Progress, 27.10.21.—The left nasal fossa is now free from growth, but there is still a portion of stony hard consistence to be felt and seen in the nasopharynx. On 4.11.21 surgical diathermy was again applied under anæsthesia.

15.11.21.—There is a very free airway. A sequestrum of bare bone can be seen in the vault of the nasopharynx. (This separated later.) There is also a loose tongue of tissue attached to the region of the left Eustachian orifice.

1.7.24.—The patient is now about 6 feet in height and powerful. The left eye is still proptosed, but there is no obstruction to breathing and no epistaxis. The nose is flattened, as the septum—both bony and cartilaginous—has sloughed away. In the nasopharynx a small tongue of firm tissue is still present. We believe that this is a portion of the original growth. It is smooth, glistening, and moist, and partly fills up the posterior nasal opening which is very large owing to the loss of the septum. There is no dryness of the nasopharynx.

SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

President—Mr H. J. Banks-Davis, M.B., F.R.C.P.

May 2, 1924.

Case of Sarcoma, originating in the Alveolus—J. Aldington Gibb, M.B.—Female, aged 67, first noticed swelling of the upper jaw in September 1923; it was more unsightly than painful, and its gradual increase in size caused the patient to come to hospital in November, when she complained merely of the swelling of the jaw, stating that it was not painful; no history of bleeding.

Examination.—Left nostril closed anteriorly with a papillomatous tumour, no bleeding on examination, no ulceration. Right nostril clear. On transillumination the left antrum was dark, with light trying to get round the sides. Right antrum clear.

Operation.—17th December 1923. Under ethyl chloride and ether. An incision was made along the alveolar margin from the right canine fossa towards the left side extending for about 4 in. along the alveolar margin, and the flap was reflected upwards. A fairly large tumour was exposed, which bled profusely. This was dissected away and was found to have four separate roots or attachments: (1) in region of right canine fossa; (2) in left canine fossa;

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(3) in left nostril (seen by anterior rhinoscopy); (4) in left maxillary antrum. The tumour was removed as far as possible, and the resulting cavity packed. The pathologist's report was "round-celled sarcoma." She was discharged from hospital on 10th February 1924.

Dr W. HILL said it would be safe to apply radium, to make sure that there were no little foci of disease. Sir Henry Butlin pointed out that some of these cases were not very malignant at first, though others were clinically very malignant. The degree of malignancy in any given case could not be determined beforehand.

Mr MUSGRAVE WOODMAN agreed it was desirable to have a section examined; he feared a recurrence on the lip; it was raw and tender, and that was a good site for the radium.

Mr E. D. D. DAVIS pointed out that the area on the lip was a radium burn.

Mr H. J. BANKS-DAVIS (President) said the Erlangen treatment was an excellent one for such cases. He had shown the Section a case of sarcoma of the antrum which was treated two years ago by this method after operation, and so far there had been no sign of recurrence. With regard to the usual terms employed "dark" or "translucent" under transillumination, between these two extremes he thought the word "dim," as used by Mr Woodman at the last meeting of the Section, was worthy of general adoption.

Dr DAN M'KENZIE said he had shown two cases of the kind, one ten years after operation, the other seven years after. One need not be too anxious about these cases of sarcoma of the nose. If the tumour were completely removed and the patient watched, it could be kept from killing her. In the event of recurrence, it could be arrested by cauterisation, as Price-Brown of Toronto had shown many years ago.

Dr GIBB (in reply) said that the growth originated in the alveolus, and it was a round-celled sarcoma. The patient showed a recurrence in the alveolus and a tube of radium was put in, which burned the lip. The antrum was quite clear of growth, and the nasal growth was completely removed. He wished afterwards he had removed the alveolus. He thought radium would quickly get rid of any recurrence.

Case of Carcinoma on Right Side of Tongue—J. ALDINGTON GIBB, M.B.—Male, pensioner, aged 64, first noticed swelling in June 1923, as a small lump on the right side of the tongue near its middle. This began to enlarge, and he consulted a doctor in July 1923. He was treated as a case of glossitis till October when he was sent to the Prince of Wales Hospital, London. There his blood was tested, and Wassermann was apparently found to be negative, for no anti-syphilitic treatment was given. Also a small gland (submental) was excised and examined, and report was sent to the patient's doctor that the condition was inoperable. Eventually I was asked to see the case and the patient agreed to another operation.

