SOCIETIES' PROCEEDINGS

AMERICAN LARYNGOLOGICAL ASSOCIATION.

FIFTY-SECOND ANNUAL CONGRESS, SWAMPSCOTT, MASS., 22nd May 1930.

(*Abstracted from the Notes of Dr. Charles J. Imperatori by Walter Howarth.*)

DR. ROY A. BARLOW, Rochester, New York, in a paper on **A New Concept of Hysterical Aphonia**, said that the loss of voice, the inability to communicate with his fellow-man, is not only of economic importance but also a serious affliction to the patient. The aphonic condition may be the result of a sinister pathological invasion associated with other symptoms to fill out a clinical picture, and as such may be dealt with according to fairly definite rules, and procedure is not to be considered in this article other than in a manner of differential diagnosis. This message stresses a condition of aphonia of functional or hysterical origin.

Hysterical aphonia is a more modern phraseology than the older term "hysterical paralysis of the vocal cords." It is not and never has been a true paralysis of the vocal cords. It is an aphonic manifestation of a hysterical or unstable psychological background.

The result will follow one of three courses: two permanent and one temporary. The permanent routes of escape would be suicide or insanity. The temporary route would be "nervous breakdown" or some manifestation of an existing complex so presented as either to arouse sympathy or to render the patient unable to carry on either in whole or in part. It may be a functional paralysis, blindness, deafness, unconsciousness, loss of voice or any one of a number of clinical pictures. This, one must bear in mind, is not malingering—it is not the will of the patient—it is a true clinical picture rendering as much discomfort and anxiety as that due to a true pathological development. It is a product of the subconscious and beyond the control of the unfortunate victim.

The treatment, then, is essentially psychoanalysis. This form of therapy may not necessarily cure the patient, but it is unreasonable to believe that by local measures one can cure a condition that is deep-seated in its origin. Hysterical aphonia is a *symptom*.

Roentgen study has given rather a different mental image of the laryngeal changes in hysterical aphonia—primarily dispelling the older term of "hysterical paralysis." It also opens up possibilities of means and aids in the teaching of proper phonation and vocal training. Hysterical aphonia should signal to the laryngologist that the patient

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is failing to adjust himself to his surroundings, and it should be his duty to see that proper steps are being taken to prevent a recurrence of the disturbance.

DISCUSSION.

Dr. GEORGE L. RICHARDS, Fall River, Massachusetts.—Dr. Barlow seems to have gone further back in the etiology than most of us have done. He speaks about a certain class of case, the result of the high-pressure life we now lead. Is it the proper thing for us to send such a patient immediately to a psychoanalyst or to have a thorough physical examination, or to try to find what is the trouble? There is no pathological condition as you look at these patients objectively.

Dr. FRANK ROBERT SPENCER, Boulder, Colorado.—We see a number of girls, particularly between the ages of 18 and 20, in the University who have attacks of hysterical aphonia. As Dr. Barlow has intimated, some mental upset may be responsible for the condition. Many girls of 18 or 19 are suffering from hyperthyroidism. Dr. Barlow has intimated this in his paper; with the increased development of the brain and spinal cord in modern civilised races, and with the higher education and strain of civilisation, there must be some degeneration of the sympathetic nervous system, and he says that this is most often observed in women. He explains many of the neuroses that one encounters in the practice of medicine as due to this change. Change the patients' environments for a time and put their minds at rest regarding some worry, and the hysterical aphonia may often disappear in a short time.

Dr. ERNEST M. SEYDELL, Wichita, Kansas.—We must call all non-organic pareses of the larynx psychogenic. Psychogenic is not identical with hysterical; that is, a psychogenic person may not be hysterical. More than this, the hysterical reaction is subordinate to the psychogenic.

According to this author, any paralytic condition may be aped by a hysterical condition. According to Gaupp, one may divide these neuroses into two forms, the thymogenic, which is produced by fright, and the idiogenic, which may be caused by fear.

I think the thing that we must emphasise is that if you are going to bring back a patient's voice, it should be done at the first sitting. You must not give the patient up; you must not treat him for a little while, and then let him come back the next day. You must do everything you can for him the first time you see him.

