Royal Society of Medicine

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

November 1, 1929.

President—Dr DAN MCKENZIE.

FURTHER REPORT OF CASE PREVIOUSLY SHOWN.

Lupus of Nasal Septum—HAROLD KISCH, F.R.C.S. (shown 3rd May 1929).*—The anterior half of the septum was involved.

The patient has been treated by diathermy, and there is now no sign of the disease. There is a small perforation. The tonsils were removed subsequently to the diathermy, but showed no evidence of tuberculosis.

The PRESIDENT said that for cases of limited localised lupus, diathermy answered very well, in his experience. He was less sure as to the value of its action when the condition was widespread.

Cases.

Retro-Orbital Abscess secondary to Acute Ethmoiditis in a Child—W. S. THACKER NEVILLE, F.R.C.S. (Ed.).—Patient, a boy, aged 3 years and 9 months.

2nd September 1929, first day of illness, temperature rose to 101°. Family doctor diagnosed intestinal toxæmia and ordered castor oil. Child was obstreperous when castor oil was being administered and banged his eye on the cup.

3rd September 1929, left eye proptosed and fixed and both eyelids were œdematous. An ophthalmologist was consulted, who questioned as to the possibility of a sinusitis, but was told by patient's father (a laryngologist) that nose was normal.

4th September, the ophthalmologist (Mr Fison) suspected presence of pus and explored orbit through conjunctiva, but no pus was found.

5th September, eyelid of right eye became œdematous. Fundus of left eye showed papillitis and dilated veins and a skiagram showed pansinusitis of left side.

The history was then reviewed and the child's nurse reported that he had complained of face-ache on the day preceding the commencement of the illness, and it was remembered that he had a slight watery discharge from the left nostril and left eye.

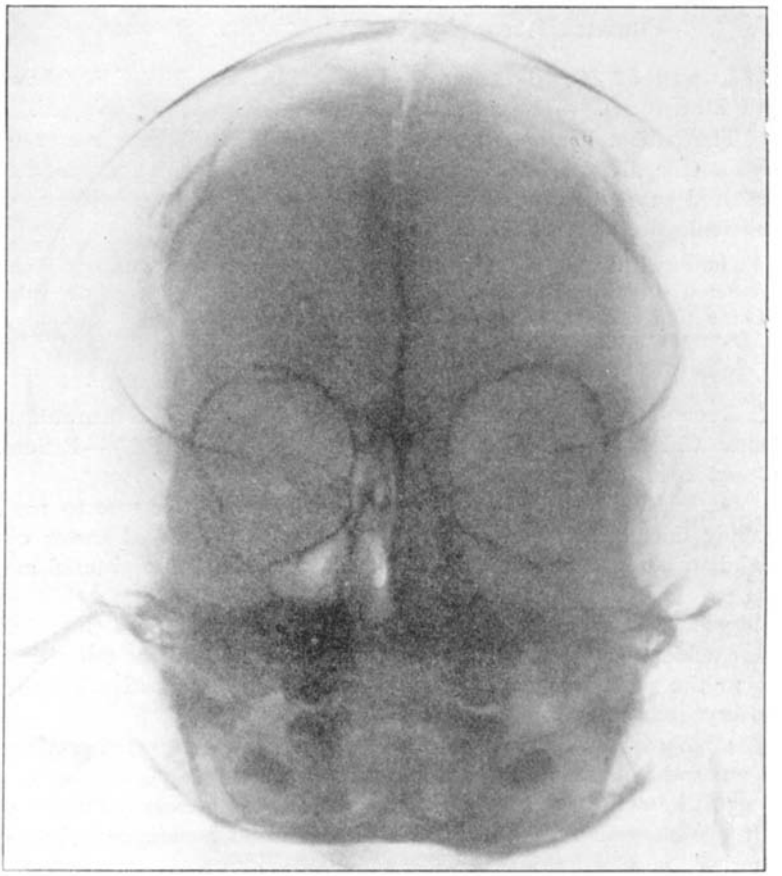
Operation (same day).—Patient was anæsthetised and I raised the left-middle turbinate. Pus filled the nose, and I then removed the left-middle turbinate and opened the sphenoidal sinus and also opened the maxillary sinus intranasally.

* See *Proc. Roy. Soc. Med.*, 1929, xxii. (Sect. Laryng.), 39.

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4th September, temperature normal. General condition good.

6th September, a brawny swelling appeared on the inner half of the lower eyelid. The ophthalmologist said that the eye was displaced upwards, and that he could not see the optic nerve; the whole fundus was cloudy. I therefore made an external incision at the inner angle



Retro-orbital Abscess Secondary to Acute Ethmoiditis. (Mr Thacker Neville's Case.)

of the orbit and found a large abscess with a dark-coloured perforation of the inner orbital plate. I made a wide opening into the nose and inserted a drainage tube into the orbit. The child quickly recovered, though there still remains an œdema of the lower eyelid.