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Examination.—An ulcer occupied the middle third of the side of the tongue, extending from the posterior pillar of the fauces to within a little distance of the tip, and also along the floor to the alveolus. The floor of the ulcer was of wash-leather colour, its edges overhung and irregular. Mobility was not impaired. The surrounding tissues were hard and infiltrated. Numerous small hard glands lay in submaxillary and submental regions, and some deep cervical glands were found hard and movable. The ulcer was not movable and had been growing at a fairly rapid rate. No loss in weight was noticed by the patient.

Wassermann reaction both on blood and on cerebro-spinal fluid was negative.

On 3rd December 1923 a wide excision of the ulcer was made by diathermy knife, and the surrounding tissue treated with the diathermy button.

Following this the tongue became very swollen, and the patient had great difficulty in breathing for two days, after which rapid improvement took place. Discharged on 29th December.

Mr LAWSON WHALE said it did not seem clear from the notes what the diagnosis of this case was believed to be. Was it regarded as gummatous, or as a neoplasm? If the latter, it must be of enormous size. Nothing was said as to it being syphilitic, except that the Wassermann was negative.

Dr DAN M'KENZIE said that if epithelioma of the tongue was to be removed by diathermy so that there should be no recurrence, it would have to be a formidable procedure. Ten months ago he removed the whole of the left side of a tongue for an ulcer on the margin, fairly far back. He first tied the carotid, and removed the glands and fascia at the side of the neck, treating the neck wound with diathermy. Even that removal was not wide enough, as recurrence took place on the other side of the neck. Removal of the glands seemed to limit the spread of epithelioma in that direction. The whole tongue should be removed by the diathermy knife; also the glands on both sides of the neck; only in this way could such cases be attacked with some hope. Hitherto the ordinary surgical treatment of cancer of the tongue had been a failure, as recurrence occurred in all cases, sooner or later. In any future case he might have of this kind, he would aim at removing the whole of the disease-bearing area, doing two or three operations if necessary.

Mr MUSGRAVE WOODMAN said that when serious growths in the mouth had to be tackled, the question of the glands in the neck must be faced, otherwise diathermy would be brought into discredit. Twenty years ago Sir Henry Butlin insisted on the necessity of removing all the glands on the side of the neck on which the tongue was affected. There was a good result in the present case, though Dr Gibb did not show that it was epithelioma. There was still a hard gland under the jaw, and sooner or later that was likely to give trouble. In one or two cases in which he (the speaker) had removed the local disease successfully, two years later a gland "flared up," and within a month the case became inoperable.

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Mr CAVENAGH said this patient had had a considerable part of the tongue removed, yet there was little interference with speech, and articulation was still very good. After diathermy a softer scar was left than after operation with the knife.

Mr W. IBBOTSON said he assumed that block dissection of glands was meant. There were many glands that were not palpable, and some that could not even be seen easily.

Mr NORMAN PATTERSON said that one frequently found, even after dividing the sterno-mastoid and clearing out the triangles, that there were glands behind the jugular vein and that vessel had to be removed. Why, in this case, was a section not taken from the growth which was removed from the tongue?

Mr H. J. BANKS-DAVIS (President) said the absence of palpable glands did not mean that no glands were involved. The actual enlargement felt was no criterion whatever that other glands were not in the process of involvement, and this should be borne in mind.