Dr. WILLIAM V. MULLIN, Cleveland.—Experiments done on many dogs and obliterating many of the branches of the sympathetic nerves and the cervical ganglion did not change any movement of the cords. Clinically, I somehow feel that it does, and I think that the sympathetic nervous system enters a great deal into the classification that Dr. Barlow has reported. I do not believe that any form of hysterical aphonia will cause a cord to stay in midline.

Dr. MERVIN C. MYERSON, New York.—We all recognise, I think, that laryngologists are agreed that a successful laryngologist must mix a little psychology with his laryngology. That would lead me to say that we all appreciate that hysterical aphonia, when we see it, has a psychological

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basis. The matter of a laryngologist bordering on charlatanism when he uses local methods or local applications does not strike me as a fair statement, because I do believe that we give these patients a little psychological stimulus when we do something to them that is quite harmless. In order to make this study of real value, I should think that we ought to be able to state in some way how many cases of hysterical aphonia have been followed by insanity or suicide. Personally, I do not know of any.

Dr. ROBERT SONNENSCHEIN, Chicago.—According to Semon's Law, in a slowly oncoming paralysis of organic nature, it is always the abductors that are first involved. Later, when the nerve is completely out of function, all muscles are involved. In a functional disturbance it is always the adductor, the most powerful group of muscles in the larynx, that is first involved. It was Semon, as well as others, who called attention to the fact that these hysterical aphonias are parapareses, and not true paralyses.

In the treatment for hysteria one must have complete self-assurance in order to impress the patient with the fact that she will be cured. Therefore, a careful and accurate diagnosis is necessary, and then you can say to the patient "you will speak."

Dr. ROY A. BARLOW, Rochester, New York.—Dr. Richards spoke of these girls in their teens. That is just what I mean by the newer concept of hysterical aphonia. It dates back. Whether the patient is 50, 55, or whatever age she may be, as a rule the original disturbance dates back to the teens. It is that complex existing in the subconscious which for years has been held down by the censorship of the conscious mind that has allowed itself no expression until, finally, the constant bombardment of this impetus to get out and express itself ends in some visceral disturbance, whether it is a visual disturbance, hysterical deafness, hysterical loss of voice, paralysis of the arm or what not.

The normal individual is the person who can adjust himself to whatever circumstance or condition arises in life, and to carry on with the material and tools he has in hand.

I did not mean to imply that the loss of voice would be followed by suicide. My statement was to the effect that these hysterical manifestations were a method of escape from a dilemma, and that sometimes they might go on to the more permanent type of insanity or suicide.

DR. GEORGE M. COATES, Philadelphia, and DR. ROSS HALL SKILLERN, Philadelphia, in a paper on **An Enormous Abscess of the Frontal Lobe following Infection of the Frontal Sinus: Operation: Recovery**: said that a woman, aged 20, presented acute frontal sinusitis and œdema of the right eye and the forehead. The anterior end of the middle turbinate was removed. Incision was made above the eye. Some pus was found. Her condition gradually grew worse. After three weeks there was a sudden collapse. She was rushed to hospital in a semi-comatose state and had left-sided hemiplegia. There was a large amount of pus (about 4 oz.) deep in the frontal lobe. The lobe, including the diseased frontal sinus, was evacuated and

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thoroughly cleansed. The patient was returned to her room and began to show signs of returning consciousness. In a few hours she was again rational. On the next day the hemiplegia had disappeared. The temperature went down and the pulse rate increased. On the following day there were signs of meningeal irritation, but they were not severe. Recovery was uninterrupted.

DISCUSSION.

Dr. CORNELIUS G. COAKLEY, New York.—I think that the authors ought to be congratulated on the apparently wonderful results they got in this case. I say "apparently" because the experience that many of us have had with very large abscesses is that the patients apparently get well and a few months afterwards abscesses develop from just what the doctors tried to do and, we hope, succeeded in doing, namely thoroughly obliterate the abscess. I should be glad to get the report of this case one or two years from now. I hope that it is successful. The result has been wonderful so far as it has gone.

Dr. HENRY B. ORTON, Newark, New Jersey.—In Dr Eggleston's service in the City Hospital we have felt that all cases of fracture of the frontal sinus involving both plates will eventually lead to meningitis or an abscess of the lobe will appear. In every case in which patients come to us with a fracture of the frontal sinus involving both plates we expose the dura at that time.