The remarkable features of this case were the absence of marked pain and the fact that toxæmia was the first feature noted. The œdema of the opposite eye made one suspect sinusitis. A skiagram

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was of value; and that it should be from the case of a child, aged 3 years 9 months, agrees with the experience of other writers.

It is well known that exophthalmos may be the first sign of an ethmoiditis in children. Congestion of the orbit, due to ethmoiditis, produces exophthalmos, chemosis, and œdema. Limitation of movement, dilatation of the veins of the fundus and diminution of vision ought to make one think of an abscess.

Mr W. STIRK ADAMS asked for further details about the fixation of the eye, because in a recent case fixation of the eye plus central proptosis was diagnosed by an ophthalmologist as an intra-orbital condition. Was the proptosis in this case absolutely central? It was important to know whether central proptosis could occur as the result of subperiosteal abscess on the ethmoidal side.

Mr J. ALDINGTON GIBB said that sometimes proptosis had no connection with œdema, but it was due to paresis of ocular muscles. Sometimes the eye was pushed on one side owing to strabismus. Often proptosis was due to Tenon's capsule becoming inflamed. In a case of proptosis without œdema of the eyelids, he did not think one was justified in concluding that the condition was either orbital cellulitis or pus.

With regard to operative procedure each case must be approached by selection. In the severe cases external approach was usually to be preferred. The milder cases might be attacked by the intranasal route.

Sir ST CLAIR THOMSON said that Professor von Eicken appeared to treat such cases surgically by passing through the os planum of the ethmoid into the orbit. That seemed to him (the speaker) a perilous way of approach, and he would think if there was a retro-ocular abscess, it would be safer to open it from the outside.

Mr E. CRAIG DUNLOP said he had had a series of these cases, and in many of them the os planum was already perforated, and there was no need to make a hole. They could be successfully drained by the intranasal route. Displacement was not reliable from the diagnostic point of view. Sometimes there was lateral displacement of the eyeball, sometimes forward only. The results of drainage by the intranasal route were good. In one of his cases some orbital fat was removed, which was protruding through a hole in the os planum, and of course through the periosteum as well.

Dr J. S. FRASER said that all cases of acute proptosis were not due to sinusitis. Recently in hospital he had seen a case of proptosis sent over from the Ophthalmological Department with the eye proptosed. The swelling appeared to be behind and to the outer side of the eyeball. The eye specialist thought it was an orbital complication of nasal sinus trouble, but there was nothing wrong in the nose. Transillumination of the frontal and maxillary sinuses was favourable, and the case was X-rayed in every direction and showed healthy sinuses. Dr Logan Turner saw the case with him, and agreed there was nothing to be seen wrong in the nose by rhinoscopic or radiographic examination. He (Dr Fraser) only

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learned the day before he left that the Wassermann reaction was positive; it was probable that there was some gummatous infiltration at the back of the orbit.

Mr W. S. THACKER NEVILLE (in reply) said that the abscess was between the periosteum and the os planum, and the fixation of the eye was probably due to œdema. The temperature was raised on the first day and on the next day the eye was proptosed, but there was no strabismus. The ophthalmologist had no difficulty in seeing the optic nerve each day, and no displacement of the eye was reported until the seventh day, when a brawny swelling of the lower eyelid appeared and the eye was displaced upwards so that the optic nerve could not be seen. It was then decided to perform an external operation.

Carcinoma of Right Bronchus—W. S. THACKER NEVILLE, F.R.C.S.Ed.—Patient, male, aged 64, a wagon builder and upholsterer, came on 26th July 1929 complaining of a cough, which continued almost incessantly. He had been expectorating liver-like substance with streaks of blood for three or four months, and one hour after eating he vomited. He used to weigh 11½ st., and then weighed 10 st. 10 lb.

On examination the larynx was normal. A rubber tube passed into the stomach without any obstruction and so a skiagram was taken. This showed atelectasis of the right upper lobe. On 29th July I passed a bronchoscope half an hour after the administration of morphine hydrochloride gr. ½, with atropine gr. $\frac{1}{75}$ and the cocainisation of the larynx. At the entrance of the right bronchus I found a tumour, which moved with respiration. After withdrawing the bronchoscope the patient coughed up a large piece. On section this was reported to be an oat-celled carcinoma, and on 30th July I injected both lungs with lipiodol, and found that the lipiodol did not pass into the upper right lobe. I then procured a 50 mgm. tube of radium from Dr Gamlen of Newcastle, and inserted it into the right bronchus. This resulted in atelectasis of the whole right lung as seen by X-rays. The patient was relieved to a great extent of his cough, but rapidly lost flesh and died three weeks later.