Dr GIBB (in reply) said that the gland was removed by Mr Howell Evans, and the case was found to be definitely one of carcinoma. It had been considered to be inoperable. The Wassermann reaction was negative. Carcinoma of the tongue was often said to rest on a syphilitic basis. He had found glands shrinking in similar cases and becoming hard. In a case reported in the *Proceedings of the Scottish Society of Otology and Laryngology*, for instance, three weeks after diathermy, a gland was removed. The surgeon had intended to do a mass dissection, but on dissecting out the largest gland, three weeks afterwards, he found the cancer cells very much shrunken, and quite enclosed by fibrous tissue. He (the speaker) thought the intense heat used had let something loose in the tissues which had some effect on the lymphatic system, perhaps blockage, or had caused a secondary effect on the growth in the gland. He asked a surgical colleague to supply him with a carcinoma of the breast which he had excised, and then he got an analytical chemist friend to make an analysis under heat from the cancer cells. The chemist obtained a lipoid, and the speaker asked him to look for lecithin lipoid; he obtained four grains of it from the carcinoma, and an extraordinary amount of fat, almost half a pound of liquid yellow fat, which did not give the reaction he would expect in normal fat. Therefore he got the chemist to make him some lecithin lipoid from an egg. Not long afterwards he saw another patient with carcinoma of fauces and pharynx, more extensive than in the present case; there was recurrence some weeks afterwards and treatment by lecithin-lipoid injections was carried out, with the result that the ulceration had now completely cleared up. There was also a reduction in temperature—a result supposed to be due to the lecithin. In mixed infections, with carcinoma, he had given lecithin lipoid, with the result that the temperature had come down to normal, this bearing out the contention that lecithin raised the body immunity. The lipoid being found in the cancer cells, the probabilities were that lecithin lipoid was loosened from the cancer cells as a result of intense heat. He was now carrying out injections, and if any member would care to try the same thing after what he had said, he would be glad to know the result.

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The theory he held was, that cancer was not a specific disease, but was an irritation-disease, *i.e.*, an irritation could be set up by endogenous or exogenous poisons. In all the cases to which he had referred, the patients had very bad teeth, and the last patient had every tooth removed. The Medical Officer of Health for the county of Kent said there had been an enormous increase of cancer there during the last few years. Lecithin lipoid was found in the suprarenal glands, and the action of it there was to raise body-temperature and to act on the katabolic side of metabolism, and there was some movement of tissue change. If epithelial cells were to originate an aberrant form of growth as a result of irritation, it was not unreasonable to suppose that lecithin lipoid might in some way moderate the action of cell growth.

He held a further theory, namely, that as cancer now attacked people of a younger age than formerly—there were many cases in the thirties—it was probable that the endocrine glands became tired, and that the lecithin lipoid was deficient, and therefore that irritation of epithelial cells had a greater effect. When he was on active service his blood pressure was at first 130 mm., but in fifteen months it had increased to 178. It was not too much to expect that the period of the war had a bad effect on the resistance of the people.

Case of Occlusion of the Left Choana—NORMAN PATTERSON, F.R.C.S.—Male, aged 19, came into hospital with acute right otitis media. Routine examination showed complete occlusion of the left choana. The patient has been a mouth-breather as long as he can remember. The hearing in the left ear is apparently normal.

Mr HERBERT TILLEY asked whether this was a membranous or a bony atresia, or a combination of both. If the patient had been operated upon, what had been the method employed. He (Mr Tilley) had had only three cases of the kind. The first showed the great tendency of the operated atresia to become blocked by granulation tissue, and how difficult it was to keep patent the newly-formed choana. In the second and the third cases he passed a chisel through the affected nasal cavity and chipped away the posterior region of the vomer, after having removed the congenital diaphragm of bone and membrane. In those two cases no after-treatment was necessary, as there was marked tendency for granulation tissue to proliferate and ultimately cicatrise.

Mr NORMAN PATTERSON (in reply) said that he had not operated upon the case, and he could not say whether the partition was membranous or bony. In two cases he had carried out the operation which had been mentioned by Mr Tilley.

Mr FRANKLIN showed some colour prints of unilateral occlusion of the choana by membrane and bone. The membranous occlusion was coloured the characteristic blue-grey, whereas the bony occlusion was a pale pink. He said that the former type might be perforated in one or more places, the latter was generally intact.

Mr H. J. BANKS-DAVIS (President) said that many years ago he showed a woman from the Middlesex Hospital who had such an occlusion. After

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repeated treatment it closed up. It always returned until she wore a rubber tube which was passed through the nose into the nasopharynx, which enabled her to breathe with ease and carry out the necessary treatment.

