Mr H. J. BANKS-DAVIS (President) asked what was the object of tying the external carotid and jugular if removal was to be by diathermy?

Mr NORMAN PATTERSON said that in a case of high blood-pressure to be treated by diathermy, ligature of the external carotid at the time of the operation reduced the risk of hæmorrhage. But he now seldom tied this vessel, since he used a button instead of a sharp-edged electrode. Ligature of veins seemed likely to increase hæmorrhage rather than to diminish it.

Mr MUSGRAVE WOODMAN said that in the first case of this kind in which he operated the carotid was not tied, and there was severe hæmorrhage. Now, however, he seldom tied the carotid, and there was no trouble. In the opinion of general surgeons the vein also should be tied; either both should be tied or neither. When only one was tied there was much bleeding and oozing, he thought. If hæmorrhage was anticipated, it would be mainly secondary. If the carotid were tied at the date of the operation, secondary hæmorrhage would supervene in from seven to ten days, and if secondary hæmorrhage seemed likely to occur, it would be wise to tie the vessel seven to eight days after the primary operation, to circumvent the collateral anastomosis which so quickly resulted after ligature of the external carotid.

SECTION OF LARYNGOLOGY AND OTOLOGY—BRITISH MEDICAL ASSOCIATION, BRADFORD.

23rd and 24th July 1924.

President, Dr W. JOBSON HORNE.

(*Abstract of Proceedings by Dr J. S. Fraser*).

DISCUSSION ON CHRONIC TONSILLITIS: INDICATIONS FOR AND RESULTS OF TREATMENT.

The discussion was opened by Dr A. Brown Kelly, who said that the two conditions mainly accountable for chronic inflammation of the tonsil were hypertrophy and sepsis. The two were commonly associated. The most usual affection of the tonsils was enlargement in children. An enlarged tonsil, though apparently healthy on pressure, was found to be diseased when examined microscopically; indeed, from the bacteriological standpoint, every tonsil was diseased, but, as we could not use this criterion, it was necessary to base our opinion on the clinical history, concomitant signs, and local aspect. Experience had shown that tonsillectomy did not destroy any important function from the deprivation of which the patient would suffer. The faucial tonsil differed in no way from any solitary lymph nodule excepting in size and complexity.

When the tonsil was removed its functions were carried on by lymphadenoid tissue elsewhere. In children whose tonsils and

https://doi.org/10.1017/S0022215100026499 Published online by Cambridge University Press

adenoids were completely removed, large granulations sometimes appeared on the pharyngeal wall. There need be no hesitation in removing enlarged or diseased tonsils from a child of two years, or even eighteen months, while it might be imperative to remove adenoids from a suckling. According to the view generally held, enucleation of the tonsils lessened the liability to contagious diseases, and, when such diseases were contracted, the attacks were milder in tonsillectomized patients. The consensus of opinion showed that in the hands of skilled operators there need be no fear of damage to the singing voice from tonsillectomy. Kelly, however, held that, when vocal training had been completed, surgical interference should be undertaken only after careful circumspection; gradual reduction might be advisable in such cases.

In adults with chronic tonsillitis, trouble due to sepsis was commoner and more important than that due to hypertrophy. The faucial tonsils were peculiarly adapted for the development of septic foci. Until lately, a secondary focus was believed to develop at a particular site in consequence of previous injury whereby resistance was lowered. The present trend of opinion, however, was to assign to the circulating virus a power of selecting a certain tissue for its lodgment. The detection of a septic focus in a tonsil was a matter of importance. Foul caseous plugs in the crypts, or enlargement of the tonsillar glands facilitated the diagnosis. The absence of such obvious signs, however, by no means excluded the presence of a small chronic abscess close to the capsule. Pavey-Smith, Lott, and Chevalier Jackson had described a narrow, sharply limited, and dark red zone on the anterior pillar in front of the tonsil. Lott regarded this as a distinguishing feature of a tonsillar focus, in which streptococci predominated. In such cases tonsillectomy yielded good results in arthritis, neuritis, etc. When a patient was sent suffering from a systemic disease which was known to be caused occasionally by a septic tonsillar focus, on what grounds was an opinion as to the advisability of operation to be based? (1) If the focus of infection were found, or if there were a predisposition to tonsillitis or cervical adenitis, tonsillectomy was indicated. The patient should be told that the operation would cure the local affection and would almost certainly benefit the general health, but that improvement in the systemic disease could not be guaranteed. (2) Was the septic focus for which search was being made in the tonsil? This was probable if the onset of the tonsillar affection coincided with that of the secondary disease. (3) Were foci of infection present elsewhere? The gums, teeth, nose and paranasal sinuses, the alimentary canal and the genito-urinary tract should all be investigated. Septic foci occurred more frequently in connection with the teeth than in the tonsils. (4) If the tonsil was clinically healthy, and if there was

