SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY.

SUMMER MEETING, 5TH JUNE 1931.

President, FRANK ROSE, F.R.C.S.

Congenital Shortening of the Œsophagus and the Thoracic Stomach resulting therefrom—LEONARD FINDLAY and A. BROWN KELLY.—The paper is published in the *Journal of Laryngology and Otology*, Vol. xlvi., p. 797, December 1931.

DISCUSSION.

Mr. HAROLD BARWELL said that this paper embodied what was largely a new conception, and he did not think that all its implications could at once be realised. He gathered that Dr. Findlay considered that the position of the cardia above the diaphragm—the intrathoracic position—was physiological in children during the act of swallowing, but Dr. Brown Kelly did not seem to take quite that view, because it was not only during swallowing, but also during œsophagoscopic examinations, that he found the gastric mucous membrane inside the thorax.

The point which caused the greatest difficulty in his (the speaker's) mind was the following :—If the intrathoracic cardia was a common condition, in what way was it connected with congenital stenosis? Was it the cause of the stenosis, or was it an accidental finding? Was an intrathoracic cardia common in children, and had attention been directed to it, because in these cases there was stenosis as well?

Sir JAMES DUNDAS-GRANT said that in the points which had been brought forward he saw an explanation of some of the cases about which he had had doubts. In connection with microscopy of scraps removed under œsophagoscopy it was necessary to remember that occasionally the œsophagus was the seat of patches of gastric mucous membrane. He thought that the movement which Dr. Findlay had described must inevitably take place.

Dr. A. BROWN KELLY (in reply) said that in the cases with stenosis he regarded the high position of the stomach as an organic condition, but in the normal children the temporary hiatal hernia was a physiological variation. Three years was not a sufficiently long time to have had these cases under observation to enable one to foretell what might happen to them at a later stage of life. It was conceivable that as these children grew older some change might take place, in consequence of which the cardia descended; but there was no post-mortem evidence of a gradual lengthening of the œsophagus. The mystery must be cleared up, but time alone would do it.

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Dr. FINDLAY (in reply) said that the relationship between the cases with stenosis and the cases without stenosis was, to him, inexplicable. There was no doubt that in the normal child the cardia during swallowing rose well above the diaphragm and that in the cases of stenosis the cardia was also well above the diaphragm. The gastric mucous membrane was recovered from the cases with stenosis at a distance of only one vertebra higher than in the cases without stenosis. The conditions, too, under which these findings were made were the same in all the patients. If the hiatal hernia was temporary in the cases without stenosis, why was it not also temporary, therefore, in the cases with stenosis? Dr. Kelly, however, identified the stenosis as at the level of the cardia. Was it because the cardia rose unduly high that cardiospasm resulted? In both conditions the cardia was high, and there was a difficulty in understanding why the raising of it a little higher, *i.e.*, only the distance of one vertebra, should induce this cardiospasm. No post-mortem material was available on the subject. The post-mortem cases mentioned by Dr. Kelly were herniae of the whole stomach, and were not comparable with those of which they had been speaking. Rivto, who had described many partial hiatal herniae, had had operations performed in three cases, but although details regarding the radiological appearances were supplied, nothing had been said as to the findings at the operations. At Great Ormond Street Children's Hospital there had been collected, over many years, ten cases, and these had been recorded last year by Drs. Sheldon and Ogilvie; they all showed the stenosis at the level of the seventh thoracic vertebra with dilatation of the œsophagus above the constriction. No dilatation was found in the lower part, but then the technique described by Dr. Brown Kelly and himself had not been adopted. One patient had died from tuberculous meningitis after being under observation for two years, and at the post-mortem examination nothing abnormal was found either on naked-eye or microscopic examination of the œsophagus.

A Permanent Tracheostomy in Stenosis of the Larynx—Sir ST CLAIR THOMSON, London.—The paper is published in the *Journal of Laryngology and Otology*, Vol. xlvi., p. 817, December 1931.

DISCUSSION.

Sir JAMES DUNDAS-GRANT said that there was an advantage in leaving the permanent tube uncorked, though in certain cases it was more advantageous to have a permanent cork. What had Sir St Clair's experience been with the different forms of tube? So far as the angle was concerned, the most satisfactory tube was that of W. Parker. It was comfortable, and was the easiest to put in, but it was also the one which came out most readily. It was adapted to the backward inclination of the trachea. He had sometimes found that a patient was more comfortable with the quarter-circle tube. The soft parts had moulded themselves in such a way that the anterior edge of the quarter-circle tube did not scrape. It improved the Parker tube to make a sliding collar on it. In many ways the Durham tube was ideal, but it approached too nearly to a right angle; the ideal tube would be more obtuse than a right angle.

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He asked whether these tracheotomised patients who had been shown were able to smell. He remembered the case of a woman, aged 20, who had a papilloma completely blocking the larynx, so that tracheotomy had been performed in childhood. It was thought that by keeping the tracheal fistula open long enough the papilloma would disappear, but it did not. She was referred to him (the speaker) and he was able with his "safety" forceps to take the papilloma away. He then removed the tracheotomy tube, and the patient was able to breathe through her nose, and she said how delightful it was to be able to smell the flowers again.

