Societies' proceedings

THE One Hundred and Third Meeting of the Scottish Otolaryngological Society was held in the Royal Infirmary, Dundee, on Saturday, 20 November 1971, the President Mr. H. M. Urquhart presiding.

In the morning fifteen cases were presented and after lunch the following three papers were read to the Society:

1. Glomus Jugulare Tumours—Radiotherapy or Surgery? by Mr. G. W. Glover.
2. Septoplasty—Mr. A. G. Maran.
3. Some Thoughts on Tympanosclerosis—Mr. A. G. Gibb.

Summaries of these papers are as follows:

THE MANAGEMENT OF TUMOURS OF THE GLOMUS JUGULARE

G. W. GLOVER

THE original concept of treatment of glomus jugulare tumours was conditioned by the fact that the previously well-documented carotid body chemodectoma was considered radio-resistant. The results obtained by irradiation in this series of seven patients strongly support the view that it is the treatment of choice in large petrosal, tumours and those with intracranial extension.

In five of seven patients surgery was undertaken for various reasons, but removal was incomplete and was followed by radiotherapy. Of six patients given radiotherapy, five are still alive and well without evidence of progression of the tumour at periods ranging from one to eighteen years following irradiation; the other died of unrelated causes.

Six of the seven patients had multiple cranial nerve palsies implying intracranial extension, together with radiographic evidence of bone erosion. Although improvement in the cranial nerve palsies has been minimal, the striking feature has been the improvement in the intracranial hypertension in the two cases where this was a feature.

Plain radiography, tomography, and detailed angiographic mapping are invaluable guides in assessing tumour size and planning the best fields for radiotherapy.

The excellent results obtained by radiotherapy, both in this series and others, entirely vitiates the arguments of those advocates for surgery. The following arguments have been used in favour of surgery; glomus tumours are radio-resistant; irradiation may cause brain necrosis or delayed amyloid degeneration of nervous tissue; the inherent tendency of these tumours to grow slowly exaggerate the reported effectiveness of radiotherapy.

These arguments are disputed and negated.

Complete surgical excision is still advocated for small middle-ear tumours,

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but surgery in those tumours with intracranial extension and multiple cranial nerve palsies is not justified.

SEPTOPLASTY

A. G. MARAN

WHILE submucous resection of the nasal septum has been in use for over seventy years it carries with it some undesirable functional and cosmetic side effects.

It may cause depression of the cartilaginous dorsum and mild to severe saddling; it may also lead to broadening and lowering of the upper lateral cartilages. These two factors cause alteration of the valve action of the lower ends of the upper lateral cartilages and this may cause nasal obstruction even with a straight septum.

Almost invariably there is retraction of the columella and drooping of the nasal tip; both of which are cosmetically unsightly.

The classical S.M.R. is of little use in dealing with an anterior dislocation of the septum, the deviated septum which also deviates the external nose, and it can be disastrous in an already saddled nose.

Septoplasty is designed to preserve as much septal cartilage as possible together with its blood supply. The basic steps are to mobilize the skin of the dorsum and then to divide the septum from the medial crura of the lower lateral cartilages by incising through the membranous septum.

A subperichondrial flap is raised on the deflected side and a similar flap, but only on the lower half of the septum, is raised on the opposite side.

The septum is then freed from its posterior attachment to the ethmoid and vomer and from its inferior aspect along the vomerine crest.

As little tissue as possible is removed to allow the cartilage to swing back to the midline unimpeded and it is pedicled on the attached mucosa on the originally undeviated side.

Once all attachments are freed most convexities will straighten but occasionally cross hatching will be required.

Fixation is by transfixion sutures through the anterior end, minimal packing, tape, and a plaster of Paris splint.

The dressings are changed at weekly intervals for three weeks.

TYMPANOSCLEROSIS

A. G. GIBB

THIS little understood condition, originally described over 100 years ago by Von Trölsh (1869), has acquired much greater significance since the advent of microsurgery. It is probably an unusual healing process following middle ear infection although a history of previous otorrhoea was obtained in less than half of a series of forty cases. So called 'chalk patches' consist of deposits of a collagenous material the exact origin of which is unknown. The incidence of tympanosclerosis seems to vary in different areas but this may be explained partly by lack of awareness on the part of the otologist. Diagnosis, although often obvious, may present difficulties, especially if the tympanic membrane is

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intact: accurate diagnosis may be of vital importance in assessing operative prognosis.

Tympanosclerosis may be classified into 'closed' and 'open' types depending on whether the tympanic membrane is intact or perforated. Conductive deafness is due to fixation or disruption of the sound conducting mechanism, the pathological process being either localized (e.g. stapes footplate area) or widespread (e.g. tympanic membrane and all three ossicles).

Operative procedures include myringoplasty, mobilization of ossicles, ossiculoplasty, stapedectomy and fenestration. In mild cases mobilization of the ossicles by removal of tympanosclerotic plaques may be successful. In localized tympanosclerosis involving the stapes area, stapedectomy gives good results and no undue sensitivity of the cochlea has been encountered. If the attic is involved the best long-term results are achieved by employing a by-pass technique either by ossiculoplasty (handle of malleus-stapes assembly) or by fenestration. The latter procedure may well prove the operation of choice in extensive tympanosclerosis as it avoids the necessity for multi-stage procedures.