Sir ST CLAIR THOMSON said he had never had any difficulty about recurrence. With postnasal forceps he punched out a considerable piece of the posterior border of the septum; the septum did not re-form. Mr Wright read an interesting paper at Glasgow on this subject (published in the *Journal of Laryngology and Otology*, 1923), making several interesting observations to show that apparently these patients did not suffer from ill-developed chests, that their palates were not arched, and that they did not become deaf. The present patient heard well. He found deafness was very rarely associated with this. It was agreed that mouth-breathing might lead to laryngitis, but not all who were mouth-breathers had laryngitis, and people wearing a tracheotomy tube did not necessarily get bronchitis.

Mr HERBERT TILLEY pointed out that it was partial rather than complete nasal obstruction which produced the mischievous effects on the ear and the skeletal development of the thoracic cage.

Dr ALBERT A. GRAY expressed his agreement with Sir St Clair Thomson; he said that the number of operations done for the relief of deafness was very great. Some thought that people with noses full of polypi did not get deaf, others that they did. He hoped that fewer operations would be done on the nose for the relief of deafness.

Mr A. R. TWEEDIE said he noted that the otitis media was on the right side, whereas it was the left side of the nose which was occluded, but he suggested that it was the partial occlusion of the nose which lead to naso-pharyngitis and involvement of the tube.

As regards intranasal treatment with a view to the relief of deafness, he considered such procedure should be limited to those cases in which there was some improvement after inflation. It was then fair to suppose that the condition of the middle ear could be improved by rectifying the intranasal affections; in these cases the rectification was as important as was dealing with adenoids for similar conditions.

Dr W. HILL said he thought that one reason why these patients did not show the more obvious defects which would be expected was, that the obstructions were congenital, and did not seem to exercise the same effect as when they occurred later in life. He himself had been puzzled at the contradictions encountered.

Mr F. J. CLEMINSON asked whether there was any asymmetry in the facial development of this patient. He thought that one of the factors governing the symmetrical growth of the face must be that the nose should fulfil its physiological purpose and be used for breathing through, or otherwise it would not develop at the same rate as the rest of the face. He thought deformity of the chest in young children with nasal obstruction was produced by the effort of the child to get air through the nose so long as it was possible. In cases of complete occlusion of the choanæ the child would appreciate the obvious impossibility, and so make no attempt at all; the chest wall would not in such a case be deformed.

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Mr CAVENAGH said it was extraordinary that, after a life-long absence of ventilation in the left nasal cavity, the quantity of secretion should not be cut down; it was apparently continuing all the time. Was the totally occluded side liable to infection?

Mr J. F. O'MALLEY said he had a case in which the patient came on account of sepsis of the right side of the nose. She had extensive antral and ethmoidal trouble, and during the operation he discovered she had an occluded choana, which he regarded as responsible, to a large extent, for the disease. It was very difficult to get a satisfactory result, and finally she ceased visiting the hospital before the end of the treatment; he had meant to open the choana. One could not be dogmatic in a general way, but he thought that where it was found that there was marked deafness from time to time, associated with an exacerbation of nasal catarrhal trouble, or a cold in the head, if any obstruction discovered in the nose was removed, the hearing would improve.

Dr P. WATSON-WILLIAMS said the question of how far nasal obstruction was a cause of chest deformities, and how far it was the cause of catarrhal ear complications, had not been settled. Mechanical obstruction of the choanæ was almost always unilateral, and therefore only partial, if the other side of the nose was normal. So long as there was no catarrhal condition there might be no chest deformity or clinical manifestations of the obstruction other than intranasal. Hence the frequent occurrence of marked septal deflection in which one side of the nose was practically occluded, without resulting chest deformity, and with no difficulty in breathing, and no ear infection. It was, however, a very different matter if infective catarrh became superadded. Usually purely mechanical conditions were of small import unless there was superadded infection.

Mr G. W. DAWSON said that it had not been stated why these patients sought relief. It was not for the nasal obstruction, but for the catarrh, which necessitated the constant use of the handkerchief. On examination the floor of the nose was found to be full of mucus. The bone causing the obstruction was frequently very thick, and the best method in these cases was to enter and remove the septum with a chisel $\frac{1}{2}$ in. in front of the obstruction.

