Mr. Herbert Tilley thought that there was no doubt that the laryngeal growth was malignant. He pointed out that the anterior part of the *left* cord was quite white and the posterior red.

Sir Felix Semon thought it a beautiful case for laryngeal fissure. Without doubt it was malignant. The sooner the operation was performed the better would be the chance for the voice afterwards. He agreed that a Wassermann test should be taken.

Sir StClair Thomson said that it was doubtless clinically malignant. He raised the question as to whether the white on the opposite cord was white froth or was due to a little thickening there.

[*Postscript.*—Wassermann reaction negative. No improvement with potassium iodide—slow, but steady increase of growth up to this date, April 20. Patient has refused operation.—C. Horsford.]

INTERNATIONAL CONGRESS OF MEDICINE.

London, 1913.

Otological Section.

Mr. A. Cheatle, *President, in the Chair.*

Abstract Report by Dan McKenzie.

Pharyngeal Drainage of Cranial Suppuration of Otitic Origin.[1] —**P. Jacques** (Nancy).—Retropharyngeal abscess secondary to ear suppuration should be regarded as of critical importance. Three cases were narrated. One was a girl, aged three, in whom acute middle-ear suppuration led to osteitis of the floor of the tympanum followed by severe hæmorrhage from the meatus which was controlled by packing. Unilateral swelling of the pharynx appeared soon afterwards which when opened gave vent to a rush of venous blood. Tracheotomy and packing of the pharyngeal cavity had to be performed. In spite of a fresh and copious hæmorrhage the child recovered after a sequestrum of the tympanic floor was got rid of. The convalescence was interrupted by temporary paralysis of the pharynx and tongue due, it was supposed, to neuritis of the hypoglossal and of the nerves in the foramen lacerum posticum. The second case was that of a man, aged fifty, who was operated on for acute mastoiditis of a few weeks' duration. Drainage of the mastoid cells and antrum was found to be insufficient and the radical operation was therefore performed. Still the fever and constitutional symptoms persisted. A few days later an œdematous swelling appeared above the root of the zygoma. The retro-auricular incision prolonged forward towards the temple revealed a fistulous opening in the squama leading to an extra-dural focus of granulation tissue through which a sound passed towards the sphenoidal lobe without resistance. Discharge of non-purulent cerebro-spinal fluid followed. The symptoms still continuing, the bone of the squama between the fistula and the mastoid

[1] See also Journ. of Laryngol., Rhinol., and Otol., January, 1915, p. 12.

https://doi.org/10.1017/S1755146300015213 Published online by Cambridge University Press

antrum was removed, in the course of which an abscess sac was evacuated in opening the antral roof. The pyrexia still persisted and the patient now began to experience pain towards the neck, with torticollis and deep sub-occipital puffiness. Incision and exposure of the base of the skull showed pus issuing from the cranium within the digastric fossa. The bone was cleared as far as the stylo-mastoid foramen and the occipital condyle posterior to the foramen lacerum. A few days later, while the temperature was falling dysphagia was experienced and an abscess in the lateral pharyngeal wall behind the posterior faucial pillar was discovered and opened. Recovery with some stiffness of the neck and difficulty in swallowing. The third case was that of a woman, aged forty-six, who developed acute otitis media and mastoiditis necessitating first the cortical then the radical mastoid with exposure of the lateral sinus. Torticollis supervened, with pain on pressure over the nape of the neck, showing a tendency for the suppuration to wander under the occipital bone. Later, dysphagia and the discovery of an abscess in the wall of the pharynx. This was opened and proved sufficient to drain the sub-occipital focus. Recovery with slight stiffness of the neck.