Dr. JOHN E. MACKENTY, New York.—One never knows how long it takes to clear up an abscess of the frontal lobe. I had one patient who went six months following the evacuation of a large abscess of the frontal lobe to the frontal sinus; the patient eventually died of the abscess.

DR. HENRY L. SWAIN, New Haven, Conn., in a paper on **An Unextracted Foreign Body penetrating the Aorta of a Ten Months Old Infant**, said he had a slide of the roentgenogram, one of the specimens and a drawing of the latter showing how the crooked piece of fine wire had penetrated the aorta about the level of the fourth rib. This wound of the blood vessel was followed by the development of the false aneurysm which finally ruptured into the œsophagus with fatal results. The very much bent and crooked wire lay across the œsophagus, one end in the false aneurysm pointing upward, and the other horizontally through the wall of the œsophagus on the opposite or left side, protruding nearly half an inch at this spot. The wire was 3·5 cm. long. The false aneurysm bulged into and displaced the œsophagus to the left. The attempt at removal was baulked by the free bleeding which nothing stopped, and the displacement of the œsophagus which made orientation impossible. The foreign body was not seen. The impression was that it might have escaped into the mediastinum. The patient was in the hospital less than twenty-four hours but was ill with indefinite symptoms for ten days before entering.

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DISCUSSION.

Dr. HENRY B. ORTON, Newark, New Jersey.—I should like to ask whether œsophagoscopy should be performed in the presence of mediastinitis, or whether one should wait until such time as nature had tried to wall off the process and then make an incision in the chest. I am reporting the cases of six patients at the Bronchoscopic Society; one only is alive at the present time and in that case we waited.

Symposium on Allergy.

In a paper on **General Allergic Principles**, DR. JOHN A. KOLMER, Philadelphia, said that the general allergic principles consist in phenomena of allergy in man, the confusion in terminology and classification, the chemical nature of exciting agents, the mechanism of allergic reactions, the principles of diagnosis of allergic diseases by skin testing, and passive antibody sensitisation, the principles of treatment for allergic diseases by desensitisation, and the etiology and principles of diagnosis and treatment of hay fever, vasomotor rhinitis and asthma.

DR. FRANCIS L. WEILLE, Boston, in his paper on **The Pathology of Allergic Tissue as seen in the Nose and Accessory Sinuses**, said one hundred and sixty specimens of tissue were removed from the noses and accessory sinuses of twenty-six patients having asthma or vasomotor rhinitis, or both, and were examined grossly and microscopically. The most interesting gross observation was the presence of occasional pus pockets in the sinus membrane. The microscopical examination of the tissue showed: (*a*) at times, metaplasia of the type of epithelium; (*b*) possibly metaplasia of individual epithelial cells; (*c*) thickening of the basement membrane; (*d*) œdema or fibrosis of the tunica propria in two-thirds of the specimens; (*e*) very active mucous glands; dilated serous glands; (*f*) increased vascularity; no special smooth muscle hypertrophy; (*g*) prominence but not predominance of œsinophils as infiltrating cells in tissues of patients with asthma operated on once; (*h*) regeneration of all tissue elements in patients operated on twice; (*i*) marked contrast between "pale" and "red" mucous membranes in vasomotor rhinitis.

DR. HILL HASTINGS, Los Angeles, in his paper on **Allergic Conditions of the Nose and Throat**, said poor and incomplete histories are found almost universally, due to lack of time and carefulness. Too much reliance is placed on skin tests. The occurrence of eczema in babyhood points to food allergy in patients with hay-fever and asthma. Symptoms and physical signs were considered in detail as commonly met with. Stress was laid on purulent infection of the paranasal sinuses being secondary to, and not the cause of, the hay-fever and asthma in allergic patients. The

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discovery of the allergic cause and the treatment for this should precede all operative procedures; fewer nasal operations will result. The discovery of allergic reactions, comparatively recently, will most likely lead in the near future to explanation of other symptoms, such as vague rheumatic pains and neuralgia. Cases of nephrosis were mentioned in which periodic attacks of œdema of the soft palate rapidly subsided after simple irrigation of the infected antrums.

