; no mastoid tenderness; no spontaneous nystagmus, past-pointing or Rombergism. Temperature 99.4; Pulse 86. *Right ear:* T. M. intact but somewhat dull. *Nose:* Slight irregularity of septum, but no obstruction to breathing and no pus or other signs of possible sinusitis; nothing seen post-nasally. 24/10/25: Radical mastoid operation performed. Malleus and incus removed and found to be covered with small granulations. No sign of extension of disease through roof or backwards towards sinus or cerebellum. Dura mater exposed over temporo-sphenoidal lobe for about 1 inch, and closed

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aural forceps passed into the temporo-sphenoidal lobe in an inward, backward, and forward direction for a distance of 1½ to 2 ins., in each case with negative result.

Present condition.—Wounds healed, drainage through meatus satisfactory and mastoid cavity healing normally; headache slight and only occasionally felt; appetite good; temperature normal since 1st inst.; ptosis, etc., as before.

Dr CONNAL said he had noticed it was stated that the temporo-sphenoidal lobe was explored with "closed aural forceps." He suggested that this was rather a futile proceeding, as one sometimes met with a thick-walled abscess sac, and if explored with sinus forceps, the sac might be pushed in front and the abscess not entered. He thought it would be better to explore with a sharp-pointed bistoury. Despite the negative Wassermann, in this case he thought a lumbar puncture should be done and the fluid examined.

Dr LOGAN TURNER thought that the aural suppuration might be merely an intercurrent affection and that the actual condition might be an intracranial neoplasm. He had tested the patient's gait and he (the patient) seemed to be a little unsteady. The headache and vomiting previously complained of had been relieved by the decompression operation, but the ptosis and the ophthalmoplegia, which were almost complete, suggested the possibility of such a lesion.

Dr SOUPER asked if an X-rays had been taken of the cranium with regard to the condition of the sphenoidal sinus, and so on.

Dr LEITCH (in reply) said he need only say that within the past week pain in the eye had become marked. The ophthalmologist's further report to-day showed complete paralysis of the right third, fourth, ophthalmic division of the fifth and the sixth nerves. Fundi were normal. The ophthalmologist suggested a tumour of the apex of the right orbit. He (the speaker) agreed that the improvement following operation had been a "decompression" effect.

ABSTRACTS

THE EAR.

The Relief of Catarrhal Deafness. Sir JAMES DUNDAS-GRANT. (*Practitioner*, June 1925.)

For practitioners the simple test suggested by the author to determine whether a case is likely to benefit by a course of inflation consists in whether or not the patient "cracks his ears" on blowing down the nose with the nostrils closed. When this occurs, and some benefit to hearing is obtained, the patient may be taught self-inflation by the author's method. A rubber tube with nosepiece and mouthpiece is used, and by means of this, chloroform vapour is blown up the

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