Mr PATTERSON (in reply) said that this patient's face was symmetrical; he slept with the patent nostril uppermost.

Case of Lupus of the Palate and Face successfully treated by Artificial Light Baths—NORMAN PATTERSON, F.R.C.S.—A girl, whose trouble commenced when she was aged 9, came to the London Hospital, 13th August 1923. There was butterfly scarring of face, with freckles and X-ray telangiectasis. Active lupus nodules were present with a periphery of scarring; considerable nodular infiltrations of soft palate.

Blood-count normal; 90 per cent. hæmoglobin.

Light treatment administered. Mercury vapour to whole body commenced 16th August 1923; fifteen minutes at first, gradually increased to one hour, continued daily for six months.

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Present condition; weight 7 st. 7 lb.; face clear of lupus; palate now shows no sign of the disease.

Second Case of Lupus of Upper Air Passages treated by Radium—H. M. WHARRY, F.R.C.S.—A boy, aged 16, had suffered for several years from lupus of the upper air passages. He was first seen by exhibitor in June 1923.

Condition at that Date.—Nose—Lupus of right nasal fossa. *Fauces*—Lupus of uvula and anterior and posterior pillars of both fauces. *Tongue*—The whole of posterior segment was covered with extensive heaped-up granulations. *Pharynx*—Some scarring. *Larynx*—Epiglottis and both vocal cords and ventricular bands affected, also interarytenoid region. *Voice*—Hoarse.

He has had several treatments with radium, and the whole condition has much improved.

Sir ST CLAIR THOMSON said that lupus appeared sometimes to get well under any treatment, or even under no treatment. He had sent cases in early days to the Radium Institute, but did not get one cure. Anything which produced good scar tissue was generally a permanent cure. He still believed nothing secured this so well as the galvano-cautery. Mr Patterson's case was quite arrested under artificial light, but so was the other (Mr Wharry's) under radium. These two cases should be shown again. He had had cases which remained well for many years and then broke down.

The cautery needed several sittings. It was useful, when the lupus was threatening to come through from the nose into the skin, or from the mucous surface of the lip to the skin, to pass the cautery from the inside deeply; he had felt the cautery point almost coming through the skin. It produced fibrosis from the inner side and, if thus used, prevented the occurrence of external scar.

Mr HERBERT TILLEY explained that Sir St Clair Thomson's remark was the reason of his being reminded of a case which he (Sir St Clair) had once shown before the Section. The patient had very extensive lupus of the soft palate, pharynx, and epiglottis, but she got quite well after a stay of six months in the country, and without local treatment of any kind.

Mr NORMAN PATTERSON (in reply) said that for extensive lupus in the nose he obtained the best results from repeated curetting, rather than from the cautery.

Mr WHARRY (in reply) said that the radium treatment of lupus was only in its experimental stage. The case he showed was very extensive, and there had only been sixteen applications of radium. The local condition had cleared up remarkably. The patient had been very hoarse, but now spoke fairly well. In a previous case, after four years of silence, the voice had returned in six weeks. He intended to continue to send cases of the kind for radium treatment. This patient was now in the reactionary stage. During this stage the radium picked out every half-healed little

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patch of lupus, and made it obvious, when otherwise it could not be distinguished by the naked eye. He thought it was a satisfactory form of treatment especially in restoring function.

Removal of Thyro-Glossal Duct and Fistula; Ten Years after Operation—DAN M'KENZIE, M.D.—The patient is a girl now aged 16 years. The operation was performed when she was 6. It consisted in the removal of the fistulous opening and tract by dissection, the thick-walled duct being followed up to the hyoid bone, which was divided in the middle line. The skin incision was closed, it is to be noted, by the subcuticular suture, and primary union followed, the immediate scar being linear and inconspicuous.

As will be seen, the scar now is broad and ugly, and the operator confesses to disappointment. Obviously, what has happened is that the scar has not only kept pace with the natural growth in bulk of the neck, it has actually outstripped it. The moral seems to be that one ought to defer the removal of the thyro-glossal duct until adult life. After all, the deformity, even when a fistula is present, is but trifling.