Retropharyngeal abscess may develop in two ways: First, directly along the petrous bone from the tympanum; secondly, indirectly, and consequent upon abscess formation secondary to the focus in the ear itself. The above cases exemplify the second of these methods. In these and similar cases a collection of pus forms under the occiput deep to the digastric groove and muscle, reaching that region from an extra-dural abscess of the cerebellar fossa. From this point in most cases the pus tends to infiltrate posteriorly towards the back of the neck, but in a few cases a weakness of the aponeurotic barriers, due to the passage through them of a vein, which the speaker described, permits the pus to gravitate towards the pharynx. The speaker suggested that in these cases an effort made to guide the pus towards the pharynx by raising the periosteum from the inferior aspect of the occiput after resecting the apex of the mastoid process and ligaturing the occipital artery might be advantageous, as pharyngeal drainage quickly cured these sub-occipital abscesses.

In reply to a question, Prof. Jacques agreed that retropharyngeal abscess was sometimes due to jugular phlebitis and sometimes to osteitis of the atlas or axis, both of which conditions had to be excluded before or during operation.

Secondary Suture after Simple Resection of the Mastoid Process.—Holger Mygind (Copenhagen).—This method, which was described by the speaker in full detail and illustrated by cases, consists in curetting away all soft granulations in the bone cavities, in mopping them out with iodoform gauze, and in permitting them to fill with blood. The edges of the skin wound are then undercut and brought together by Michel's clamps. The method is thus a modification of the blood-clot dressing. Naturally it is suitable only in cases which are free from any complication and in which the wound and the skin around it are quite healthy. The method was tried in ninety-one cases, mostly children and in twenty-four the blood-clot suppurated, and the wound had to be re-opened; in forty-two cases the healing was ideal. The method can be adopted in from eight to twenty days after operation.

Prof. Moure (Bordeaux) had for years practised closing the wound, leaving a drain into the antrum. By so doing cure results in three or

https://doi.org/10.1017/S1755146300015213 Published online by Cambridge University Press

four weeks. Should the wound become septic, the sutures can be divided and the skin re-united later on if necessary.

Prof. KUBO (Japan) practised regularly secondary suture after the simple mastoid operation in from one to three weeks after operation. Primary suture he found to be dangerous, as a concealed focus of pus may remain.

Dr. GORHAM BACON (New York) employed the method advocated by Mygind. The blood-clot method with immediate suture he had abandoned. He had found the blood-clot method with secondary suture useful after the radical mastoid when healing was slow.

Dr. F. L. JACK also disliked the primary suture over blood-clot, but Mygind's suggestion seemed to him to be more promising.

Prof. ALEXANDER (Vienna) recommended sterilised wick drains and dressings of antiseptic gauze, frequently changed so long as discharge is profuse.

Prof. FERRERI (Rome) employed primary periosteo-cutaneous suture in acute staphylococcus and pneumococcus mastoiditis limited to the mucosa of the antrum and not affecting the bone. In all other cases secondary suturing was employed when the granulations were healthy, and the loss of substance had not been excessive.

Prof. DENKER (Halle) warned against primary suture in cases where the operation had taken place before all the cells had been converted by the disease into one single cavity. In two such cases he had seen deep extra-dural abscess develop with erosion of the posterior semicircular canal.

Prof. MYGIND, in reply, said that in his experience, the microbic character of the infection had no influence on the healing process. He thought, also, that it was as easy to get primary healing in large osseous wounds as in small ones.

Osteomyelitis of the Petrous Bone.—L. Bar (Nice).—At times, in the course of acute or chronic suppuration of the ear, or even without any foregoing disease at all, osteomyelitis of the petrous bone manifests itself. The period of invasion is, as a rule, very short, and it is followed by a slower but progressive advance of the bone disease, and that even after the primary focus has been removed by operation. It is most commonly found in children and young people, presumably because the vascularity of the bone in early life provides a predisposing cause. The disease may advance to affect the whole of the skull-cap. Even when confined to the petrous region it is no less dangerous. Sometimes it is rapidly fatal, leading in the most serious cases to involvement of the facial canal, the dura mater, the lateral sinus, and the brain. Its progress is remittent in character, with a period of quiescence after each surgical intervention, but tending finally to a fatal issue because of the difficulty of eradicating the bone-infection. The speaker reports two cases.

(*To be continued.*)

https://doi.org/10.1017/S1755146300015213 Published online by Cambridge University Press