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nothing pointing to a relation between the tonsil and the systemic disease, tonsillectomy should not be recommended. (5) When a systemic disease caused by a primary septic focus in the tonsil had been present for a long time, no benefit might be obtained from removal of the tonsils and focus.

In the discussion Mr Scott Ridout suggested that the meeting should formulate a fairly definite line to guide the practitioner regarding operative treatment in the "border-line" type of case. One urgent indication for treatment was the failure to cure as a result of tonsillotomy. The speaker compared the tonsils with forts around a city—useful at first but not when they were in possession of the enemy. Mr E. D. D. Davis said that enucleation of the tonsils had taken the place of the blood-letting operation of our ancestors. He had been asked to enucleate the tonsils for frequent "colds," pyrexia of unknown origin, tuberculous cervical glands, goitre, infective arthritis, endocarditis, chorea, nephritis, colitis, chronic appendicitis, septic diseases of the skin, enuresis, and asthma in children! In the hunt for a septic focus the tonsils were always under suspicion. Mr W. S. Syme said that the most troublesome tonsil was the buried one. The usual examination of the tonsil was much too cursory. The anterior pillar should be pulled back and pressure made in order to see the tonsil properly. Mr J. F. O'Malley believed that the absence of tonsils and adenoids diminished the incidence of infectious diseases. Mr A. B. Pavey-Smith stated that in nearly 100 cases operated upon for chronic arthritis and allied conditions, all the tonsils showed some signs of infection. In two-thirds of the cases no throat symptoms were complained of. Mr H. Bell Tawse said that in some cases he reserved the decision as to whether the tonsils were septic until the child was under an anæsthetic. He placed the ring of the guillotine against the posterior pillar and gently pressed the tonsil against the angle of the jaw. If pus did not exude he considered the tonsil normal and did not remove it. Mr F. Holt Diggle held that complete enucleation was the only operation that should be adopted. He considered that in children many innocent tonsils were removed. Dr Jobson observed that the symptoms in two cases of long-standing duodenal ulcer had cleared up after removal of septic tonsils. The President, Dr W. Jobson Horne, stated that some years ago he had come to the conclusion that the tonsil had a very definite function in childhood but that later in life it was of little or no value.

NASAL NEUROSIS.

The discussion on nasal neurosis was opened by Dr Neil Maclay, who stated that cases of nasal neurosis were far too often regarded as cases of "cold in the head." He gave an account of the anatomical

https://doi.org/10.1017/S0022215100026499 Published online by Cambridge University Press

and physiological aspects of the subject, and described interesting experiments on rabbits, in which guanidin was injected intravenously, with the result that there was an increase in salivation and in the nasal secretion, with turgescence of the turbinals. These signs and symptoms were almost at once reduced by the intravenous injection of calcium salts. In addition to intestinal auto-intoxication, Dr Maclay also mentioned hay pollen, animal emanations, and bacterial infection.

