Dr. H. J. Davis did not think anything in the method of drainage of the abscess had had very much to do with the patient's recovery when she was at the point of death. He thought the intra-spinal injections of serum had been invaluable in this respect.

Anatomical Preparations of the Temporal Bone, in situ.—G. J. Jenkins.—Mr. Jenkins showed the bases of three skulls in which the temporal bones had been dissected from the middle and posterior fossæ. These dissections showed the relation of the middle-ear tract and external auditory meatus to the middle fossa. The labyrinth was shown in some cases with its dense capsule intact—the diploetic bone removed—and he held that the thickness of the capsule of the vestibular element was not sufficiently appreciated, as in most dissections he had seen this dense bone had been largely removed. In these specimens the relation of the seventh cranial nerve, geniculate ganglion, carotid artery, lateral sinus, and other soft parts could be demonstrated. In other dissections half the wall of each of the semicircular canals had been removed to show the relation of the canals to one another on the same and opposite sides. He pointed out as important features that the canal did not lie in a single plane, but was twisted on itself to lie in multiple planes, and also that these canals vary in different specimens as regards actual plane relation to one another and to planes of the skull.

ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

May 1, 1914.

Dr. D. R. Paterson, *President, in the Chair.*

Pharyngeal Pouch.—Sir W. Milligan.—X-ray photographs of pharyngeal pouches in three patients, aged respectively fifty-five, fifty-four and sixty-three, were exhibited.

The President asked whether the patients had been operated upon. He reminded the Section that there had been two or three cases shown by Dr. Kelson[1] and others. Dr. Kelson had operated upon his under local anæsthesia, and had a very good result. The danger was from septic trouble.

Sir W. Milligan replied that he had brought photographs of four cases. Three had been operated upon, and the fourth was being prepared for operation, but was not yet ready because he suffered from carious teeth, and the general condition of the mouth was not as it should be. External operation had been done on the three, and the pouch removed, and these patients all recovered. He had had one fatal case, due to septic pneumonia. He thought it was owing to an error in judgment in removing the feeding tube too soon, for it seemed to have been ingestion pneumonia. Altogether he had seen seven such pouches. The first case he had placed under the care of the late Sir Henry Butlin, and it was the third pharyngeal pouch which had been operated upon in this country.

[1] Journ. of Laryngol., Rhinol. and Otol., vol. xxix, p. 98.

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

The diagnosis in that case was originally cancer of the œsophagus, but he did not agree with it, neither did Sir Henry Butlin. The patient was still alive, and his age was now eighty. He was indebted to Dr. Hill for calling attention to Halstead's operation. He had not yet performed it. In his series of cases the operation was done at one time. The wound in the œsophagus was as carefully sewn up as possible, and a tube passed through the nose beyond the point of the operation, and kept *in situ* for a week. In the first case he saw with Sir Henry Butlin the wound leaked into the neck for days, but no harm resulted. He felt inclined to do a Halstead's operation in his next case.

Carcinoma of Œsophagus.—Sir W. Milligan.—X-ray photographs of carcinoma of the œsophagus in two patients, aged respectively forty-nine and seventy-one, were exhibited.

Removal of Foreign Bodies from the Œsophagus.—Sir W. Milligan.—(1) *Safety-pin removed from the œsophagus of female patient, aged twenty.*

(2) *Safety-pin removed from the œsophagus of a female patient aged twenty-five.*—Patient arrested for being drunk and disorderly. At police station confessed to having swallowed a button. Button passed ultimately *per rectum.* Two days later had a rather severe attack of bleeding from the throat, followed upon the next day by a still more copious hæmorrhage. Confessed then that she had also swallowed a safety-pin. Admitted to the Royal infirmary. On examination, œsophagus found to contain blood and a safety-pin—the safety-pin lying about the level of the sixth dorsal vertebra. Safety-pin removed with forceps. Œsophagus sponged with solution of H_2O_2. Rectal feeding. Temperature chart shown. Development of acute suppurative mediastinitis; death. *Post-mortem* examination revealed two ulcers leading through the wall of the œsophagus into the posterior mediastinum.

The PRESIDENT said it was difficult to remove a safety-pin with the point directed upwards, and he would like to know what form of forceps was used. If one could see the point it was well to do as he did in one case, pass a very fine tube over the point, and then not trouble further about the point, but seize the other portion of the pin and withdraw it, knowing that there need be no anxiety about the point. When the point was embedded it was somewhat difficult to manipulate the tube over it.