Dr. Harold G. Tobey, Boston, in his paper on **General Principles of Treatment**, said the treatment for illness caused by hypersensitiveness to foreign proteins may be directed along several lines, namely avoidance or removal of the specific cause, avoidance or removal of contributory cause, specific treatment with protein and symptomatic treatment. The treatment for pathological nasal conditions in relation to asthma is based on three hypotheses: 1. The pathological nasal condition is *per se* the cause of the asthma. 2. The pathological nasal condition is due to the same cause as the asthma and may be considered a part of the asthma. 3. The condition results in a greater permeability to the toxins that cause the asthma.

Discussion.

Dr. Henry L. Swain, New Haven, Connecticut.—Those of us who are normal can be bombarded by all kinds of pollens and all kinds of foods and do not have any trouble. The fellow who has the antibody has the trouble. Involuntary muscle fibres are exceedingly sensitive in allergic people, as is known to all of us clinically, because we can get such tremendous contraction by the use of epinephrine. Sometimes one removes great masses of tissue, and then when you get at the real allergic cause, you do not have to do any more of these operations. I have seen patients whose polyps disappear after removal of the allergic cause.

Dr. Arthur W. Proetz, St. Louis.—There are two types of membrane and they are easily demonstrable with the roentgenograms presented. In one type the membrane is vacillating; one day it is thick and the next day it is thin, the contours are concave, as you see on the right, and that membrane may be perfectly normal to-morrow. The other type is not nearly so thick, possibly only 2 or 3 mm., if as much, is quite smooth in outline, and does not rise and fall with the attacks. It is the same after an asthmatic attack as it was before. I think that the second type is, possibly, a true hyperplasia, and that if any result is to be obtained by operative procedure it is probably in that type and not in the other one.

Dr. James A. Babbitt, Philadelphia.—Dr. Hastings reminded me of a case that I wanted to allude to in this discussion. This was a case of nephrosis with rather marked allergic vasomotor rhinitis. Roentgen and other studies indicated involvement of the ethmoid and antrum. We operated on the patient, who got well. Four months later the child returned with the same degree of œdema and the same rather critical

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condition. Roentgenograms and studies indicated that further operative work should be done, but accidentally an abdominal condition set in and an abdominal operation was going to be performed in the surgical department. This precluded, for the time, any operative interference with the nose, and while simple measures were continued, nothing further was done. Within three or four weeks the child became well again, the swelling disappeared, and the patient left hospital.

Dr. WILLIAM B. CHAMBERLIN, Cleveland, in his paper on **Dysphagia of Septic Origin resembling Foreign Body in the Œsophagus,** said that a detailed case history of a child aged $5\frac{1}{2}$ years is given. Inability to swallow and some hoarseness is manifest. There was a moderate temperature with one high rise following a peritoneal infusion.

Roentgenograms taken of the œsophagus were unsatisfactory and the contrast mixture promptly regurgitated. Later on the patient developed definite pneumonia of the right lung followed by mastoiditis. He recovered from the pneumonia and the mastoiditis. A small feeding-tube was introduced through the nose so that he could be fed. Within six weeks after the onset of the dysphagia and a clearing up of all his other symptoms he began to swallow. The throat was negative to Klebs-Löeffler bacilli and there was no evidence of poliomyelitis. It would seem that this was a functional paralysis, but the exciting cause was undetermined.

DISCUSSION.

Dr. BURT R. SHURLY, Detroit.—There is a close relationship between the laryngeal muscles and the muscles of deglutition, and one of the things that one should not forget is that wonderful and marvellous psychic relationship that one sees constantly in patients of this type.

Dr. MERVIN C. MYERSON, Brooklyn.—I would offer the suggestion that perhaps because this child had pneumonia that was localised to the hilar area, he very likely had pleurisy of the mediastinum, which may have been responsible for a periœsophagitis which caused a spasm of the œsophagus.

Dr. LOUIS M. CLERF, Philadelphia.—I saw a patient whose complaint was difficulty in swallowing. Œsophageal studies both by the Roentgen rays and by the œsophagoscope were negative. The patient died within a few days, but no definite conclusions were reached as to diagnosis.