The patient's symptoms were cough, dyspnœa, expectoration, hæmoptysis, loss of weight, and fever, and so one sees how easily one could diagnose such a case as tuberculosis of the lung. When I first saw him, I thought he had a mediastinal tumour or an aneurysm, and I did not suspect a bronchial tumour until I saw it with a bronchoscope.

Atelectasis seen in a skiagram suggests the presence of a tumour: it is the commonest sign of—and in many cases the only clue to—malignancy. In this case there were no signs of suppuration, such as have been reported by other writers, and so I did not think of abscess or bronchiectasis of the lung.

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The malignancy of this tumour is classified as No. 3 Broder by Dr F. B. Smith of Harrogate, that is to say, it was highly malignant. This agrees with the findings of most writers, although some have reported patients alive four and eleven years after the removal of malignant tumours.

The treatment in this case was radium; the usual intensive X-ray treatment was not at my disposal.

Dr BROWN KELLY said there were several features in this case which suggested a diagnosis other than that given. Thus, it was stated that the tumour at the entrance to the right bronchus was expelled on introducing the endoscope and that on inspecting the region afterwards no growth was seen. The microscopical characters of the piece expelled were unusual. Was this really a tumour? He asked whether the possible presence of an abscess in the liver had been considered. This could make its way into the right lung, whence its contents would be coughed up. The discharge would resemble the liver-like substance expectorated by the patient. In one of the skiagrams the diaphragm was higher on the right side.

Mr V. E. NEGUS said that a point brought home by this case was the necessity of examination with the bronchoscope in all cases in which carcinoma of the lung was suspected. He had had two cases in which this did definite good. One was that of an elderly man, whom Sir St Clair Thomson allowed him to examine. There was an obstruction of the right bronchus by masses of new growth; bronchoscopy made the diagnosis definite, and the clearing away of the masses afforded considerable comfort, though the patient died afterwards. The second case was one which Miss Mildred Warde had allowed him (the speaker) to see. There was a new growth in the right bronchus which had caused collapse of the right lung. There was no air entry owing to the mechanical obstruction caused by the growth. He cleared away a good deal of pus, as it was better to carry out removal after this procedure. He then removed the growth as a single tumour; pedunculated. An excoriated area was left on the bronchus and this he painted with silver nitrate. The growth was an adeno-carcinoma, and the man was apparently well for the time being; the skiagram showed the lung to be clear, there were no symptoms and the man had gone back to work. Probably many cases of carcinoma in the lung originated in the bronchus, whence it was possible growths might be easily removed. Even if this patient should have a recurrence he was rid of the trouble for the time.

The PRESIDENT said that carcinoma of the lung seemed to be increasing, and if that were so, one wondered to what the increase was due. A collection of cases, with full details, would be of considerable interest. If cases could be seen and diagnosed early, radium or other means might be applied with some prospect of benefit.

Mr W. S. THACKER NEVILLE (in reply) said he did not think the condition was liver abscess, as both Mr Barnard and Dr Smith reported carcinoma. Carcinomata of the bronchi were not very well classified. Mr Negus's case appeared to have been like this one; it was strange that the right lower lobe was not obstructed.

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Chevalier Jackson stated that formerly 1 per cent. of primary carcinomata were in this situation but that, lately, primary carcinoma of the bronchus had increased 15 to 20 per cent., giving as the probable reason the petrol and the tar used on the roads. The only way to diagnose the cause of a chronic cough was to pass a bronchoscope, and this procedure could be rendered more acceptable by using local anæsthesia.

Three Cases of Non-Opaque Foreign Body in the Right Bronchus (illustrated by Lantern Slides)—V. E. NEGUS, M.S.—(1) Male, aged 54. Cough with much sputum for about sixteen months.

Rabbit vertebra removed at second bronchoscopy, with local anæsthesia.

(2) Girl, aged 6.—Piece of Brazil nut in right bronchus causing ball-valve obstruction. Removed, with local anæsthesia, twenty-four hours later. Almost immediate cure.

(3) Nut, from milk chocolate, in right main bronchus, for twenty-one days, causing ball-valve obstruction. Right bronchus cleared by suction through bronchoscope, under general anæsthesia. Signs cleared up rapidly. Child became perfectly well.

Sir JAMES DUNDAS-GRANT referred to a case of a rabbit's vertebra in the left bronchus. It was sufficiently opaque for the skiagram to show it fairly well, and he extracted it.

Mr M. VLASTO said that during the ten years that he had been on the staff of the Queen's Hospital for Children, he only remembered one case which he had been asked to investigate for a possible non-opaque foreign body. The patient was a young child with extensive signs in the left chest, chiefly affecting the upper lobe. The child's general condition was precarious. His temperature had been swinging for weeks, and he had a very high leucocytosis. There had been no history—at the time—of the aspiration of a foreign body. It was only later that the parents remembered that the child had choked when eating pea-nuts, some considerable time before he was taken ill.