Dr Brown Kelly laid stress on emotional conditions as an exciting cause of the nasal neurosis, *e.g.*, patients working for examinations or individuals who had suffered from a recent bereavement. Dr Kelly stated that he was giving up the tests for sensitizations to various articles of diet, but that he was continuing tests with animal emanations, hay pollen, etc. Mr O'Malley also laid stress on the importance of intestinal toxæmia in these cases. He had found local operative procedure on the nose very unsatisfactory. Mr O'Malley had tried calcium chloride and lactate, but was of opinion that we could not raise the calcium content of the blood by giving these drugs by the mouth. He held that parathyroid was the best remedy. He had also given parathyroid preparations in otosclerosis, and believed that they did good. Dr Dunlop mentioned hyperchlorhydria as associated with rhinorrhœa in people suffering from exhaustion, *e.g.*, after a long sitting in the Out-patient Department.

In reply, Dr Maclay stated that calcium salts did get into the blood when given by the mouth, even though the physiologists could not find any increase. The calcium might be in a colloidal or "locked-up" form, whereas the physiologists could only estimate the free calcium. Dr Maclay recommended large doses—from 20 to 30 grains of calcium lactate.

CANCER OF THE ŒSOPHAGUS.

A paper on this subject was read by Dr William Hill, who stated that success was only obtained in cases in which the gullet was affected above the level of the clavicle. The results in cases of cancer at the lower end of the gullet were very bad, because the revealing signs of cancer of the gullet appeared so late that the disease was only diagnosed when it could no longer be cured by operation. With regard to the middle portion of the œsophagus, lateral thoracotomy was so fatal that the operation was not worth attempting. Dr Hill then mentioned palliative measures, such as dilatation, intubation, the use of the galvano-cautery or diathermy. The paper, however, dealt mainly with the use of radium. It was important to obtain applicators of sufficient length to radiate the whole growth at one time. In some cases the applicators required to be as long as two inches. A radio-active dose of 50 mgm. was necessary for every cm. in length of the growth. Dr

https://doi.org/10.1017/S0022215100026499 Published online by Cambridge University Press

Hill also dealt with the screen and time dosage. As regards the repetition dose, he waited for six weeks before making a second application.

Dr Hill had treated 77 cases, and in only 3 of these was the fatal result attributable to the use of radium. In a paper published in 1911, 21 cases had been recorded, and in 3 there had been complete temporary disappearance of the growth as seen through the œsophagoscope. One case was cured for five years, and the patient died, not from local recurrence but from secondary growths in the liver and abdominal glands. Two cases had lived for three years. In a further 7 cases great improvement had been obtained, and, in six, some improvement.

In the discussion, Mr E. D. D. Davis said that the results of radium treatment in œsophageal cancer varied very greatly. American observers had claimed that simple dilatation gave as good results as radium. Mr W. S. Syme had used diathermy in one case, with excellent results.

Clinical Demonstration at the Royal Eye and Ear Hospital, Bradford.

Mr Appleyard showed the following cases :—

Case 1. Left internal carotid artery visible on the posterior pharyngeal wall. *Case* 2. Bilateral congenital microtia in a baby, aged 7 weeks. The general opinion was against operative treatment in this case. *Case* 3. Facio-hypoglossal anastomosis. Female, aged 17, was first seen on 17.2.21, with right chronic otorrhœa and a post auricular sinus. Immediate operation was advised but refused. Two days later she developed right facial paralysis. Radical mastoid operation was performed on 19.2.21 ; a large cholesteatoma was found. In May 1921 facial paralysis was still total, so the hypoglossal nerve was split and the proximal end anastomosed to the distal end of the facial nerve. Some improvement was noticed seven months later. There is still some weakness present in involuntary smiling, though forced movements are quite good. Mr Appleyard thought it possible that, as the right half of the tongue was not atrophied, the case might really be one of spontaneous recovery. Attention was called to the short period allowed to elapse between the onset of facial paresis and the nerve anastomosis.

Case 4. Pneumatocele of mastoid process following Schwartze operation for acute mastoiditis. The patient complained of a swelling behind the ear. There was no pain. On pressure, the swelling disappeared but reappeared on Valsalva's inflation. *Case* 5. Œsophageal diverticulum with X-ray plate. Male, aged 53, complained of difficulty in swallowing, of eighteen months' duration. He had lost a stone in weight in the past twelve months. After a meal he could force food back into his mouth by pressure just above the episternal notch. The radiogram showed a diverticulum behind the posterior œsophageal wall. The opinion was expressed that if the patient continued to lose weight he should be operated upon.