Mr. HERBERT TILLEY asked how the point was disengaged, and whether Sir W. Milligan closed the safety-pin first.

Sir W. MILLIGAN replied that he used what was practically the President's type of forceps, only longer, heavier, and thicker. They were excellent. For some cases it would be an advantage to have the blades serrated. He passed down the pharyngeal tube so as to cover the point of the pin. In Case 1 he saw the point distinctly, but not in Case 2. He had read of the President's method too late to apply it in this case.

Carcinoma of the Thyroid Gland treated by Radium.—Sir W. Milligan.—Female, aged fifty-six. Operation attempted and found impracticable owing to adhesion to and involvement of the growth in the left common carotid artery and the lateral wall of the trachea. A radium emanation tube (100 mg.) inserted into the growth and left *in situ* for twenty-four hours. Shrinking of the growth noticed within forty-eight hours followed by improvement in swallowing and in general comfort. A microscopical section was exhibited.

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

Inoperable Fungating Carcinoma of the Œsophagus treated by Radium.—Sir W. Milligan.—Male, aged thirty-six. Treated by means of a radium emanation tube (80 mg.); tube retained *in situ* for eighteen hours, followed three days afterwards by a further application of radium (50 mg.) for twenty-four hours. Marked improvement in swallowing; diminution of fœtid secretion and of hæmorrhage.

Sir Felix Semon said he recently saw an operation performed by Mr. Trotter, in which an extra-laryngeal carcinoma was removed, and by the urgent wish of the patient himself a tube containing 80 mg. of radium emanation was inserted in the place from which the growth had been taken. The operation was beautifully performed, but at first the results were apparently disastrous, because all the tissue round the radium tube melted away like butter in the sun, and the carotid was seen pulsating, lying in a big hole, which extended almost from the clavicle to above the larynx. It was feared that the disintegration of tissue might extend into the chest, and that the carotid might be eroded, but that did not occur. However, unfortunately the patient got pneumonia, from which he died on the ninth day after the operation. Thus the mere insertion of radium emanation in a wound in that neighbourhood was not free from risk. With regard to insufficient screening, the radium emanation and screening were prepared by Mr. Pinch, of the Radium Institute, who had had a very large experience in such matters.

Mr. Harmer said that at his hospital radium had been buried in several cases for carcinoma, either because of glands or of growth in the pharynx, and there was very grave risk that the wound would never close. Two months ago he put some radium in a patient's neck after removing a mass of glands because there was a growth in the mediastinum which could not be removed; 150 mg. of radium were buried in that growth and left there for eighteen hours. Afterwards the wound absolutely refused to heal, and nothing that could be done seemed to influence its indolence. He feared that mediastinitis would result, and possibly death. It should be recognised that there was a difference between applying radium down through the throat and radium buried from the outside into the neck. He believed that radium buried from outside sometimes had a bad effect.

Mr. Somerville Hastings said he had had experience with radium in some sixteen or eighteen cases, but in only one was there sloughing, and that was where he had not taken the trouble to clear out the mouth, but had left some septic teeth remaining. In that case the sepsis came on in the third week after the application. For the œsophagus he had sometimes embedded radium in the posterior wall. But his usual method was to pass a Symonds's tube through the growth and then take the radium tube, cover it with pure india-rubber, and, guided by the œsophagoscope, drop it into the Symonds's tube, attaching a piece of lead to the top of it to prevent it slipping too far down the tube. It kept in position very well, and could be pulled up again quite easily by the attached silk. He found that by this means he was able to keep the radium in the required position much more easily than by means of the usual bent wire arrangement. Moreover, the silk was much less irksome to the patient than the wire. He dilated with the œsophagoscope tube in position and then passed the guide before withdrawal of the œsophagoscope. The Symonds tube or funnel was then threaded over the guide and pushed down the œsophagus the necessary distance.

Sir StClair Thomson asked whether any member had ever had a

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

successful case of operation for carcinoma involving the thyroid, taking as a standard of success the absence of recurrence for three years. He had not found a case suitable for operation, and he had frequently persuaded subjects of this condition not to have an operation done. In some cases in which that advice was not followed he knew there was cause to regret it.