As soon as the bronchoscope had penetrated the left main bronchus, there was a fit of coughing with the expectoration of a quantity of pus and debris of organic matter. Dr Owen, who was at the moment auscultating the chest, advised me to cease instrumentation because he could now hear bubbling breath sounds coming through over the area which had hitherto been silent. The episode was rather dramatic, because the patient after being almost moribund, made a complete recovery.

The PRESIDENT said the moral of these cases was that the idea of a foreign body should occur to the mind of the physician more frequently than it did. Possibly this applied also to laryngologists.

Dr T. B. JOBSON asked whether an asthmatoid wheeze had been present in the cases in which there was obstruction. He (the speaker) had reported a case, during the previous year, in which that clinical symptom

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had been evident. It was that of a child with a foreign body—a flake of bone—in the left bronchus, and the "wheeze" had put him—Dr Jobson—on the right track.

Mr A. LOWNDES YATES said that he had had a case which showed how small a foreign body could cause obstruction to a bronchus. The son of a doctor was running along a hedge with a stick in his mouth, when he bit off a shred of wood from it and inhaled it. The result was a lung abscess, and only with difficulty was the foreign body removed with forceps, after the pus had been aspirated from the abscess, the walls of which were formed by the bronchial tubes. These were enormously dilated, although the foreign body had been in position for only three days. This was the more remarkable in view of the very small size of the foreign body, which was only of the thickness of paper, $\frac{1}{4}$ inch long and $\frac{1}{4}$ inch wide. He took it that the bronchial tubes beneath even this very small obstruction filled up with fluid very rapidly in this case—and probably in other cases—and that permanent damage might be caused with great celerity.

Mr F. C. W. CAPPS spoke of a child, aged 6 months, previously healthy, who had been playing with a pea-pod. As he presently had a choking fit, the mother considered that a pea had been inhaled. When brought to hospital the child was distressed and cyanosed. Screening with X-rays gave no sign. The physician said there was no air entry on the left side. He (the speaker) passed the finest tube which he had down the trachea, and directly it reached the bifurcation, though no foreign body was seen, the child breathed well. The entrance to the left bronchus seemed rather red and pouting. As the instrument was withdrawn the child vomited a pea, which had probably been lying in the œsophagus, and obstructed the left bronchus from behind. The child died twenty-four hours later, and was found to be riddled with miliary tubercle.

Mr V. E. NEGUS (in reply) said it was sometimes difficult to get physicians to allow cases to be examined in this way. In many cases of lung disease and lung suppuration he regarded the bronchoscope as of equal importance with the stethoscope. He would consider the foreign body—as compared with Sir James Dundas-Grant's case—as relatively non-opaque ; against the collapsed lung tissue it did not show.

In regard to Mr Vlasto's case, where there was a vegetable foreign body one must not concentrate just on the piece of foreign body, but must think also of the local swelling of the mucous membrane. In many cases there was a violent tracheo-bronchitis, which necessitated tracheotomy. In long-standing cases it was the granulations which blocked the bronchus, not the foreign body. The small piece of nut originated a great deal of swelling, and not until that piece had been removed did the swelling disappear and the child get well.

In answer to Dr Jobson, the right bronchus was concerned and there was no air entry, and in such cases no breath sounds were heard. To cause asthmatoid sounds there must be some air entry. In lung abscess or bronchiectasis there might be obstruction owing to formation of

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granulation tissue, and much improvement was affected by getting rid of the granulations. In answer to Dr Capps the foreign body in his case had been only a small one; a large one might press on the trachea. The œsophagus should be examined too; in some cases it was difficult to differentiate as to whether the foreign body had been swallowed or inhaled.

Disappearance of Epitheliomatous Outgrowth of Pharynx after Application of Diathermy.—DAN MCKENZIE, M.D.—Male, aged 52, first seen at the Central London Throat and Ear Hospital, 27th May 1929, complaining of sore throat and difficulty in swallowing, of twelve months' duration.

A large, smooth, rounded tumour was attached to the posterior pharyngeal wall towards the left of the middle line, and lying over the larynx in such a position as to prevent a view of the interior.

On 4th June a piece was removed for examination, and the tumour was traversed in several directions with a live diathermy electrode.

The pathological report (G. Scott Williamson) showed the growth to be an "epithelioma of basal-celled type." (Slide on exhibition.)

As the application of diathermy was followed by a shrinking of the growth to a mere nodule on the pharyngeal wall, this nodule was itself submitted to diathermy on 25th June. By this time the vocal cords had become visible, and the left cord was seen to be fixed. On 8th July this cord was moving and the nodule had disappeared.