Dr. HENRY L. SWAIN, New Haven, Connecticut. — To me, the tremendously interesting feature of the report is the age of the patient. I have never known of anyone so young who has had either spasm or difficulty in swallowing of that type except the two types mentioned by Dr. Chamberlin—diphtheritic paralysis and the oncoming of poliomyelitis.

This type has always interested me because the man with whom I worked as a student in Germany was about the first who ever had, to my knowledge, any physical explanation of the globus hystericus, and it was he who called attention to the fact that the lingual tonsil is enlarged but,

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what is more to the point, that the tremendously large plexus of blood vessels on which the lingual tonsil lies is capable of considerable engorgement, and during that period of engorgement one has difficulty in swallowing.

The Pathology of Chronic Accessory Sinus Diseases. A paper on this subject was read by Dr. ANDREW A. EGGSTON of New York. In brief, the article consisted of an attempt, based on the study of surgical specimens, to explain the pathological processes involved in the production of chronic accessory sinus disease, based on the vascular changes in the tissue involved; these vascular changes resulted in three types of pathological changes:—1. The hypertrophic or polypoid type of sinusitis results from phlebitis and lymphangitis, with an inflammation of the adjacent perivascular stroma. An obstruction of the proper drainage of the parts results in turgescence and polypoid formation. 2. The fibrotic or atrophic types are due to a fibrosis secondary to arteriole inflammation and a loss of the blood supply and nourishment to the tissues with replacement fibrosis. 3. In the third type a mixture of hypertrophy and atrophy exists in the same sinus, resulting in rugae or sulci, producing the so-called papillary type of membrane. In this instance, there is involvement of the venules, lymphatics and arterioles.

DISCUSSION.

Dr. JOSEPH C. BECK, Chicago.—A great deal of work has not been done along the line of histological changes in conditions of the nose and throat, and this presentation, I think, will stimulate many men to do this type of work.

The presentation of histological specimens in black and white, as presented, is valuable but it is not to be compared with tinted specimens. The latter are of much more value.

Dr. RALPH A. FENTON, Portland, Oregon.—May I ask Dr. Eggston if, in his judgment, the occurrence of a perivascular infiltration may not often be the indication of a defence reaction rather than of a process already degenerated?

Dr. FRANK R. SPENCER, Boulder, Colorado.—I should also like to ask Dr. Eggston whether some of these changes account for the fact that certain percentages of patients with sinus changes really have to be operated on, and whether the changes in the bone are responsible for the continuation of the sinus disease.

Dr. HENRY L. SWAIN, New Haven, Connecticut.—I understood Dr. Eggston to say that the osteoblasts, when they cannot get their proper supply of calcium from the blood owing to inflammatory change, take the calcium from the bone and, therefore, the osteoblasts become osteoclasts in a certain negative phase. Do the osteoclasts ever become active and keep on taking calcium from the bone even if more calcium appears in the blood?

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Dr. FRANK B. KISTNER, Portland, Oregon.—Perivascular infiltration should lead one to suspect that the tissue is syphilitic, but we have many cases in which by no clinically diagnostic means could we say that the patient had syphilis. I think that the perivascular fibrosis is characteristic of a long-standing infection, whether it is a purulent sinusitis or a non-purulent sinusitis.

Dr. E. ROSS FAULKNER, New York.—It is interesting that the microscopical observations in these conditions correspond accurately with the gross observations. After all, inflammatory processes everywhere are a vascular phenomenon, and the end-results during the course of an inflammatory process vary a great deal according to the tissue involved. While there is no exact analogy of paranasal sinuses in other parts of the body, the inflammatory process is really carried on in about the same way as it is elsewhere.

The syphilitic infection is characterised by inflammatory changes leading to sclerosis or fibrosis, wherever it occurs. The tuberculous process is characterised by peculiar softening, a specific process which breaks down into a cold abscess. The pus organisms, depending somewhat on which tissue is involved, produce various changes such as necrosis. If the process is in a dense, bony tissue, or if it is in a dense fibrous tissue, a carbuncle forms in the cancellous bone; it will also produce necrosis, depending on the severity of the inflammation. There is no question but that infections in the nose have varying characteristics, not only in their acute phenomena but also in their end-results. There are some acute infections in the nose that produce strange pathological changes which are never recognised. The general practitioner believes that any acute process in the nose is accompanied by an acute coryza. This is not the case. One of the strange pathological changes that occur in the nose in a virulent streptococcal infection is often a dry nose with practically no coryza, and no secretion, until perhaps at the end of four or five days or a week.