The PRESIDENT reminded members that several discussions had ensued at the Section on the treatment by radium. One case of Mr. Tilley's was very satisfactory, so that there was nothing to see when the patient appeared at the Section. Mr. Hastings also showed one patient, who was now well. The present type—namely, the œsophageal ones—seemed more difficult to treat. Information was still needed as to the ultimate effect in these œsophageal malignant strictures. One wanted information as to how long the effects of radium lasted; whether the result of the application was only temporary or permanent. Reference had been made that day to some evil effects of radium, at all events of burying radium in the tissues. The application of this substance should be made with care when dealing with the food passages or air passages. The whole question appeared to be yet in a fluid condition; more information was required before definite views could be formed.

Sir W. MILLIGAN, in reply, said he was referring, not to the use of a radium salt, but to the use of emanation tubes. The point was to get the effect of the γ-ray, and exclude the deleterious effect of the α and β rays. He therefore agreed with Dr. Hill as to the necessity for careful screening. But that was difficult on account of not being able to estimate properly the size of the growth in these regions. A perspective view of the growth might be deceptive. Much remained yet to be learned in regard to screening. In answer to Sir Felix Semon's remarks, he regarded it as impolitic to irradiate healthy tissue. In the case narrated by Sir Felix, a tumour was apparently beautifully removed, and presumably completely, by the operation, and yet the healthy tissues were irradiated, and sloughing resulted. Mr. Tilley's case was sarcoma, and if there was one condition which disappeared quickly under radium it was sarcoma. It was quite different with carcinoma, and even now the exact dosage of radium for different types of carcinoma was not known. In several years' time probably the profession would have definite information as to dosage for different types. He agreed with Sir StClair Thomson's remark as to malignant disease of the thyroid. He had seen a fair number of such cases, but he did not know of any one, whether operated upon or not, which was alive three years afterwards. It was difficult to determine whether the thyroid was adherent to the trachea. The lady referred to was examined by two or three of his colleagues, and it was thought that the growth was not adherent to the trachea. When he cut down and found it was adherent he gave up the operation, knowing how unsatisfactory these cases were. For that reason, also, he put in an emanation tube, and it had a very extraordinary effect in relieving the symptoms, though he did not expect that it would do more than that. Certainly it had increased her comfort both in swallowing and breathing. With regard to the other case, since he wrote the note the patient had died. He had acute pericarditis, with much effusion into the pericardium. He did not know whether it was connected with the application of radium or not. The patient was an old rheumatic subject, and had had endocarditis. He had only three days' illness. In his case the radium was well worth using, because it relieved his condition so much. The emanation tube was kept in twenty-four hours, and he

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

had no attack of hæmorrhage after its application, and within a few days the pain in his ear had disappeared.

Laryngeal Neoplasm.—W. Jobson Horne.—The patient, a woman, aged fifty-two, had suffered from loss of voice for over twelve months. The aphonia gradually developed. The neoplasm sprang from the anterior part of the larynx. The patient was by no means an easy subject for direct or indirect laryngoscopy. The mouth was not opened well, and the tongue was thick and unyielding. With a little training he hoped that it would not be necessary to fall back upon the direct method. When removed the growth would probably be found under the microscope to be innocent.

Mr. Clayton Fox thought it was an œdematous hyperplasia, springing from the anterior end of the left vocal cord, and not from the commissure.

Mr. Cyril Horsford considered that the growth had an infiltrating character, that it grew from the anterior half of the left vocal cord, but there was much surrounding congestion and thickening of cord, and if a piece could be removed he thought it should be carefully examined under the suspicion of malignancy.

Dr. Jobson Horne replied that at present he was not quite certain where the growth originated. He looked upon the growth as an excrescence, not as infiltrating, and he regarded it as innocent.

Unusual Webbing of the Soft Palate.—W. Jobson Horne.—The patient, a man, came under notice on account of deafness. There were no symptoms referable to the throat. The soft palate, however, presented a most unusual appearance. The arches between the uvula and the anterior pillars of the fauces were filled in with a web which extended down to the tip of the uvula. The webbing was extreme.

Mr. Clayton Fox thought the condition of the palate was congenital. He knew of a similar case (in a female) though not so pronounced. It was not giving rise to any phonetic troubles, for although there was occasional hoarseness, this was due to chronic laryngitis, the result of nasal obstruction. He suggested a submucous resection as the only treatment applicable to such a case.