Up to the time of writing (24th September) there has been no sign of recurrence, but the future is dubious, of course.

The sudden and apparently complete disappearance of the large neoplasm resembles the surprising change that sometimes follows the use of radium in pharyngeal sarcomata, but this is the first time I have seen that event following diathermy.

The PRESIDENT said that with regard to the diagnosis of basal-celled carcinoma of the pharynx, pathologists were making that diagnosis more frequently than formerly, and he asked what was the relative malignancy of these cases; was it about the same as that of rodent ulcer? Did it affect the glands? And what was the outlook for the patient?

Sir JAMES DUNDAS-GRANT—They answer to irradiation better than prickle-celled epitheliomata.

Diathermy Removal of Soft Palate for Epithelioma—DAN MCKENZIE, M.D.—Male, aged 58. Operations in February 1929: (1) Removal of cervical glands and ligature of external carotid. A chain of glands under the sterno-mastoid necessitated removal of part of the muscle. Subsequent serial examination by G. Scott Williamson, however, revealed no sign of new growth in them. (2)

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Removal of soft palate ten days later. The growth was extensive, involving the left side of the palate and spreading back on to the lateral wall of the pharynx.

The consequent gap is closed by an obturator attached to a denture.

Extirpation of Tonsils by Diathermy. Coagulation. — DAN MCKENZIE, M.D. Tonsils very large, removed by weekly applications extending over six months. Patient, a subject of exophthalmic goitre, shows considerable improvement in symptoms.

Dr J. S. FRASER asked what was the object in using diathermy in the second case; there remained some tonsils on both sides. The case seemed a suitable one for dissection. He did not think anything was gained by taking a long time over the operation.

Mr W. S. THACKER NEVILLE asked whether there was any œdema of fauces or palate. He did not think age constituted a reason for not dissecting out the tonsil. He himself had dissected out—under local anæsthesia—the tonsil of a woman aged 72, on account of rheumatism.

Mr T. RITCHIE RODGER said he thought the injected appearance of the anterior pillars showed the tonsils to be still septic.

Mr W. STUART-LOW said that he had used the galvano-cautery in preference to diathermy; it was safer and less alarming to the patient.

Mr E. CRAIG DUNLOP asked how the decision was reached that the deeper parts of the septic tonsil had been removed. The serious sepsis could not be exterminated by removing the protuberant part of the tonsil. The sepsis was chiefly in the deeper part of the crypt, and there appeared to be some tonsillar tissue remaining; he would therefore like to know whether the exhibitor proposed to go further.

Dr T. B. JOBSON said that, so far, he was favourably impressed with this method. The cases for which he particularly chose it were those with infective arthritis, and those with a flat septic tonsil. After tonsil enucleation there was often a flare-up of the rheumatic condition. He did not understand why Dr McKenzie was not a little more strenuous in his application, because most of the greater portion of the tonsil could be removed by two or three applications, most of it at the first sitting. In three or four weeks the removal could be completed. He had never had to wait six months for that result. There was little swelling of the fauces, and it was a satisfactory method for a particular type of case.

The PRESIDENT, in reply, said that the use of diathermy in the second case was by way of experiment. The applications were all made under local anæsthesia. The difference between the galvano-cautery and diathermy was very great. After the use of the former there was scarring and a closure of the crypts, but after diathermy there was no scarring of the crypts. He preferred to make small advances so as to minimise risks of hæmorrhage. For patients who were unsuitable for operation he was sure diathermy coagulation would become the routine treatment.

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Epithelioma of the Vocal Cord (with Illustrations showing the Condition of the Larynx during the Application of Radium) — HAROLD KISCH, F.R.C.S. — Patient, male, aged 62. History of six months' hoarseness following cough and cold.

On Examination. — Warty growth of right vocal cord, with hyperæmia and a very slight hesitation in movement. Tubercle and syphilis were excluded in the usual manner, but no portion of the growth was removed for examination.

On 9th July 1929 five needles of radium, each containing 1 mgm., were inserted on the outer side of the larynx, through a window made in the thyroid cartilage. The skin incision was completely closed; no tracheotomy was performed. The needles were removed after five days, the total dose of radium being 600 mgm. hours.

The patient was very tolerant of examination, so that accurate drawings could be made during the whole period of treatment, and these are exhibited.

On 31st September 1929 the right cord showed some hyperæmia and slight œdema, but there was no sign of the growth.

I am indebted to Miss Hulke, House Surgeon at the Royal Ear Hospital, for the drawings for these illustrations.

Dr J. S. FRASER said these cases ought to be followed up and reported on regularly. Three had been reported by him at a recent meeting in Scotland, and he had since then treated three others. If all cases were followed up as Sir St Clair Thomson's were one could then compare the results of treatment by laryngofissure with those obtained by radium therapy.