Dr. ANDREW EGGSTON, New York.—Most of the tissue was taken from private cases that have been thoroughly worked up and in all of whom a Wassermann test had been done. I admit that one of the cases with arteritis with perivascular mononuclear cells is rather typical of syphilis, but in that particular case the Wassermann reaction was negative, and as far as we know the patient did not have syphilis. There are reactions that simulate syphilis. I think the fact that syphilis will produce destruction in the nose becomes an argument in favour of the vascular changes, particularly the arteriosclerotic changes, being the basis of a great deal of the pathological changes that take place in the nose.

Someone asked whether the perivascular reactions were thought to be a defence reaction. I think that they are, particularly in acute inflammation.

There is a great deal of argument about osteoblasts and osteoclasts in their particular function and histologists do not know much about it. They know that the cells have something to do with the ducts and the absorption of bone. Some say that they are entirely different cells; some say that they are one and the same cell, which with the physio-

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chemical changes will adopt one function or the other. Certainly the osteoclasts will retain bone and take away calcium. Whether they will do that and whether or not there is a decreased amount of calcium in the body I do not know.

A paper on **The Displacement Method Diagnosis of Conditions of the Sinus and Treatment: Its Advantages and Limitations** was read by Dr. ARTHUR W. PROETZ, St Louis, who said the method consists in the introduction of fluids into the sinuses either for treatment or for diagnosis, and has not been changed since the first presentation. The use of radiopaque oils has been supplemented by a special and definite technique of radiography and interpretation which is presented in detail.

DISCUSSION.

Dr. FRANK R. SPENCER, Boulder, Colorado.—In a man who had been severely kicked on the forehead, a badly infected frontal sinus and, subsequently, a frontal lobe abscess developed. During the course of treatment iodized poppy-seed oil, 40 per cent., was used for injection into the frontal sinus and it spread back into the abscess of the frontal lobe, the ventricles, and the spinal cord. Shortly after this meningitis developed. The interesting feature of this case is that the patient made a complete recovery, or an apparently complete recovery, after a rather stormy attack of meningitis.

Dr. HENRY M. GOODYEAR, Cincinnati.—Late in 1925 we started using iodized poppy-seed oil, 40 per cent., in making the diagnosis of sinus conditions, especially of the antrums; the method that was then used is still followed. The antrum is usually filled through the normal opening with a double curved cannula and, with the head bent, is filled as full as it can be until there is some return. While it is being filled the number of cubic centimetres that go in from the syringe are measured and counted, so that one can often tell something about the sinus from the number of cubic centimetres that enter the antrum, *i.e.*, it may hold only 2 c.c. or 3 c.c., so that one is reasonably sure there is something in the antrum taking up the space that should be occupied by the oil. If the sinus holds from 15 c.c. to 30 c.c., as it occasionally does, one is fairly sure that the antrum must be normal.

Dr. Proetz did not say much about filling the frontal sinus. It is rather difficult to fill, but by placing the patient's head in the knee-chest position, dropping the oil into the nose (getting the patient to hold the nose and draw back—thus creating a vacuum) one can get bromipin to run into the frontal sinus. It can then be plugged with cotton-wool to keep it from running out, or, if the opening is very small, oil may remain in the sinus after the X-ray pictures have been taken. That is one way to do it. Another way is to seat the patient in the chair with his head bent until it touches the stool; then drop in the oil.

As far as using the displacement method in the sphenoid is concerned, all our cases have been done by directly filling the sphenoid sinus, *i.e.*, putting a cannula right into the sinus.

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As far as the ethmoids are concerned, a great deal of work, and very careful work, is required to get satisfaction out of displacement diagnosis in the ethmoid condition.

Dr. RALPH A. FENTON, Portland, Oregon.—I should like to ask Dr. Proetz if he has had, in addition to the allergic phenomena from various oils which I think some of us have noticed in using this excellent method, an exacerbation of thyroid symptoms in susceptible people. We have happened, by chance, to see two persons in whom thyroid symptoms seemed to be intensified by the iodine-containing oils.