Mr Donald Watson showed—*Case* 6. Osteoma of the frontal sinus.

https://doi.org/10.1017/S0022215100026499 Published online by Cambridge University Press

Male, aged 29, was operated upon fourteen years ago by another surgeon for tumour of the right frontal sinus. Headaches, vomiting, and giddiness complained of for last two years. Bony tumour shown by X-rays in mid-line 2 inches by 1½ inches. Tumour removed by operation: normal convalescence. *Case* 7. Female, aged 22. Xanthoma multiforme affecting mucous membranes of mouth and larynx as well as the skin. Patient had diabetes insipidus, the cause being in all probability a xanthoma nodule in the pituitary body. *Case* 8. Case of lupus, aged 13. When first seen the soft palate was firmly adherent to the posterior pharyngeal wall. Now there is a small opening into the nasopharynx. It was pointed out that the choice lay between cleft palate speech and the present stenosis. Dr Brown Kelly advised that a palate hook be attached to the posterior end of a dental plate. *Case* 9. Male, aged 53, labourer holding rivets inside a concrete mixer whilst repairs were being done. There was a great deal of noise inside the mixer. On emerging the patient was deaf, and has been so since. He complained of tinnitus. Rinne is positive both sides: monochord 11,500 right, 12,000 left. Caloric test—nystagmus appears in about forty-five seconds: past-pointing and falling tests normal. Is this nerve deafness following his exposure to noise? The opinion was expressed that this was a case of hysterical deafness, and a "bogus" operation was suggested. *Case* 10. Female, aged 34. Bilateral and congenital microtia: no meatal canals. *Case* 11. Aged 39, mucocele of larynx extending into neck. In April, 1923, after an attack of tonsillitis and laryngitis, a swelling appeared in the neck the size of an orange. The patient became hoarse and remained so. On examination there was a swelling, the size of a hen's egg, in the right anterior triangle at the upper lateral border of thyroid cartilage. The swelling became tense when the patient coughed. Laryngoscopy showed on the right wall of the vestibule of the larynx a round, red swelling the size of a hazel nut. It was sessile and hid both true and false cords. The tumour was removed through a collar incision. It was deep to the depressors of the hyoid and communicated with the saccule of the larynx. The cyst wall was lined with mucin producing cells in irregular layers and was filled with a pultaceous material. *Case* 12. L. G., aged 21, has had swelling in upper jaw for seventeen years: operated upon nine years ago and again five years ago. Case diagnosed as osteitis of superior maxilla. A radiogram showed a dense, bony growth occupying the body of the right superior maxilla. Dr Ritchie Rodger suggested the Wassermann reaction, after a provocative dose of 606. He mentioned a case reported by him as leontiasis which had turned out to be syphilitic.

Dr Mitchell showed three cases of cancer of fauces and tonsil successfully treated by diathermy.

EARLY TREATMENT IN ACUTE OTITIS MEDIA.

A general discussion on the importance of early treatment in acute otitis was opened by Mr J. F. O'Malley, who called attention to the importance of school clinics and of Child Welfare centres, and to the dangers arising from otitis media and its *sequelæ*. At the Evelina

https://doi.org/10.1017/S0022215100026499 Published online by Cambridge University Press

Hospital all children suffering from enlarged tonsils and adenoids had been found to show changes in the middle ear. Mr O'Malley divided acute otitis media into four stages: (1) Deafness, pain, and congestion of the drumhead; (2) bulging of the tympanic membrane; (3) discharge; (4) mastoiditis. He called attention to the importance of early treatment. In his opinion acute otitis media should be compared to acute appendicitis.