Sir ST CLAIR THOMSON said that he had had some cases, but he did not himself apply the radium. He would say there were some "misses" as well as some "bulls' eyes." Some patients had declined laryngofissure or laryngectomy, though the cases had seemed favourable for operation. After radium treatment the condition had cleared up as if by magic.

One case was that of a medical man who had declined treatment by operation. He returned to his practice with a full voice, but within two years he died. In one of these cases treated by radium the history went back very far. It was necessary to wait until at least three years had elapsed since the treatment. Restoration of voice was a small matter in comparison with saving life. He had shown before the Society four medical men who were still alive and well at four, five, seven, and eight years after operation, with voices sufficiently good to enable them to carry on their practice.

It was instructive to see the drawings which had been exhibited, as they showed that the action of radium was not limited to the cords. It would be necessary to find out afterwards what was its action on the larynx. In Germany and America there was literature showing the disastrous late effects of irradiation on the cartilages of the larynx. Unless laryngologists agreed to publish all their cases there would not be much progress.

Sir JAMES DUNDAS-GRANT said there was a good case for thyrotomy when the disease was limited. He had just heard from a patient on whom

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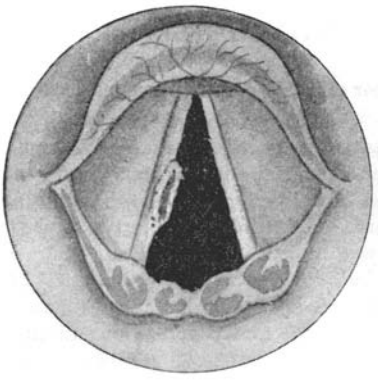


FIG. 1. — Before insertion of radium. Cord partially fixed. (9.7.29.)

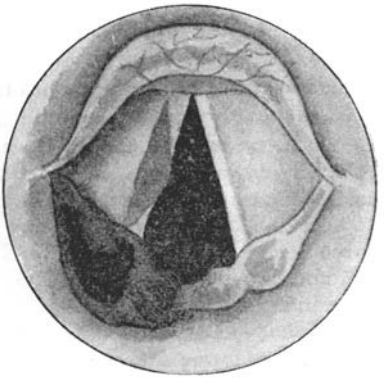


FIG. 2.—Thirty-six hours after insertion of radium. Cord immobile. (11.7.29.)

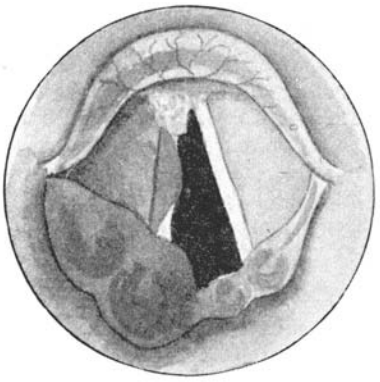


FIG. 3.—After 3 days. Cord immobile. (12.7.29.)

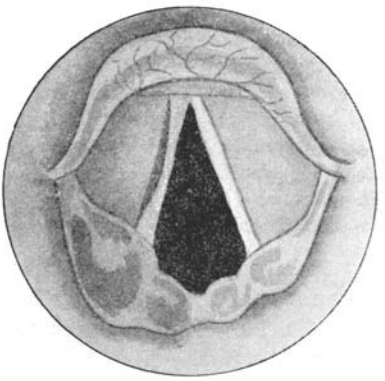


FIG. 4.—Just before removal of radium. Cord immobile. (14.7.29.)

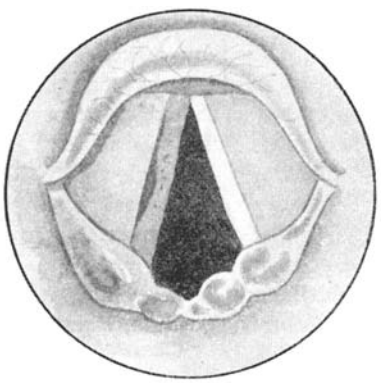


FIG. 5.—Four days after removal of radium. Cord quite mobile. (18.7.29.)

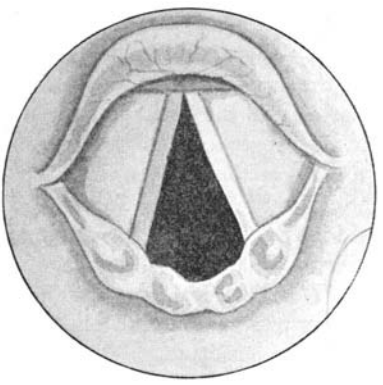


FIG. 6.—Three months after treatment.

Epithelioma of the Vocal Cord: showing the condition of the cord during the application of radium. (Mr Harold Kisch's Case.)