Much depended on the nature of the trouble which had caused the obstruction in the larynx, though Sir St Clair Thomson had shown examples of practically every kind.

Mr. HERBERT TILLEY said that Sir St Clair had summed up the conditions in which tracheotomy was a valuable method of treatment and at the same time had pointed out the evil possibilities of a high tracheotomy. Those who had had much experience in laryngology would recall those sad cases in little children who had been tracheotomised for diphtheria, and the tube had been inserted in the neighbourhood of the cricoid cartilage, a procedure which often caused more or less permanent stenosis—so difficult to cure, whatever measures were adopted. He had spent much time and trouble in trying to cure these stenoses by the technique introduced by Sargnon and Ballatier.

With regard to the harmlessness of tracheotomy, he had recorded the case of a patient who thirty years ago had had bilateral fixation of the vocal cords in the adducted position and probably due to some rheumatic condition. He was still living and carrying on his occupation.

Mr. RITCHIE RODGER said that his own case, to which Sir St Clair Thomson had made reference, was a good illustration of what was the main contention of the reader of the paper in bringing forward these cases, namely, that one should be content if there was a good airway. The patient had had tuberculous laryngitis with perichondritis eleven years previously and continued to wear his tube. He (the speaker) induced the man to take a walk with his tube blocked, but he would not go to bed without it, and he (Mr. Rodger) was not content with that; he felt that the result was unsatisfactory so long as the tube was being worn. Out of that dissatisfaction arose a consultation with Sir St Clair Thomson, and both he and the patient were much relieved that Sir St Clair's opinion was that they should be content with things remaining as they were. The man lived many years after that, continuing to wear the tube.

On the previous day he had seen the grandchild of the patient in the first case of tuberculous laryngitis in which he performed tracheotomy thirteen years before, and the old lady was still greatly pleased with her condition.

Five years ago he had read a paper on the subject, having then tracheotomised four patients suffering from tuberculous laryngitis; all of these had recovered quickly after the tracheotomy. Some members thought that he was recommending tracheotomy as a routine measure in tuberculous laryngitis, but that was not so; what he had said was that a patient who was choking from tuberculous laryngitis had quite as much

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right to the benefits of tracheotomy as had a patient who was choking from any other cause. These patients were quickly cured of their laryngitis after the insertion of the tube, but they still wore the tube.

Mr. WALTER HOWARTH said that members had been impressed, not only by the variety of the conditions for which the tracheotomy had been performed, but also by the extraordinary pleasure and the comfort the patients appeared to have in the wearing of the tube. So that one wondered whether one's surgical attempts to correct stenosis were worth while, or even justifiable. He had, in his time, attempted to enlarge the airway in a number of cases. One condition for which operation was performed was a case of stenosis due to double abductor paralysis, in which the recurrent laryngeal nerve had been damaged in a partial thyroidectomy. He had used Jackson's operation of ventriculo-cordectomy and he had shown to the Section on a previous occasion two cases on which two separate removals had been made. It always resulted in failure because of the new cicatricial cord which formed, and which, in a few months, caused a fresh stenosis.

It was difficult, also, to achieve permanent success in displacing the arytenoid outwards, as in the Réthi operation, or by displacing the cord downwards, as suggested by Wittmaack. Patients with double abductor paralysis were better off with a permanent tracheotomy, and it was, perhaps a mistake to embark upon any form of surgery for dealing with the stenosis. Later in the day he would be showing a patient who had cicatricial stenosis due to healed lupus, and one of the reasons for showing her was the failure of surgery up to the present time. In this case he had used the diathermy knife under suspension laryngoscopy to remove the web which, however, re-formed. Then, through a lateral pharyngotomy, he exposed the upper end of the larynx and satisfied himself that he had removed the whole web and had secured a free airway, but that also closed up in time, and now the patient was content to wear a tracheotomy tube. She was now having progressive dilatation with rubber tubes, but he would not yet say whether it would be successful.

A third form in which surgical interference was difficult was that to which Mr. Tilley had referred, in which there had been a faulty tracheotomy, with a falling-in of the cricoid cartilage. Laryngo-tracheostomy was a laborious procedure, and it meant keeping the patient under observation for six months or longer in a nursing home or hospital. Some other methods of dealing with it involved two years of supervision, and if patients could be as happy with a tube as those now shown obviously were, one wondered whether it was not better to be content with a permanent tracheostomy.

Professor GEORGES PORTMANN said he would like to raise the question whether, in cases of cicatricial stenosis following war or other wounds, or after tracheotomy for diphtheria, it was not better to perform tracheotomy, remove the cicatricial tissue and dilate by a tube and, after a year or two, carry out a plastic operation. He thought that was more agreeable to patients than perpetually wearing a tube. In France there were many who had been war-wounded in this way, and in some of these cases, in which he had transplanted rib cartilage into the neck, the result seemed to be a complete cure.