Dr. Jobson Horne replied that he was aware of some nasal obstruction; he had, however, shown the case, not with reference to the nasal septum, but on account of the abnormal condition of the soft palate with which he did not propose to meddle.

A Further Report upon a Case of Laryngeal Neoplasm.—W. Jobson Horne.—The growth occupied the right vocal cord. When the patient, a man, was before the Section at the January meeting[1] opinions were divided as to whether the growth was an epithelioma or a gumma. Prior to that meeting anti-luetic treatment had been instituted, and since then it had been pushed, and salvarsan had been given. Dr. Jobson Horne had heard that the laryngeal condition had cleared up considerably under the treatment.

Complete Paralysis of the Left Vocal Cord.—E. A. Peters.—E. S——, previously exhibited (March 6)[2] with left abductor paralysis and œsophageal growth. The patient was seen again on March 16, when

[1] Journ. of Laryngol., Rhinol., and Otol., vol. xxix, p. 208.
[2] *Ibid.*, vol. xxix, p. 510.

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

it was evident that the left cord was completely paralysed. The cord was curved and the arytænoid prolapsed forward. There was no respiratory movement. The patient spoke with a husky, thin voice. On vocalisation the left cord does not approach the other, but remains in the cadaveric position.

Mr. CLAYTON FOX remarked that there was a twitching of the arytænoid on the paralysed side, showing that there was no ankylosis of the crico-arytænoid joint.

Dr. JOBSON HORNE said that the case illustrated the importance of noting an alteration in the voice as possibly a valuable clue to a deep-seated disease, and also the importance of investigating the cause of that vocal change by means of the laryngoscope. Loss of voice, or even huskiness, due to paralysis of the vocal cord, through implication of the left recurrent laryngeal nerve, might be the first indication of the œsophageal growth.

Dr. PETERS replied that when he previously showed the case there was only abductor paralysis of the left cord; and in view of Sir Felix Semon's remarks that it was exceptional for these cases to be traced through from one stage to the other, and as within a week of exhibiting the patient at the Section, complete paralysis of the left cord had developed, he hastened to bring the case up. There was a growth a considerable way down the œsophagus, and he thought the history and present condition excluded ankylosis. He regarded it as a paralytic condition due to involvement by glands.

Microscopic Specimen of Growth on Anterior Third of Left Vocal Cord.[1]**—James Donelan.**—A woman, aged twenty-six. In view of the suggestions made in the course of the discussion, the removal of the growth was attempted by the direct method. Owing, however, to the patient's perfect set of teeth, and the unusually short distance from them to the epiglottis, it was impossible to pass a tube behind the epiglottis in a satisfactory position for an operation of this kind, though several attempts were made by a colleague accustomed to the manœuvre as well as by the exhibitor. The growth was removed a day or two later by indirect method, when it was found to have the structure of a papilloma.

Microscopic Specimen from a Growth on the Anterior Third of the Right Vocal Cord.—James Donelan.—By a curious coincidence a day or two before the preceding case was operated on this patient, a woman, aged forty-four, presented herself with a warty-looking growth in an exactly similar position but on the opposite cord. It was decided also in this case to attempt the removal by the direct method. The patient being endentulous an excellent view of the larynx was obtained, but just at the moment when the forceps were being introduced for the removal of the growth the battery, which had been used for a long time in connection with the previous case, suddenly failed, and as it was impossible at the moment to get another the removal was deferred and was carried out easily on the following day under local anæsthesia by the indirect method. The specimen appears to show the structure of a papilloma.

Sir STCLAIR THOMSON, referring to both these cases, pointed out that the attempt was made to remove the growth by the direct method, but it failed in each case; and in one of them it was said the growth was "easily" removed the following day by the indirect method. That led him to ask if it was becoming the fashion to use the direct method first

[1] JOURN. OF LARYNGOL., RHINOL., AND OTOL., vol. xxix, p. 510.