In the discussion, Dr Macdonald (York), laid stress on the education of the general practitioner. Very often the specialist was called in hours, weeks, months or years too late. Dr Macdonald held that not one general practitioner in fifty could give a competent opinion on the condition of the drumhead. Mr William Hill was of opinion that every practitioner should be able to examine the ear, and pointed out that the present generation was being better educated than formerly. It was important that school medical officers should be well instructed in ear work. Mr Kelson and Dr J. S. Fraser called attention to the difficulty in diagnosis between furunculosis with mastoid swelling and mastoiditis. Mr Scott Ridout and Dr Dunlop were strongly against the treatment of acute suppurative otitis media by means of syringing. Dr Neil Maclay was in favour of early incision, and held that good radiograms were of advantage in the differential diagnosis between furunculosis and mastoiditis. Dr Maclay and Mr Tawse favoured the wet method of treatment. Dr Maclay did not believe that it was possible to infect the tympanic cavity by syringing the meatus. With regard to paracentesis, Mr Holt Diggle was of opinion that this procedure was called for if pain continued, even though the drumhead was not bulging. Mr Tawse, on the other hand, rarely performed paracentesis. Mr Diggle considered that bacteriological examination of the discharge was important, because streptococcal cases almost always developed mastoiditis. Mr Tawse was of opinion that a mastoid operation should be performed if the discharge continued more than fourteen days. Dr Ritchie Rodger stated that in 95 per cent. of cases adenoids were the cause of acute middle-ear suppuration. Adopting Mr O'Malley's classification, Dr Rodger said that during stage one he removed adenoids alone: in the second stage he not only removed adenoids but he also performed paracentesis: in the third and even in the fourth stage, he regarded paracentesis as very important in order to enlarge the perforation. Some cases of mastoiditis had cleared up after this small operation. The President, Dr Jobson Horne, called attention to the question of middle-ear suppuration in fever hospitals and the Resolution passed by the Otological and Laryngological Sections of the International Medical Congress in 1913. The Metropolitan Asylums Board had now got special hospitals for the treatment of otitis media and mastoiditis.

https://doi.org/10.1017/S0022215100026499 Published online by Cambridge University Press

Mr O'Malley, in reply, did not propose to settle the quarrel between the "wets" and the "drys." Some of the opponents of the wet method stated that syringing was useless, because fluid did not reach the tympanic cavity, while others were of opinion that it might cause a mixed infection by reaching the tympanum through the perforation. He pointed out that those who opposed the wet method could not have it "both ways." Mr O'Malley advocated removal of adenoids at the time of the mastoid operation.

Dr W. S. Syme read a paper on **Definite Diagnosis in Affections of the Ear, Nose, and Throat.** Dr Syme held that the ear was never properly examined until the nose and throat had been thoroughly investigated. These latter cavities should be put in a satisfactory condition first of all. Stress was laid on the importance of posterior rhinoscopy. Dr Syme had found that furunculosis of the external acoustic meatus might be associated with enlarged tonsils and adenoids, or with nasal affections. Otalgia might be caused by enlargement of the posterior ends of the inferior turbinals, while disease of the posterior group of paranasal sinuses might produce vertigo. In cases of enlarged tonsils and adenoids it was important to examine the nose for turbinal enlargement, nasal polypi, and septal deviations. Dr Syme held that nasal polypi were the outward and visible signs of an inward and invisible disgrace, *e.g.*, ethmoidal or sphenoidal inflammation. He was of opinion that even if proof puncture were negative, the antrum might be diseased. Too many tonsils escaped operation owing to insufficient examination.

Dr J. S. Fraser read a paper upon **Cerebellar Abscess**, and Mr W. H. Kelson one upon **Some Osseous Growths of the Nasal and Adjacent Bones**, and gave a review of the subject with numerous case records. A large number of specimens were shown. Both papers will appear in full in the *Journal.*

The following Resolutions were unanimously passed by the Section of Laryngology and Otology:—

1. That tonsillectomy by enucleation is the only efficient operation in dealing with tonsillac disease, and that partial removal by operation is not effective.

2. That the operation of tonsillectomy should be no longer conducted as a minor operation, but as one of the lesser major class of operation, and should be undertaken in that spirit.

3. That the discussion which has taken place on the indications for removal of the tonsils has shown that the operation should only be undertaken after expert opinion has been given.

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