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Mr. E. D. D. DAVIS said he found that patients were more comfortable with a low tracheotomy. He thought the reason for a high tracheotomy having been performed so frequently was that the patient's head and neck were not sufficiently extended during the operation. When the anæsthesia was local, patients were embarrassed when the neck was fully extended. Division of the isthmus of the thyroid was an essential step in doing tracheotomy.

He had used the speaking valve frequently and found it useful. The valve prevented the expectoration of mucus through the tube and diminished the soiling of the neck and dressings.

He would like to hear more about the type of tracheotomy tube Sir StClair used. At first he (the speaker) had liked the Durham tube, as it was not coughed out, but later on he had inserted the Edinburgh pattern of tube, which was a curved cannula with an opening on the summit of the curve to allow the passage of air through the larynx.

Mr. MICHAEL VLASTO said that he had recently had a case with some interesting points bearing on the present discussion. He had been rung up by a doctor at a seaside town asking for assistance in the following case: A girl, aged 12, had been urgently tracheotomised during an attack of croup. It was then a fortnight since the operation, and the patient was unable to breathe except through the cannula. The doctor was of the opinion that the child was "playing up," and that the condition was not organic. The fact that she was still unable to breathe under moderately deep anæsthesia seemed to dispose of the functional diagnosis. It was impossible to differentiate the laryngeal structures by direct laryngoscopy owing to their œdematous condition, and a soft rubber catheter could not be passed through the glottis. The cause of the obstruction was obviously due to a glottic and subglottic œdema. Inspection of the wound showed that the tracheotomy had been made through the cricoid ring. A low tracheotomy was performed, and the original wound was sutured. It was observed that the isthmus of the thyroid, which was divided, was unusually bulky. It was not until a fortnight later that the child recommenced to breathe through the mouth. But even at a later period, when there was nearly no stridor, she still wished to retain her cannula. He thought that some patients were not averse to attracting sympathy and interest by retaining their tracheotomy cannulas.

When this patient was last seen there was still a very slight stridor, and he would like to have Sir St Clair Thomson's views on the ultimate prognosis, in view of the fact that the patient was allowed to remain over two weeks with a faulty tracheotomy.

Sir STCLAIR THOMSON (in reply) said he thought his thesis had been accepted by the Section, because nearly all who had spoken had come to the same conclusion.

It was gallant of Mr. Howarth to tell members he had made those efforts, inspired by Continental literature, to do away with the tube by means of a laryngo-tracheostomy, an operation which had not been adopted in this country. Chevalier Jackson's ventricle-stripping was not heard about here now. Professor Hobday still supported his operation for the cure of roaring in horses, but he (Sir StClair) sometimes talked to his

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"horsey" friends, and it seemed that it was helpful at first, but many horses had to be tubed later. Perhaps on some occasion Mr. Howarth could bring before the Section a paper on the "tubing" of horses.

Professor Portmann had told of the successes in France in war-wound cases. It was possible that better results were obtained in these traumatic cases than in old, chronic fibroid conditions like lupus, as in the case of the lady he had shown. She had been a patient of Sir Felix Semon from childhood, owing to lupus, though she never had the disease in her nose. She had had it all over the pharynx, in the larynx, on the inside of the cheeks, and finally on the gums. She had been nine times under chloroform, and he (Sir StClair) had pushed the galvano-cautery needle from the mucous membrane until he felt it nearly come through the skin outside. Now she had not had any manifestation of lupus for eight years. That case pointed to two great curative methods: time and the galvano-cautery.

If any members could bring forward successful cases of laryngo-tracheostomy, he hoped they would do so; he had not himself seen many cases, either here or abroad. Cases he did see labelled "cured" were not cured; there was still stenosis. There was a professor abroad who was a great protagonist in this repect, who had sent to him (the speaker) a lady as a cure, but he found that she had a little fistula in her neck, which whistled occasionally and, when she talked quickly, her stridor was evident. He did not speak of any patient as cured when there was stridor. Everybody who had stridor during sleep should undergo a tracheotomy, the only exception being cases of tuberculosis. He had had several cases of tuberculosis of the larynx with stridor, in which he had advised tracheotomy to relieve the stridor and as a helpful cure. The stridor in these cases disappeared without a tracheotomy, not by the disease getting better, but by its getting worse! The vocal cords ulcerated away, and masses of granulation tissue disappeared. He had had two doctors who refused operation; they stayed quietly in bed for a month or two, and with the slowed respiration their stenosis ceased. Both those doctors required tracheotomy later. It was then only a palliative. If they had accepted it early it might have helped to a cure.

If Professor Portmann would come another year and read a paper on laryngo-tracheostomy, the Section would be delighted to welcome him.

Each laryngologist had his preference in the matter of tubes. He did not say the "Durham" was ideal, but it was good after operation, as it did not tend to slip out. For permanent wear he thought the Edinburgh modification was good, as also was the Parker.