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in laryngeal cases, and if so, why? He also asked if it was becoming more frequent on account of the haste to be in the fashion. He had no hesitation in speaking on this subject, because he did not feel that he was behind the fashion, seeing that he was one of the first to go to Freiburg to study the method, and he believed King's College Hospital was one of the first institutions to have Killian's outfit in London. He asked Professor Killian recently in Berlin, and he had also asked Professor von Eicken the same question, whether they always used the direct method? The reply was that they never used the direct method when the indirect sufficed. He believed it was a Hippocratic principle which should be remembered, that removal of anything should be *tuto, cito et jucunde*. He asked anybody present to let a skilled person pass a Brüning's tube into his larynx, in order to cauterize or perform a simple operation, and then to let him (the speaker) do it by the indirect method, and report as to which was the more "*jucunde*"! He had no hesitation in saying that the majority would detest the direct method, and there would be no complaint in the majority of cases from the indirect method. He heard of this tube being passed down into the larynges of unfortunate tubercular patients in order to have lactic acid swabbed about or to have the galvano-cautery applied—a most unsuitable method. By the indirect method one had before one the whole larynx in a panoramic view, and it was much easier to apply the galvano-cautery, and it could be done more thoroughly "*tuto, cito et jucunde*" than by the direct method. He made that appeal for the sake of the patient. Both these patients now reported were submitted to several attempts, even by a colleague accustomed to the necessary manœuvres, yet it had to be given up. Perhaps Dr. Donelan would explain why, in the case of each of these patients, he did not use the indirect method. He (the speaker) regarded the indirect method as most unsuitable for growths in the anterior commissure also. In order to be in the fashion years ago, in several cases he tried the direct method, and in one case in which he failed he removed the growth easily by the indirect method by the help of Horsford's epiglottis suture. The patient told him afterwards what a torture the first procedure was, and how tolerable was the second. He was not now referring to suspension laryngoscopy, because there were cases in which the suspensory method was very suitable. What he wished to do was to enter a plea against attempting to do work on the larynx by the direct method when it could be done more "*tuto, cito et jucunde*" by the indirect.

Dr. Jobson Horne agreed generally with all that Sir StClair Thomson had said. To his own patient he mentioned that it would be necessary to remove the growth, and the patient expressed a wish for a general anæsthetic. Personally, he would prefer to remove it under cocaine and by the indirect method. The Section was much indebted to Dr. Donelan for having brought the cases. They were very instructive as showing the importance of teaching the rising generation how to use the indirect method. Years ago in that Section he expressed the hope that the art of removing laryngeal growths by the indirect would not be killed by the direct method in the way that the art of miniature painting had been killed by photography. Moreover, it must not be forgotten that direct endoscopy has its mortality.

Sir Felix Semon said he had at first not intended to take part in this discussion, because he belonged to the "old guard," and had retired. Anyone who, under such circumstances, spoke in defence of an "old-fashioned" method, like indirect laryngoscopy, was likely to be considered as an old fogey. But when it was said that the younger

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

laryngologists would not "take the trouble" to learn the indirect method, the old fogey could not help asking himself, "Were they laryngologists, or were they not?" If that were the attitude of the younger generation, it was a very unfortunate one for the specialty to which he had devoted his life. The art of removing laryngeal neoplasms by the indirect method had in his own day justly been looked upon as the "blue riband" of laryngology. He agreed with Sir StClair Thomson's remark that operations should be done not only *cito* and *tuto*, but also *jucunde*. In 1901[1] he had published lectures which, at that time, caused considerable controversy about the use of modern methods of treatment in diseases of the upper air passages, in which he had quoted the Gilbertian saying that, "The punishment should be made to fit the crime." He still was of opinion that it was the duty of the laryngologist to make the "punishment"—*i.e.*, his method—fit the "crime"—the disease. The direct method, which surely was anything but pleasant for the patients, should not be applied when the indirect one would suffice. He had always tried to avoid being in the rearguard, and he had welcomed all useful new methods, whether they were direct or suspension laryngoscopy, but he would deeply regret if the indirect method of removing growths from the larynx, which not so long ago was considered the main reason why laryngology should be recognised as a distinct specialty, should be superseded simply because some of the younger generation did "not want to take the trouble" to learn it.

Mr. Waggett pointed out that the younger members of the specialty did not to-day get many chances of removing growths from the larynx, and he was inclined to urge them to take every opportunity of practising with angled probes and forceps, lest an essential element in the delicate art of laryngology should be forgotten and wholly superseded by the easy but comparatively rougher methods of direct endoscopy.