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he had operated sixteen years before for epithelioma of the vocal cord who was still quite well and talkative.

Dr ANDREW WYLIE said it was satisfactory to hear such good results following radium treatment for epithelioma of the larynx, but what proof had been furnished that this was a case of epithelioma? It seemed to him to be a small warty growth on one cord. He believed in always having a piece removed for examination. He was aware that Sir St Clair Thomson did not always agree that this should be done, but as he (the speaker) had once made a serious mistake he considered it absolutely necessary, and if a piece had been removed in Mr Kisch's case and reported as malignant the diagnosis would be complete.

Mr H. KISCH (in reply) said he must remind Members that he was not sure it was epithelioma, but it was so clinically. If radium were never tried in such cases no conclusion could be arrived at as to whether it was of any use. Not much damage was done by it even if it failed, because removal by surgery could still be carried out. The object of applying radium was not only to affect the part itself, but to cut off the lymphatic drainage. The fact of the whole larynx being affected was a strong point in favour of using radium. A screen of one-fifth mm. of platinum formed the screen. He had used it now in three or four cases in five years, and he would try to collect the particulars. The case was shown to demonstrate, by pictures drawn from life, the naked-eye appearances of what occurred in the larynx during the application of radium.

Foreign Body (Halfpenny) in Œsophagus removed by Jackson's Œsophageal Speculum—W. S. THACKER NEVILLE, F.R.C.S.Ed.—I believe this to be the most suitable instrument for removing a foreign body hidden behind the crico-pharyngeus muscle.

The patient was a child, aged 5 years, who had swallowed a halfpenny four days before admission to hospital. He was able to swallow food in spite of the presence of the halfpenny, but he was brought to hospital on account of a commencing dysphagia.

A skiagram was taken and the halfpenny was lying placed frontally at the upper end of the œsophagus. An œsophageal speculum was passed and the usual prominent muscle known as the crico-pharyngeus at the upper end of the œsophagus had to be pushed aside in order to expose the halfpenny which was hidden by the muscle and tightly wedged in place. A foreign body in such a place can easily be overridden by an ordinary œsophagoscope, whilst this instrument allows one to use a powerful leverage and so expose the halfpenny.

The head-rest was that used in Haslinger's Hajek clinic, which allows one to place the child's head in Jackson's position, without the aid of an assistant.

Laryngeal Case for Diagnosis—G. BOTROS, M.B. (introduced by Mr T. B. LAYTON).—S. S., male, aged 49, referred to Guy's Hospital, 16th September 1929, on account of hoarseness and discomfort in swallowing for the last eight weeks.

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On Examination.—Voice strong but slightly husky; slight discomfort referred to left side of throat, mostly marked in the morning, passes off later in the day. No pain, cough, or dyspnœa.

Larynx.—Mucous membrane of right arytenoid and laryngeal surface of interarytenoid region is slightly congested and studded with several small papilliform points. Left ventricular band is swollen and the overlying mucous membrane is smooth and slightly redder than normal. On the posterior extremity of the band is an ulcer 6 mm. in diameter, with irregular margin and shallow floor, covered with a greyish membrane. No inflammatory areola. Cords move well. No laryngeal tenderness. No swelling of glands. Wassermann reaction negative. Examination of chest for tubercle, negative.

Patient is a light smoker and drinker.

Family History.—Nothing important.

Mr HAROLD BARWELL suggested that this was a septic laryngeal condition, secondary to a septic condition in the nose.

Dr J. S. FRASER said he considered that the diagnosis lay between malignant disease and tuberculosis. He inclined towards the former. It was, however, difficult to decide without removing a piece for biopsy.

Dr BROWN KELLY said he thought this was a growth of uncertain nature involving the anterior two-thirds of the cord.

Sir GEORGE BADGEROW—I think it is a growth that has become septic.

Dr JOBSON HORNE said he was entirely opposed to the opinion expressed that the condition in the nose was responsible for the disease in the larynx.

Sir JAMES DUNDAS-GRANT—A portion should be removed for microscopical examination. I think it is probably epitheliomatous.

Aneurysm, (?) Ascending Pharyngeal. — E. BROUGHTON BARNES, F.R.C.S.Ed.—Female, aged 59. A dilated tortuous vessel can be seen pulsating immediately beneath the mucosa of the lateral pharyngeal wall, behind the left posterior pillar of the fauces. The diameter of the vessel appears to be almost equal to that of an ordinary lead pencil.

The PRESIDENT questioned whether this was aneurysm, and also whether it was the ascending pharyngeal artery. Many years ago he had seen an aneurysm of the internal carotid, but pulsation was greater than in this case. A surgeon opened the neck, and was sorry he did so, as the patient died.