Mr. Tilley had referred to bad tracheotomies. There was no excuse for leaving a patient permanently with a bad tracheotomy. One should not, however, criticise colleagues too readily; the operation might have been performed in a cottage, as an emergency, by the aid of candle-light. But even in the case of these "cricotomies," if the doctor would, within a few days of the first operation, put in a tube lower down, the upper one could be abandoned; it would have done no harm, for it would not have started the subglottic thickening and other troubles.

In reply to Mr. Vlasto, patients could do without the tracheotomy tube if the airway was sufficient. Functional cases in children could be got over without the patient knowing it, by gradually corking up the tube.

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Mr. Davis had mentioned the very important matter of securing complete extension of the neck for the operation. He (Sir StClair) objected to a pillow under the neck, as it threw up the larynx and depressed the trachea. There should be a series of flat, oblong pillows under the shoulders, placed one on the other until the head was hanging loose. Then flat towels should be packed in under the occiput to support it.

He had never had to regret an unnecessary tracheotomy. Better one tracheotomy too soon, and even unnecessarily, than the results in many instances in which the tracheotomy had been performed too late. The experience in this connection might be likened to that of the late Baron Ricord, the well-known French syphilographer, who, when reproached on his death-bed with "having seen syphilis everywhere," replied that what he regretted was the number of cases of syphilis which he had missed.

Chronic Suppuration of Left Frontal and Ethmoidal Sinuses cured by External Operation after Eight Intranasal Interventions.—HERBERT TILLEY, F.R.C.S.

Miss W. J., aged 28. *Symptoms:* Chronic nasal obstruction, discharge, and headaches over left frontal region. *On examination:* Extensive polypoid degeneration and suppuration in left ethmoidal region. Purulent discharge washed from left frontal sinus. Different surgeons had given temporary relief by intranasal procedures, including one by exhibitor (exenteration of ethmoid, enlargement of fronto-nasal canal and drainage of antrum), but the subjective and objective symptoms quickly recurred.

Since the external operation (March, 1931) the frontal sinus has ceased to discharge pus, but there has been a recurrence of polypi and ethmoidal suppuration.

Mr. W. STUART-LOW said that he now very seldom performed exterior operations for chronic nasal discharge, as restoration to a healthy condition could be obtained simply by operating repeatedly from the inside. Repeated partial operations were safer and more effective and avoided all risk of facial blemish. He was strongly opposed to nasal douching, as, in his opinion, this only prolonged and spread the sepsis. For years he had employed suction, as opposed to "washings" for clearing the nasal passages, the sinuses and ethmoid cells, and in very few cases had this failed.

Dr. Watson-Williams was now an energetic advocate of suction and intranasal methods instead of the extensive surgery on the frontal sinus that he used to carry out.

Dr. P. WATSON-WILLIAMS said that in the immense majority of cases chronic sinusitis yielded to intranasal operation, but a considerable percentage were unsuitable for treatment by this pernasal route. Anatomical conditions which could not be foreseen sometimes made intranasal methods fall short of a satisfactory result, and for these the external operation should be preferred. It was fortunate that when the frontal sinus was large and deep, it was, nearly always, relatively easy to treat the case pernasally, while it was more difficult to get completely satisfactory results by the

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external operation without any defect or deformity. It was the very small and ill-developed frontal sinuses which most frequently presented difficulties for intranasal approach. He was not an advocate of either method to the exclusion of the other.

Dr. DAN MCKENZIE said the important point was that the patient had had eight intranasal operations before the external operation was carried out. He himself possessed the photographic reproduction, from one of the reputable medical journals, of a patient who had had no fewer than thirteen external operations on the frontal sinus. The fact was that, no matter what particular form of operation was adopted, the results of surgery in nasal sinus suppuration were bad. There was in the disease an uncomprehended factor, and it was this unknown element that defeated our surgical efforts; for, let it be clearly stated, our surgery was not victorious, it was defeated.

Mr. J. B. HORGAN said that this patient had a polypoid condition of the maxillary antra, and her nose was of the narrow type which made intranasal surgery a questionable proceeding. If he had been treating the case he would first have opened the canine fossa on each side and removed the ethmoidal labyrinth from below and outside; he would have been surprised if the patient had not been free from headaches afterwards, and if the consequent drainage had not given her great relief. By doing this one would have opened up what Mr. Tilley had aptly described as the cross-roads of the nasal sinuses, *i.e.*, the infundibulum, and then, by sweeping a Moure's curette forwards to the frontal process of the maxilla, it would have been possible to remove a large part of the ethmoidal disease and establish good drainage. He did not share Mr. Tilley's opinion that the case was cured, but thought that it would still be necessary to open from the canine fossa on each side to attain that result.

Sir JAMES DUNDAS-GRANT said he did not think that, on the whole, Dr. Dan McKenzie was justified in his pessimistic remarks. This case was, for the moment, a disappointing one, but it did not constitute a reason for giving up faith in one's capacity to cure this condition. Taking the bulk of the cases shown to the Section, they were such as to warrant the belief that the laryngologist was not working in vain.