The President said members would all feel indebted to Dr. Donelan for his cases, because by bringing them forward he had performed a service to the Section. He (Dr. Paterson) had used both methods for a considerable time; and he thought everyone would agree that, where a general anæsthetic was necessary, the direct method was the one possessing the greatest advantage. He did not know that suspension had made much difference in the matter of diagnosis, or for the removal of growths from the anterior commissure. He still thought suspension laryngoscopy unsatisfactory in that respect. Only two days ago he found it difficult to remove by that means the remains of a papilloma from the anterior commissure of a patient, perhaps partly because laryngo-fissure had been performed on the patient a year before and the larynx was fixed by scar tissue to the skin. The remarks of Sir StClair Thomson should be borne in mind; there was no doubt some people tolerated the direct method very badly. He remembered the days before the Killian tubes came in, when Kirstein's tubes were used, involving considerable pressure on the tongue, so that only one-sixth of the patients he tried it on at that time could tolerate it. He therefore gave up the method until Killian produced the tube-spatula, which required less pressure and was very much better for the patient. If he could get away a growth by the indirect method, he preferred it; he considered it was better for the patient, and he did not find it difficult as he had been trained to it. But, on the other hand, many men had become very facile with the direct method. He remembered Prof. Hartmann, three years ago, speaking of the value of local treatment in tuberculous laryngitis and showing a tube-spatula, which differed but

[1] *Brit. Med. Journ.*, 1901, ii, pp. 1313, 1396.

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

little from the ordinary one, except that it had a wider entrance; Hartmann said it was easily introduced, and that he had been using it in tubercle of the larynx with great advantage. Perhaps patients in this country were not so tolerant as those on the Continent. Attention should be paid to what Sir Felix Semon and Sir StClair Thomson had said, but he would be very sorry now to give up either method.

Mr. DONELAN replied that Sir StClair Thomson had apparently forgotten their conversation about one of these cases at the previous meeting, in the course of which he (Dr. Donelan) had suggested this might be a good opportunity of getting up an informal discussion on the relative merits of the two methods. "Why" he had used the direct method in these cases was simply that he felt he had as good a right as anyone else to do what was apparently the everyday practice at present and he felt that for once he ought to be in the fashion. As regards the "*jucunde*" part of it, as both patients were very nervous he gave them chloroform. They consequently suffered no inconvenience and had so little subsequent irritation that it was possible to remove the growths completely next day by the indirect method. With the exceptions already referred to, he was a believer in the advisability of at any rate attempting the removal of all laryngeal growths by the indirect method. He had long ago learned and practised that method under Sir Morell Mackenzie, one of its most brilliant exponents. He was sorry to gather that the rising generation were not more regularly practising the indirect method, as, apart from the removal of the growths, its use conferred great dexterity in all kinds of intra-laryngeal treatment. Perhaps he might usefully recall the suggestion of Sir Morell Mackenzie that it was not at all necessary to have a "phantom" larynx or other elaborate arrangement for practice. A dice-box served very well, and he had frequently seen Sir Morell Mackenzie "keeping his hand in" by picking small objects out of one by the indirect method.

An Œdematous Fibroma depending from the Left Vocal Cord.—L. H. Pegler.—Patient, a woman, aged fifty, complaining of hoarseness. On the left vocal cord can be seen an œdematous fibroma which occupies the greater part of its free border and rises above the glottis on expiration.

Dr. JOBSON HORNE regarded the growth as one for removal by the indirect method, which showed it very well. Exception, he thought, might be taken to the term "œdematous fibroma," by which the growth was described in the notes. Speaking generally, the terminology of growths of the vocal cords was far from perfect, inasmuch as it was not sufficiently descriptive of their histo-pathology. The œdematous appearance of growths springing from the anterior part of the vocal cord or the sinus of Morgagni was due to dilatation of the lymph-spaces and cystic degeneration.

Mr. DE SANTI regarded it as solid fibroma, not cystic.

Dr. PEGLER replied that the growth was essentially a fibroma, œdematous from position. He showed an almost exactly similar case about seven years ago (reported in the first volume of the Society's *Proceedings*).[1] He would remove the growth by the indirect method.

Note.—Dr. Pegler wishes to add (June, 1914) that the growth was removed in one piece by Mackenzie's laryngeal forceps. Under the microscope the section showed a highly œdematous, but not cystic fibroma.

[1] *Proc. Roy. Soc. Med.*, 1908, i, pp. 8, 29.