Dr BROWN KELLY remarked that in the *Journal of Laryngology*, 1925, p. 15, reference was made to 85 cases of this kind. The appearance in the pharynx was due to tortuosity of the internal carotid. Every now and then such cases were described as aneurysm. The vessel was not the ascending pharyngeal, which was small and on the posterior wall of the pharynx.

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He had operated on several of these cases, in which there was a bulging of the artery into the pharynx. The tonsil during removal should be drawn forwards and inwards and thus away from the artery.

Mr M. VLASTO said that about eight years ago, when he was carrying out a simple removal of tonsils by the reversed guillotine method, there was a sudden gush of blood, and the patient died in a few minutes. The post-mortem revealed a very superficial and tortuous carotid artery. The guillotine blade had undoubtedly been too sharp, and he had removed more of the posterior pillar than was justified.

The PRESIDENT said it was well to know of these accidents, as the knowledge prepared the mind for them and one could then know what to do. The Section was grateful to Mr Vlasto for having reported such an accident.

Late Result of too high a Tracheotomy—E. BROUGHTON BARNES, F.R.C.S.Ed.—Girl, aged 17. Emergency tracheotomy when aged 5. Tube appears to have been inserted through the thyroid cartilage and the crico-thyroid membrane. There is a considerable scarring in the glottis, the size of which is much reduced. The right cord is almost fixed, but she has a very good voice.

Sir JAMES DUNDAS-GRANT said we should be lenient in our judgment when criticising a practitioner for having made a tracheotomy too high in view of the circumstances attending laryngeal diptheria. He had had referred to him a young child in whom this occurred, and he was able to get him well by using intubation tubes larger than were suitable for a child of his age. By means of a nasal tube it was possible to feed the child, who recovered and grew up to be a strong man. In such cases as the present the treatment was to make another tracheotomy opening lower down, and allow the larynx to have complete rest, after which the question of laryngostomy came in, but he thought this patient was doing well enough and would not need further interference.

Hoarseness: Thickening over Right Arytenoid. Case for Diagnosis—A. L. MACLEOD, M.B.—P. C. B., male, aged 27. Seen in January 1928, on account of hoarseness of twelve months' duration. Slight cough and expectoration.

On Examination (4th January 1928).—Thickening seen over right arytenoid. Slight ulceration in front of arytenoid, not on cord. Movements of cord restricted.

Sputum, negative. Wassermann reaction, negative. Family history of tuberculosis. Patient has been in hospital at Ventnor for six months, having silence treatment; whispering has been allowed. Discharged three weeks ago—no active mischief.

Present Condition.—Still hoarse. Thickening still seen over right arytenoid, involving aryepiglottic fold and ventricular band; cord still partially fixed.

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Abstracts

Dr JOBSON HORNE said he regarded the lesions in the larynx as due to tuberculosis. He advised treatment by absolute silence in a sanatorium where it could be more easily carried out than in the patient's home.

Sir JAMES DUNDAS-GRANT said examination of the sputum frequently gave negative results until an enforced cough, which could be brought about by sniffing oil of mustard, was produced. If that failed, the administration of iodide of potassium for a few days often brought about a positive sputum.

Laryngo-Scleroma (?). Case for Diagnosis — R. J. CANN (for Mr W. M. MOLLISON).—Male, aged 46. Complained of hoarseness three years ago. Attended out-patients' department in 1927. Has had dyspnœa for the past twelve months; this became acute in May 1929. Tracheotomy performed in St Giles' Hospital, 29th May 1929.

Wassermann reaction negative.

Sputum examined several times; no tubercle bacilli found.

Sir JAMES DUNDAS-GRANT said there was a growth below the right cord, and he suggested the removal of a portion of it with Mackenzie's forceps, to make a diagnosis and possibly, at the same time, to relieve the breathing.

ABSTRACTS

EAR.

The Comparative Anatomy and Physiology of the Perilymphatic Space. H. M. de BURLET. (*Acta Oto-Laryngologica*, Vol. xiii., Fasc. 2.)

The perilymphatic space forms a protective covering for the membranous labyrinth, which it separates from the cartilaginous or bony capsule. In many of the lower vertebrates the space is filled with a loose connective tissue containing in its meshes the perilymph. The nerves and vessels on their way to the sensory end-organs in the wall of the membranous labyrinth pass along strands of this connective tissue mesh-work.

Many of the fishes have a completely encapsuled labyrinth with a well-developed and closed perilymphatic space. In others the capsule is incomplete on the inner or cerebral side, so that the membranous labyrinth is applied directly to the brain. In a few, like the sea-horses, the outer or lateral wall is also absent, so that the labyrinth lies free beside the brain in the cranial cavity, and there is nothing to distinguish the perilymphatic from the subdural space.

The author passes in review the changes of form and function which the perilymphatic space has undergone during the course of its phylogenetic development. The sensory end-organs of the vertebrate

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