Mr. TILLEY said he was glad that the case had evoked criticism, but there was some misapprehension about it. When last he saw the patient after the operation she was free both from headache and discharge. The right sinuses had not been operated on because all the symptoms had been on the left side, and therefore he considered that if these could be relieved it would suffice for the time being. He wished to point out definitely that the frontal sinus was cured of purulent discharge; one could insert a large sinus catheter without difficulty, and irrigation brought away no pathological secretion. No signs of frontal sinus infection were present. The external scar was now healed and almost invisible. The inner antral wall had been removed, and a cannula could easily be passed in, so that there was no question of free drainage. The disappointment was the obvious recurrence of ethmoidal disease, in spite of the effort which had been made to deal with it when the external operation on the frontal sinus was performed. Further treatment by the external or internal route would be necessary.

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Societies' Proceedings

Large Papilloma of Uvula.—T. A. CLARKE, M.D.

M., aged 55. The uvula is replaced by a large papillomatous mass. There is a small secondary papilloma growing from the upper part of the left posterior pillar of the fauces. A papilloma of the uvula was removed seven years ago and has been growing again for six years.

Sir ST CLAIR THOMSON said he took a section from the growth in this case five years previously, but he did not attempt removal of the papilloma, as the case was sent to him by the insurance office for an opinion only. His report was that the growth was innocent.

Dr. T. A. CLARKE (in reply) said that he had been mistaken as to the original operation. He proposed to remove the growth; he had not had another microscopical examination made, but it was obviously papilloma.

Occlusion of Naso-pharynx.—C. F. BEEVOR, M.B.

Patient, female, aged 24. Came to hospital on account of chronic ear discharge. On routine examination the palate and fauces were found to be fused together, leaving a small hole, which would barely admit a lead pencil, immediately below the uvula. Wassermann reaction, negative. The condition appears to be due to a severe attack of scarlet fever with extensive faucial ulceration in childhood. Nasal airway is only slightly affected. Any attempted plastic operation would probably lead to formation of further scar tissue.

Mr. RITCHIE RODGER said that the patient's mother had informed him that when the child had the scarlatinal throat the medical attendant told her to swab the throat with carbolic acid, a bottle of which he supplied; when he saw the throat on the next day he told her to stop doing so.

Mr. J. F. O'MALLEY said that one occasionally saw similar cases, in which there was no history of the application of any such thing as carbolic acid. In some acute scarlatinal cases there existed an intense œdema, and so there was pressure between the pillars of the fauces; an ulceration followed and, consequent on this ulceration, there was scarring. He had shown before the Section a boy who had had a similar condition of throat following scarlet fever. He had shown the case in order to elicit opinions as to treatment. Some members favoured an attempt being made to enlarge the opening, but others discouraged that. He took the opinion of the former, to his great regret, as the patient did badly and a fresh suppuration occurred in the ear; there was trouble with that patient for months. When, finally, the further trouble had settled down, the fauces were in the same condition as originally.

Œsophageal Spasm.—WILLIAM IBBOTSON, F.R.C.S.ED.

Female, aged 64. First seen 20th May 1930.

History.—Dysphagia for fluids since November 1929; sudden onset, following a very severe "cold," and has persisted ever since. Can swallow all solids without any difficulty. No vomiting or hæmorrhage.

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Examination.—Infected tonsils; paresis of right vocal cord. Very cachectic in appearance. Hard, discrete cervical adenitis in the anterior triangles.

Diagnosis.—Very suggestive of early carcinoma, either of the upper end of the œsophagus or in the posterior mediastinum.

27.5.30.—Both vocal cords moved equally and well. Clinical and radiographical examination of chest showed fibrosis of both lungs, but no evidence of neoplasm. It seemed to me that this might be a case of œsophageal spasm initiated by tonsillar infection, and so, on 21st June 1930, I performed tonsillectomy.

18.7.30.—The symptoms practically disappeared and patient felt very much better.

17.4.31.—Patient came to see me again because of the return of symptoms; she was able to swallow liquids only by taking them in sips. Felt ill and had much dyspepsia. There was now slight paresis of the right vocal cord, and she looked definitely cachectic. Radiography of œsophagus showed neither a stricture nor any evidence of post-cricoidal neoplasm, though the radiographer, Dr. C. Shanks, noted some difficulty during the act of deglutition, which to him suggested a neuro-muscular lesion.

It then occurred to me that there might be a parathyroid lesion, leading to a diminution of the calcium in the blood, but examination showed a slight increase, viz., 12·8 mm. per cent. Nevertheless, I put her on calcium lactate gr. 10 t.d.s., and on 5th January 1931 she reported that she could already drink "much better" though not very fast as yet. On 14th May 1931 she was still improving.

Epithelioma of Vocal Cords Four Years after Operation.—W. H. JEWELL, O.B.E., M.D.

F. M., male, aged 52. Was present at the March and April Meetings, 1927,* when the general opinion expressed was that a laryngectomy was required.