Discussion

Considerable discussion followed Mr. Glover's paper on Glomus Jugulare Tumours. He had pointed out that several people do advocate radiotherapy even for small tumours without a biopsy but he considered we were speaking of two separate tumours (histologically the same), the glomus jugulare tumour which he did not think was surgically accessible and the glomus tympanicus tumour which was easily resected and operation should be considered in these cases. In the latter type, in old people, it was worth while doing nothing but watch the patient. Mr. Munro said that not all glomus tumours were highly vascular and this was supported by Mr. Gibb who described exploring by tympanotomy, a patient who presented with a pink drum, and removing a soft tumour without bleeding, the eardrum being simply replaced without packing. It was reported histologically as a glomus tumour. She had radiotherapy and when she died several years later, was found to have an acoustic neuroma on the same side.

The President had commented that it was really only since the mid-forties that the condition had been accepted as a condition on its own and Mr. Mitchell recalled a case operated on by Mr. Mather in the early 1940s with very severe haemorrhage at operation and it was diagnosed histologically as 'haemangioma'. On review of his slides by the pathologist, when shown at the last meeting in Dundee a few years ago, the diagnosis was glomus jugulare tumour. He wondered whether it was wise or safe to consider that two separate entities (glomus tympanicus and glomus jugulare) existed and whether glomus tympanicus was not just the tip of the iceberg.

Mr. Glover replied that histologically the Glomus Jugulare is a normal structure present in the jugular bulb and the glomus tympanicus is a separate structure. With the larger lesions, it is difficult to say whether they have arisen in one or other but the smaller ones which present on the promontory he considers they are glomus tympanicus cases.

Mr. Brennand presented a case of a hypertensive lady with a throbbing noise in her right ear and an audible bruit over the mastoid. A vertebral

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angiogram had not solved the problem and Mr. Weir wondered whether this was due to a glomus tumour despite the normal eardrum and hearing and negative mastoid X-ray.

Mr. Russell queried an arterio-venous fistula as he considered the retinal veins pulsatile.

In the discussion after Mr. Gibb's paper, he said in reply to the President, that he had never experienced any activity in this condition and while he had opened some ears two or three times, he had seen no recurrence of the plaques: He had operated on a girl of 15 and even then the condition seemed to be completely quiescent. While there was a history of suppuration in about one-third of all ears showing the condition, he considered tympanosclerosis and cholesteatoma which occasionally were seen together, to be separate conditions.

In reply to Mr. Farquharson, who asked about selection of cases for operation, Mr. Gibb agreed that the issue of a hearing aid as an alternative to operation should always be considered in these cases because the surgical problem was much more difficult than with other types of conductive deafness such as otosclerosis. Difficulties such as brittle ossicles which crack easily and the need for a second operation had to be considered. Mr. McLay agreed that tympanosclerosis was an unfriendly field for the operating otologist and he instanced such problems as the plaques involving the footplate and the stapedius tendon covered by tympanosclerosis.

Mr. Gibb favoured fenestration when the middle ear could not be reconstructed separately and was supported in this by Mr. McDowall. Mr. Gibb commented on how much simpler the fenestration operation seemed now than formerly. He advised against removing plaques from the inner tympanic wall when doing a first stage myringoplasty for 'open' tympanosclerosis as they prevented adhesion and if removed must be followed by the insertion of Silastic. Mr. Mitchell, commenting on the frequency of the condition in the Eastern region, said that many cases have concealed tympanosclerosis which cannot be diagnosed until the middle ear is entered. He thought there was a high incidence in the attic and Mr. Gibb agreeing with this said he may have given a wrong impression regarding the frequency of plaques in the attic. Mr. Mitchell was not very much in favour of fenestration because it produced a cavity which modern surgery tried to avoid.

Several cases illustrating the discussion were shown.

There was a long discussion after Mr. Maran's paper. In reply to the President he agreed that the septum seemed to spring back into a central position if all attachments were freed and if it did not do so, trimming and cross-hatching helped it to do so. He did not operate under fifteen years because surgery disturbs the growth rate between bone and cartilage but Mr. Gabriel disagreed and felt that some cases arose before this age who did need septal surgery.

Mr. Maran felt local preparation and, if possible, a bloodless field were very desirable. Dr. Farquharson felt that this was an operation of great merit and referred to the type of case which was liable to get drop of the tip following S.M.R. and required Tip Septoplasty following this operation.

Tip spread, if it occurred, was easy enough to correct said Mr. Maran.

Mr. Gibb felt that it was essential for E.N.T. Specialists to be able to cope

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with all nasal problems and not hand them on to the plastic surgeon who pays little attention to nasal function.

Mr. Maran agreed and said that the key to the nose was the septum which few plastic surgeons really understood.

In reply to Mr. Mitchell, he said the septum can be straightened if there is not a lot of fibrous tissue. If the septum is thick and damaged, it can be handled by resecting bits of cartilage, creating a saddle nose and then putting in a bone graft. He said it was essential to 'read' the nose first and this was very difficult. Mr. Bailie commented that a lot of this type of work could be avoided by better early treatment of minor injuries which tended to be left to junior staff at the end of the list and were not well done.

Discussion

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Mr. Ballantyne (replying to questions) agreed with the President that adequate illumination was absolutely essential to the proper conduct of per-nasal surgery, and he found that the Clar headlight provided excellent visualization of the operative field. He preferred general to local anaesthesia both for the pre-operative preparation of the nose and for the operation itself because it provided greater comfort both for the patient and for the surgeon.

It was perfectly true that he had inherited the method of preparation which he had described from a senior and revered colleague; and having adopted it, he had continued to use it because it produced entirely satisfactory operating conditions.

Mr. Ballantyne was convinced that the results of per-nasal removal of nasal polypi were almost uniformly excellent if the preparation was carried out carefully, if the operation was performed properly, and particularly if the underlying vasomotor disturbance was treated energetically after the operation and provided that these requirements were adhered to, he could conceive of no situation in which almost a hundred radical operations by an external approach could possibly be required by any one surgeon in a period of less than twenty years.

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