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

Chondrosarcoma of the Pharynx.—C. I. Graham.—Patient had complained of sore throat for one year. During the last two months he had noticed a swelling in the pharynx which increased rapidly in size; for fourteen days a swelling below the jaw on each side of the neck. There had been no dysphagia, but occasional attacks of choking. He thought that he had lost weight. He had been subject to bronchitis for many years. Recently there had been an excessive expectoration of blood-stained mucus. In the region of the left tonsil there was a large nodular swelling of a grey colour, but not ulcerated. On the right side a similar smaller mass could be seen; also some nodular growths on the arch of palate. The submaxillary glands were enlarged on both sides. Sections of growth were reported to show chondrosarcoma.

Mr. DE SANTI thought it a very good case for diathermy. Part of the growth could be scooped out and the residue treated by diathermy. It would not cure the patient, but would give considerable comfort and prolong life.

(?) **Lupus, Syphilis, or Mixed Infection of Nose, Right Ear, Pharynx, and Larynx.—P. de Santi.**—Boy, aged sixteen, who for two years has had severe ulceration of soft palate and pharynx, with a purulent right ear discharge. For eight months he has had an exuberant ulceration of left alæ nasi. No history of syphilis, congenital or acquired; no phthisis in family. No tubercle bacilli in expectoration; Wassermann reaction twice at Westminster Hospital strongly negative; twice elsewhere once negative, once modified Wassermann positive. The patient was sent by Dr. Sibley, who is treating the boy for his skin lesion. A section of the nasal region has been made and pronounced to be "typical epithelioma." On seeing the boy the one thing I was positive of was that the microscopic diagnosis was wrong. Examination reveals old scarring of soft palate and pharynx with typical syphilitic appearances. Uvula and epiglottis gone. Swollen, pear-shaped arytænoids and ulceration of vocal cords. The patient was shown by Dr. Sibley at the Dermatological Section in January; half the members were positive as to a syphilitic and half as to a lupus origin. My opinion is that the disease is lupus. Another section from the nasal lesion reveals lupoid tissue with giant cells.

Dr. H. J. DAVIS suggested that the condition might be glanders, and that the patient's reaction to mallein should be tried. He agreed that the palate condition looked like syphilis, but syphilis, as a rule, yielded to treatment and so did lupus.

Mr. CLAYTON FOX thought the condition was lupus all through.

Mr. DE SANTI replied that the case was first sent to him with the diagnosis of epithelioma. A piece of growth had been taken from the nose by Dr. Knowsley Sibley, and the microscopic report was, as already stated, "typical epithelioma." This it certainly was not, however. The scarring of the soft palate and posterior wall of the pharynx was highly suggestive of syphilis. The patient had lost his uvula and epiglottis. The Wassermann test had been done four times; thrice it had been negative, and once mildly positive. There were no evidences of syphilis in the patient or the family. Among dermatologists some said it was syphilis and others that it was lupus. He regarded it as lupus throughout. There were giant cells in a fresh section taken from the nose growth, but no tubercle bacilli had been found at all. He was at present giving iodine of potassium.

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

Perithelioma of Pharynx.—J. Coubro Potter.—Female, aged forty-seven, married. Complained one year ago of swelling behind angle of jaw, right side. Thought it was a gland. No previous illness. No loss of weight. Family history: Father died of cancer, aged seventy-five. Present illness: Patient complained of slight pain in throat. No pain on swallowing. When examined, a large swelling could be felt on right side of pharynx; movable, not painful. Growth was bulging soft palate. On palpation with finger behind angle of jaw the growth was the size of a hen's egg and was easily movable. It was tense, and felt somewhat cystic. The opinion was, at the time of examination, that the growth was encapsuled. No definite attachments could be made out. Previous to coming to hospital the family doctor had explored with a hypodermic needle, with negative results. No enlargement of glands or any other growth. Treatment: Examination under $CHCl_3$ confirmed the diagnosis, and the tumour was enucleated. Very slight hæmorrhage. Examination of growth: Naked eye showed a definite capsule. On section the appearance somewhat resembled adipose tissue, and one portion was specially hard. Microscopically, the pathologist reported perithelioma.

Dr. LEATHEM said he cut the sections, and he regarded it as an endothelial tumour. He was doubtful whether to apply the name perithelioma or endothelioma; it was encapsuled. Endotheliomata were mostly benign, although occasionally they formed secondary growths. The tumours sprang from the endothelial cells lining lymph spaces or from small blood-vessels. In this case, he would say, from the latter origin, as so many of the spaces contained blood.