Left vocal cord fixed and ulcerated, anterior portion of right cord infiltrated.

Laryngo-fissure, April 1927. Left cord removed, together with surrounding tissues, also anterior quarter of right cord. Cricoid divided and subglottic extension excised on the left side.

Sir ST CLAIR THOMSON showed a drawing from a similar case. At the time it was shown he had suggested that tuberculosis should be excluded before active measures were taken. The majority of speakers believed that the condition was malignant, and that the only course was laryngectomy. Both the biopsy before operation and the sections afterwards reported it to be epithelioma.

* *Proceedings*, 1927, xx., 1398, 1630 (Sect. Laryng., 46 and 62).

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The present case was a remarkable one, and showed what could still be done by an extended, partial laryngectomy through a laryngo-fissure. There had been little cicatricial stenosis afterwards. The left cord was fixed, and he would like to know whether the vocal process was free. At the other extremity of the cord the disease had not penetrated into the anterior danger zone, the petiolus, but had crossed the commissure to the other side, and Mr. Jewell must have hit off the anterior commissure exactly—a great secret of success. He had never seen a better result or a wider larynx after a fixed cord and part of its fellow had been removed. Such a case as this caused laryngologists to consider carefully whether perseverance with extended laryngofissures might not help to avoid some laryngectomies.

Mr. W. H. JEWELL (in reply) said that in the main he tried to carry out Sir St Clair Thomson's method, but he did not remove the alae of the thyroid, and he divided the thyroid cartilage and the cricoid with a knife and saw, as he thought these were preferable to the shears. In this case he removed a piece before operation, by means of Haslinger's directoscope, which enabled him to obtain a better portion for microscopical examination than he could have by the indirect method. The vocal process was free and was not removed.

Stenosis of Larynx due to Lupus, now being treated by Progressive Dilatation.—WALTER HOWARTH, F.R.C.S.

E. S., aged 25, first seen in 1924 with active lupus of palate, pharynx and larynx.

Treated by general hygienic measures at the seaside.

Tracheotomy performed 1925, to rest the larynx. Complete healing with extensive scarring. The entrance to the larynx was closed by a web with only a pin-point opening through it.

In 1927 it was thought that this web might be excised with the diathermic knife. This was carried out under suspension laryngoscopy but the scar-tissue re-formed.

In 1928, after a lateral pharyngotomy, the web was again excised and a free entrance to the larynx established, but stenosis recurred.

Progressive dilatation was begun eighteen months ago but the patient refused to have it continued.

Six weeks ago a doubled rubber tube was drawn through the stricture and anchored above and below (Iglauer's method). It has been removed to-day and a larger one will be inserted to-morrow.

Dr. DAN MCKENZIE said that the question of the treatment of lupus required to be revised. In the past, laryngologists had been inclined to lay most stress on local treatment, but recently he had had an experience in which general treatment had acted surprisingly well. It was a case of lupus of the hard and soft palate, which was being treated by diathermy; but although the patch to which the diathermy was applied always healed up, another patch would appear beside it, so that he had to keep on pursuing the disease. Finally he found, on looking at the larynx, that

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though there were no symptoms, the introitus laryngis and epiglottis were infiltrated with lupoid masses, and he did not care to embark upon the diathermy treatment in that situation. He thought, however, that if he treated the patient as though he had phthisis of the lungs and had him removed to a sanatorium it would be better. This was done, and in a few months the disease had become inactive over its whole area, and now, after six months at home, the improvement was maintained and the disease quiescent.

Mr. HORGAN said that he had found arsenic was good in the treatment of these cases.

Sir ST CLAIR THOMSON said that at Midhurst Sanatorium, where he examined all patients, whether they were husky or not, many had had lupus of the larynx which had been cured without treatment and without having shown laryngeal symptoms. The disease in such cases was on the epiglottis or the aryepiglottic folds. Therefore, when radium, or arsenic, or pink-green, or anything else was recommended, it should be remembered that lupus of the larynx would be cured spontaneously, particularly when the larynx was put at rest by tracheotomy. He agreed that lupus cases were potentially tuberculous cases, and if the patients continued to be exposed to bad conditions most of them became tuberculous, especially women who married and had children. Sanatorium principles should be carried out in all cases, and if lupus caused stridor in the larynx, a tracheotomy was the best remedy.

Mr. HOWARTH (in reply) said he brought the case particularly to reinforce those which Sir St Clair Thomson had shown at the morning meeting and to illustrate the futility of trying to make an airway once there was such extensive scarring as in this case. He had established a very free airway on several occasions and by several methods, only to be confronted with further stenosis at a subsequent period. At the patient's request he was trying dilatation, and had kept a double rubber tube in for six weeks, but, as members would admit, the results were disappointing. He thought that she would have to put up with the tracheostomy as a permanency.

Permanent Tracheostomy in a Case of Lupus of the Larynx.—V. E. NEGUS, M.S., F.R.C.S.