Otherwise, the operation has been so far successful that no recurrence has taken place. Apparently the plan of dividing the hyoid, which has been recommended for these cases, may be relied upon. It is curious to observe, however, that in none of the cases in which I have operated has it been possible to trace the duct upwards into the substance of the tongue, still less as far as the foramen cæcum. It appears to tail off and come to an end just behind the hyoid. At all events the thick duct wall disappears at this point, apparently blending with the periosteum of the bone.

Mr H. J. BANKS-DAVIS (President) said he did not think there was much disfigurement in the scar. He referred to a case he showed of thyro-glossal cyst in a child, which he dissected out, closing up the wound with collodion. It healed by first intention, but two days afterwards she had a temperature of 104°, and a very rapid pulse. He had learnt now that if the wound in these cases was stitched up, thyroid secretion would escape into the blood stream, with resulting thyroidism. In all cases a tube should be inserted for the first twenty-four hours.

Case of Epithelioma of Maxilla cured (?) by Radium and Diathermy combined—ROBERT WORTHINGTON.—Male, aged 67, was first seen in October 1922. He had had "nasal catarrh" for many years, and for some months blood and pus from the left nostril. He had recently had some very carious septic teeth extracted from the left upper jaw, since when he had noticed a painful swelling in the left canine fossa spreading into the cheek.

He had obviously a suppurating left antrum, but I was uncertain if the swelling outside was inflammatory or new growth.

First Operation.—Intranasal antral operation. Tissue curetted

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from within antrum—section showed this to be granulation tissue. A piece of tissue was removed from the canine fossa—sections showed this to be *epithelioma.*

Second Operation.—In conjunction with Mr D. Miller Muir I treated the tumour in the canine fossa by diathermy. In the resulting cavity 50 mgms. of radium bromide were inserted packed in gauze and left for twenty-four hours.

Healing uneventful; outer wall of antrum and portion of alveolar margin separated as a sequestrum.

In January 1923 a nodule of growth appeared in the cheek. This was treated by two radium needles containing 33 mgms. radium bromide, introduced from within and left *in situ* thirty-one hours; this was followed on the next day by a dose 2/3 B. of X-rays filtered by 3 mm. aluminium.

The combined treatment resulted in a mild erythema of the skin as seen three weeks later. Six weeks after the treatment the recurrence had completely disappeared.

So far there has been no further recurrence.

Case of Syphilitic Cranio-tabes, simulating Frontal Sinus Disease—J. ALDINGTON GIBB, M.B.—Male, aged 15.

History.—Swelling over right frontal region, lanced by his doctor several weeks ago. Also small fluctuant swellings under scalp in vertex and occiput. Patient had been told he had got tuberculosis. Had an operation for removal of glands of neck seven years ago.

Family history.—Mother: one miscarriage; one child dead (breech presentation); one child healthy.

Condition on admission.—Ears: normal. Nose: sunken bridge. Throat, normal. All other systems: normal.

18th February 1924.—Wassermann reaction: strongly positive.

Treatment.—19th February 1924: Neo-kharsivan, 0.3 gram.; mercury inunctions; potassium iodide, gr. viij., t.d.s., p.c.

28th February 1924.—Swellings smaller: less fluctuant.

6th March 1924.—Neo-kharsivan, 0.3 gram. continued.

7th March 1924.—Temperature, 102.4° F.

17th March 1924.—General condition greatly improved. Frontal and occipital swellings now almost disappeared and barely palpable. Neo-kharsivan, 0.3 gram.

11th April 1924.—Neo-kharsivan, 0.3 gram.

13th April 1924.—Contramine, 0.25 gram.

Congenital syphilis of bone is not rare, but the particular form in which it appeared in this case rendered confusion with frontal sinus disease easily possible.

The case was first treated at the Ramsgate Hospital, and the incision seen between the supraciliary ridges was made there.

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The actual condition when seen by me was as follows:—

Well-marked swelling of supraciliary ridges and glabella, with some superficial fluctuation. At the margin of the hair in the middle line was a small fluctuant swelling, and similar conditions were present in the neighbourhood of the anterior and posterior fontanelles. The incisor teeth were not notched, but were wedge-shaped and suggested syphilis.