Dr. WILLIAM B. CHAMBERLIN, Cleveland.—I should like to ask Dr. Proetz two questions. In the first place he spoke of not using any astringent in the nose, such as ephedrine or epinephrine, in order to secure a better dilatation of the opening. I should like to ask what his definite objection to that method is.

Secondly, he spoke of treatment for accessory sinus disease by this method, and in the treatment the only drug to which he referred was ephedrine. If such is the case, why should we resort to the displacement method? Why could not he accomplish as much by simply packing the nose with epinephrine, following it with ephedrine alone. Evidently the ephedrine has no efficacy other than the promotion of drainage.

Dr. FREDERICK M. LAW, New York.—We have used iodized poppy-seed oil, 40 per cent., at the Manhattan Hospital a great deal, with a great deal of success. We find the injection method more satisfactory. One should learn to read plates or films stereoscopically.

Dr. Eggston's contribution describing the types of changes occurring in the periosteum in the bone is distinctly and clearly shown in every perfectly taken roentgenogram of the sinus. Learn the technique of the roentgenographer, and together you will determine a diagnosis that will not, in many cases, necessitate the injection of opaque fluid.

Dr. ARTHUR W. PROETZ, St. Louis.—Dr. Law will be as surprised as anybody to hear that I do not think you can tell as much about a sinus without iodized poppy-seed oil as you can with it, if a careful study is made, that is as far as the topography is concerned. When I talk about iodized oil in connection with displacement I refer particularly to drainage time, and we can learn a great deal about the physiology and pathology of the sinus in an individual case from the drainage time than can be learned merely from the topographical information we get from iodized oil.

In answer to Dr. Fenton's question about the effect on thyroids, I have never, in any case under my own observation or under the observation of those with whom I have been in contact, seen any effect on the thyroid.

Dr. HENRY M. GOODYEAR, Cincinnati, in a paper on **Psammoma (Brain-Sand Tumour) removed from the Nose** said Psammoma —or "brain sand" tumours—probably always originate from the meninges; rarely do they extend through the cribriform plate into the nose. Microscopically the tumour appears to be made up of many small concentrically laminated calcareous deposits.

The tumour described was removed in two operations. First by an

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intracranial operation (Dr. George Huer) with the closing of the dura by a transplantation of fascia lata and, secondly (eight months later), by an external opening of the ethmoid area (Dr. Goodyear). Vision, which was practically gone, returned within twenty-four hours and headaches ceased.

Psammoma in this area might most commonly be confused with osteoma and epithelioma. The author cited two cases of the former and one of the latter in which he operated on the patient by an external exposure of the ethmoid region.

VIENNA LARYNGO-RHINOLOGICAL SOCIETY.

MEETING OF 4TH NOVEMBER 1930.

(*Monatsschrift für Ohrenheilkunde*, January 1931.)

Abstracted by ALEX. R. TWEEDIE, F.R.C.S.

Case of Tonsillectomy with Unusual Complication—Dr. REVAY.—A woman, aged 23, was operated on under local anæsthesia for tonsillectomy on account of recurrent sore throats.

Local anæsthesia was induced in the usual way, that is to say, two injections of novocain were made in the anterior pillar of the fauces, one injection in the plica and one injection through the posterior pillar of the fauces. There was no difficulty in the operation itself and very slight bleeding, but, four days after the operation, the patient complained of a sudden discomfort in swallowing and pain in the throat. On examination, a swelling was found in the submaxillary region tracking down to about the middle of the neck, tender on pressure, whilst internally there was a diffuse swelling extending to the left lateral pharyngeal wall, with œdema of the uvula and epiglottis and corresponding ary-epiglottic fold.

The temperature was 38·8° but fell during the night when the patient expectorated a large amount of pus—the precise origin of which, however, could not be determined.

In the exhibitor's opinion the infection resulted from the injection of novocaine and not from the infection of the wound itself.

In the discussion which followed, the general opinion was to the effect that such post-operative abscesses and cellulitis were due to failure to restrict the injections of novocaine to the immediate tonsillar area.

Cyst of the Naso-pharynx with Secretory Middle-Ear Catarrh — L. FORSCHNER. — A young man was shown, who had complained at the hospital of impaired hearing in the right ear for two years for which he had received repeated special treatment.

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