November 1922. Female patient, then aged 47, complaining of roughness in roof of mouth, noticed for four years. Also had loss of weight, cough at night, loss of voice, and much dyspnœa on exertion. Nodular appearance on hard palate; infiltration of epiglottis and aryepiglottic folds, with ulceration of vocal cords, movement being normal. Appearances typical of lupus. No definite physical signs in lungs, but X-ray examination showed signs suggestive of early tuberculosis in left lung. No tubercle bacilli in sputum.

May 1924.—Extension of lupus to dorsum of tongue.

May 1925.—Dyspnœa more marked. Lesion in lungs not active, but probable cavitation of right apex. Wassermann reaction negative.

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Low tracheotomy performed with local anæsthetic. Chevalier Jackson's cannula inserted.

1927.—Laryngeal condition much improved. Patient appeared to be well. Signs of quiescent lesion in both apices.

1929.—Laryngeal lesion healed.

1931.—Patient is quite well and breathes freely through larynx, but prefers to retain the tracheotomy, as she feels safer, although the cannula is completely corked.

This case illustrates what Sir St Clair Thomson demonstrated this morning, namely, that a person can lead a happy life with a permanent tracheostomy. Once I thought tracheotomy a terrible thing, because it puts the nose out of action for warming and moistening the inspired air, and also puts the vocal cords out of action for regulating the intake of air, and the degree of opening and shutting, to conform with physiological necessity. It is only when one sees these patients leading successful and happy lives, without bronchitis, with a permanent tube, that one's fears vanish. This patient can do without her tube, but she does not like to, as she feels safer with it; she would be unhappy if it were taken away.

Permanent Tracheostomy in Laryngeal Stenosis.—V. E. NEGUS, M.S., F R.C.S.

Patient, female, aged 39.

Influenza in 1918. Abscess at side of trachea opened; patient recovered, but three months later had dyspnœa.

Admitted to King's College Hospital. Tracheotomy performed by Mr. C. W. M. Hope. Patient was then three months pregnant. A healthy child was born and she has had two more children since. She is quite well. The voice is good and clear when she closes the tube. She has an expiratory valve, but does not like it. Vocal cords seen close together, quite immobile, apparently due to fixation of crico-arytenoid joints.

This is not my case, and I was not at the hospital when it was treated, but I brought the patient to the meeting because she illustrates what has been shown by other cases. She leads a comfortable and happy life and does not desire to have the tube removed.

Sarcoma of the Trachea. — E. WATSON-WILLIAMS, M.C., F.R.C.S.

Girl, aged 6, had had no previous illness of importance until about Christmas 1930, when she had "croup" with severe dyspnœa for three or four days; this cleared up completely. Early in March 1931, without discoverable cause, she rather suddenly developed respiratory difficulty, which rapidly became severe; the difficulty was

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mainly inspiratory, and improved slightly when she lay down, but was always very bad at night. A loud inspiratory stridor was heard, with a lesser expiratory one; on inspiration there was very marked sucking in at the suprasternal notch. No hoarseness; voice and cry rather weak but otherwise normal; the child was not cyanosed, but avoided all unnecessary movement. Indirect laryngoscopy showed the glottis to be normal, but below it a narrowing of the airway, the original diagnosis being chronic subglottic œdema. Direct laryngoscopy under cocaine anæsthesia confirmed this finding, but owing to distress only a very short examination was possible. The obstruction increased and for several nights it seemed as if every breath must be her last. It was therefore resolved to make a complete examination under general anæsthesia, although the risk appeared to be considerable.

On 10th April 1931 Dr. Feneley arranged a gauze mask, through a hole in which a tube led from a cylinder of oxygen. The gas was turned on and very gradually ethyl chloride and ether was dropped on the mask; induction took twenty-five minutes, not one of which was free from real anxiety. As soon as the child was unconscious she ceased to breathe; I therefore passed the laryngoscope and seeing masses in the trachea which seemed soft, I slipped an intratracheal catheter through them, by which means respiration was restored. However, she began to get really blue a minute later and I had to perform tracheotomy, through the third, fourth, and fifth rings of the trachea. On opening the trachea it was found that the soft masses of what seemed granulations extended from just below the cricoid to the fourth ring; they appeared to block the trachea completely, although it was possible to discover a potential lumen. The accessible part of the mass was scooped out and a tracheotomy tube inserted, respiration becoming tranquil at once, producing an extraordinary change in the general appearance. There was relatively little bleeding, and the masses, quite soft, stripped readily from the trachea, which did not appear to be at all infiltrated. The masses were reported by Dr. Fraser to be spindle-celled sarcoma.

The condition appears to be exceedingly rare, and I should be grateful for suggestions as to treatment; at present, radium is the only suggestion.

I desire to pay a tribute to the masterly way in which Dr. Feneley administered an exceedingly difficult anæsthetic.

Mr. LIONEL COLLEDGE said he did not see any necessity for doing more at present. If there were no recurrence, and the patient survived several years, removal of the tracheotomy tube might be considered.