Mr. LAYTON did not agree with the verdict given on the section. Though he was not a pathologist, it looked to him like an epithelial tumour. The late Mr. Targett, with whom he had seen many sections, laid it down that a tumour should not be called endothelioma until it was certain it was not anything else; and there should be evidence of its arising from the lining of blood-vessels or from endothelial tissue. There did not seem to be any sign of that in this section. There were two or three layers which did not seem far removed from stratified epithelium. He suggested it was an adenoma, with a large amount of fibrous tissue from the wall of the pharynx. Another suggestion was that it was a tumour arising in gland tissue.

Dr. JOBSON HORNE said he saw the case before the removal of the tumour, and he did not regard it as malignant, but as innocent. He suggested that Dr. Potter be asked to bring the case up again, complete with all the clinical notes and histological reports on the growth for further discussion. (Mr. Shattock, the pathological referee, reports that the growth is a perithelioma.)

Epithelioma of the Epiglottis and Base of the Tongue.—William Hill.—Man, aged sixty-two, had been under treatment at hospital for two months for Eustachian obstruction. At his last visit, a week previously, it was noticed that the patient was a little hoarse, though he had never complained of throat trouble. On examining with the throat mirror the epiglottis looked as if it had been partially amputated, and was nearly $\frac{1}{3}$ in. thick; the lesion looked more like old lupus than subacute tuberculosis, but as the mammillated swelling was also seen in the glosso-epiglottic fossa the possibility of its being malignant was recognised. The rest of the larynx was normal in appearance. A portion was removed for microscopic examination, and the case was proved to be

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press

one of epithelioma. As the disease was at present rather limited, and no enlargement of the glands could be *felt*, the case appeared to be very suitable for operation. Would a subhyoid pharyngotomy give sufficient access for removal of the epiglottis and adjacent parts of the tongue?

Mr. DE SANTI said that in the four or five cases he had had in which the growth was quite limited to the epiglottis, he had obtained good results from median thyrotomy—laryngo-fissure. It allowed one to get well at the base of the tongue, and it disturbed the patient less than did a lateral pharyngotomy. Three of the cases were still well, two and three years after the operation. In every case he removed the glands on both sides of the neck thoroughly, whether they were enlarged or not.

Abstracts.

PHARYNX AND NASO-PHARYNX.

Neuenborn, Robert (Crefeld).—The Operative Treatment of Hard Fibroma or Fibro-sarcoma of the Base of the Skull. "Zeitschrift für Laryngologie," Band vi, Heft 6.

The author remarks that cases are on record in which naso-pharyngeal fibromata have disappeared spontaneously about the age of twenty years. Until comparatively recent years, cases of hard fibroma have been treated by general surgeons who either split the hard and soft palates or performed temporary or permanent resection of the upper jaw. The author holds that it is questionable if these operations are not more dangerous than the tumour itself. On the other hand, attempts have been made with the cold wire or galvano-caustic snare, electrolysis, forceps, spoons, and curettes to remove the growths by the natural passages. These methods require many sittings. Neuenborn has had eleven cases and has operated on none of them. *J. S. Fraser.*

Trautmann, Gottfried.—A Plastic Variation in the Operation of Tonsillectomy by Blunt Dissection. "Münch. Med. Wochenschrift," Nr. 22, 61 Jahrgang.

In cases in which the anterior and posterior pillars are parallel, or where the former has a more medial extension than the latter, the author was in the habit of removing a crescentic part of the anterior pillar, the curved incision extending from the lingual prolongation of the pillar to the base of the uvula. This procedure was adopted in order to avoid subsequent functional disturbance.

In order to preserve the anterior pillar in all cases of tonsillectomy, Trautmann now dissects the above-mentioned crescentic portion of the anterior pillar free from the tonsil capsule from the plica triangularis downwards to the base of the tongue, and, holding it forwards with a forceps until the tonsil is removed, he tamponades it back in the tonsillar depression, the tampon being held in place for from four to six days by loose stitches through the faucial pillars. Whilst admitting that this latter procedure has more to recommend it than that first described, it is difficult to see what real advantage is to be derived from this method, which prolongs both the operation and the patient's subsequent discomfort.

J. B. Horgan.

https://doi.org/10.1017/S1755146300014669 Published online by Cambridge University Press