At first sight the condition might have been mistaken for one of frontal sinus disease, but my original diagnosis was syphilitic craniotabes, and the results of treatment have amply supported it.

Mr J. F. O'MALLEY said he had a case with swelling over the frontal sinus and disease in the nose. On incising the frontal sinus he came upon diseased bone, and he drained the frontal sinus. There was no satisfactory result over some weeks. Then he had the blood tested, and it gave a positive Wassermann reaction. On putting this man on to iodide of potassium, the condition cleared up.

Case for Diagnosis—CYRIL HORSFORD, F.R.C.S.—Male, aged 57, by occupation a carman, complained of hoarseness for one and a half years. No loss of flesh was noticed.

On examination.—Larynx shows irregular thickening of the right vocal cord with a granulomatous mass over posterior part of cord and an excavation or ulcer anteriorly. Left vocal cord mostly congested, but on apposition fits into the irregularity of the opposite cord.

Patient was sent to me without complete report from the tuberculosis department, St Pancras Dispensary.

Mr H. J. BANKS-DAVIS (President) said that there was obvious subacute laryngitis, quite apart from anything else.

Mr LAWSON WHALE said he had obtained a good view of the case, and saw a definite sessile-granulomatous tumour projecting from the middle of the right cord, something like the granuloma seen in tuberculous laryngitis.

Dr P. WATSON-WILLIAMS thought the case suggested diffuse pachydermia laryngis. He considered there was a definite humping over the anterior part of the left vocal process, and on the opposite side a deep notching of the vocal cord. Against that diagnosis was the appearance of cicatricial band or adhesion between the anterior sixth of an inch of the vocal cords in front, suggesting a previous ulceration. He suggested a Wassermann test, and asked if the case might be seen again. It might be the late result of syphilis, or some other ulcerative condition.

Dr L. POWELL said he saw the humping mentioned, and thought it might be exaggerated by the cord being missing in the posterior part. Recently he had had a similar case, and had nipped a piece off the hump; this relieved the breathing. He had sections cut, which were found to consist of fibrous tissue. The present case he considered to be syphilitic.

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Mr CYRIL HORSFORD (in reply) said that he saw the patient for the first time six days previously, and there was no evidence of tuberculosis. He thought there must have been some disease of the vocal cord previously, as there was a history of eighteen months of hoarseness; he did not suppose it was a growth during all that time. In the anterior part of the right cord there was an excavation, and in the posterior part corresponding, a firm and distinct swelling. The excavation was evident when the cords were opposed, and the right cord was much infiltrated. The congestion and slight irritation seemed to be due to the irritation of the lump on the opposite side. He thought it was a case of growth superimposed on chronic inflammation. Tuberculosis caused more destruction of the voice than this man showed: and malignant disease would produce a harder voice than the patient had.

He would have a Wassermann reaction done, and show the man again, carrying out no treatment in the meantime.

Postcript. — Since the Meeting the following notes have been obtained: "Wassermann reaction negative; slight evidence of phthisis both apices; tubercle bacilli in sputum."

ABSTRACTS

EAR.

The Psychology of Vertigo. W. F. MENZIES. (*Lancet*, 1924, i., 949.)

The author formulates the hypothesis that vertigo is a purely subjective sensation, and is the realisation in consciousness of the instinctive emotion of anxiety connected with the maintenance and adjustment of antigravity postures. He gives clinical examples of the emotional nature of the condition, and draws attention to the facts that the reaction time of vertigo is two to three seconds, and that hitherto no direct fibre connection has been traced between the vestibular nuclei and the thalamus. On this hypothesis he suggests that vertigo processes are: (1) a peripheral afferent stimulus, ocular, aural, or somatic; (2) a vestibular stimulus; (3) an adjustment response; (4) an emotion; (5) its realisation, consciousness. He states that vertigo "is rare in the dark," also that he "cannot pretend to any opinions concerning intra-aural states beyond the routine neurological examination." The latter statement excuses the fact that the paper does not square completely with the etiological concept of vertigo. MACLEOD YEARSLEY.

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