Mr. ERIC WATSON-WILLIAMS (in reply) said that he had inserted 25 mgm. of radium with a one mm. platinum screen for five days. The

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next adventure was that in removing the radium the silk cord, after he had taken out the packing, snapped, the child drew a breath, and down went the radium. It was in a container 7 mm. across. The child ceased to breathe. The sister who was helping him held the child up by the hips, he put a finger into the tracheal wound, a shake brought the radium into view, and he was able to fish it up with hæmostatic forceps. He had attempted to dispense with the tube, but after five days the child began to get distressed, some granulations bled, and she coughed violently. Though she breathed nicely with the bronchial tube, she would not allow the tube to be taken out. He had, in the beginning, told the mother she must regard permanent tracheotomy as a favourable result. He would report later on what happened. The second incision was high in the trachea because the growth occupied $5\frac{1}{2}$ rings of the trachea, and he wished to ensure that nothing was overlooked.

Laryngeal Obstruction in a Man suffering from Lymphatic Leukæmia * **(Specimen).** — Sir JAMES DUNDAS-GRANT, K.B.E., F.R.C.S.

Patient, male, aged 54, was referred to the throat department of the Cancer Hospital on 18th March 1931 on account of weakness of voice of six weeks' duration, and regurgitation of liquids on drinking of three weeks' duration. There was then seen irregular infiltration of both vocal cords and the inter-arytenoid mucous membrane; the right cord was irregularly thickened and along the posterior two-thirds of the left cord was a longitudinal slit, wide at the posterior part and narrow in front. There was very incomplete adduction, so that the voice was very feeble and liquids regurgitated into the larynx on drinking. Patient looked haggard and distressed on account of the inability to take liquids. He was instructed to drink through an indiarubber tube, with his head bent far forward, following Wolfenden's method, and with this he could drink quite satisfactorily.

A year previously he had suffered from deep-seated phlebitis of the right leg, followed two weeks later by phlebitis of the left one, and in September 1930 noticed enlarged glands in his neck, followed four weeks later by glandular swellings under his arms; later these developed in both groins; the abdomen was distended; the liver and spleen were enlarged; there was œdema of the right arm. The Röntgen rays revealed enlargement of mediastinal glands. Blood-count, October 1930, R.B.C.'s 4,200,000 per c.mm.; Hb. 75 per cent.; W.B.C.'s 45,000 per c.mm. *Differential:* Neutros. 2 per cent.; eosinos. 0·6 per cent.; lymphos. 94·7 per cent.

* Shown at the Meeting held on 1st May 1931. Publication was deferred in order that the description of the specimen, which was remounted and shown again at the June Meeting, might be given with the notes of the case.

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January 1931: W.B.C.'s 14,800 per c.mm. *Differential:* Neutros. 0·5 per cent.; eosinos. 5·5 per cent.; lymphos. 92 per cent.; lymphoblasts 2 per cent.

Liver treatment afforded no benefit. X-rays have been applied to various parts of the body on numerous occasions.

At present the infiltration of the vocal cords is much the same as before, but the cords are now much more closely approximated and only very slight abduction takes place for inspiration. Very frequent inspiratory stridor and occasional attacks of struggling for breath. He was afraid to try to drink without the tube, and with his tendency to asphyxia it was perhaps better that he should not make the trial. He was being carefully watched and was prepared for tracheotomy if the dyspnœa increased.

At first sight the appearance of the vocal cords suggested tuberculosis, but no bacilli were found.

The patient died before the meeting at which he was to have been present.

Specimen.—The larynx showed extreme œdema of the aryepiglottic folds, but this disappeared to a great extent soon after removal from the body. It has been opened from the front, as in laryngo-fissure, and the arytenoid eminences are seen to be enlarged and infiltrated. The vocal cords are swollen, and underneath each of them is a longitudinal fissure running from before backwards to the vocal process and then upwards. This cleft on each side is filled with a yellow, cheesy material of dense consistency. The region of the lingual tonsil is beset with a multitude of rounded elevations. Masses of glands were found on both sides of the neck, in both inguinal regions, and in various parts of the body.

The Larynx—A Site of Infection in certain Diseases of the Lymphatic Glands: Demonstration of Specimens.—JOBSON HORNE, M.D.

Dr. JOBSON HORNE said he had read that it took twelve years for a new medical scientific fact to become commonly known and accepted. In December 1901 he had published in the *Journal of Laryngology and Otology*, Vol. xvi., p. 684, under the above title, the post-mortem findings in a group of cases which presented the clinical features of Hodgkin's disease. He used the term "Hodgkin's disease" in a comprehensive sense, to cover the various terms used in the literature, such as adenia, lymphadenia, lymphadenoma, lymphadenosis, lymphogenic diathesis, lymphoma, lymphomatosis, lymphosarcoma, malignant lymphoma, pseudo-leukæmia, a nomenclature in itself evidence of uncertainty.

The cases had two important points in common. Firstly, ulceration of the larynx—the ulceration being situated on the glottic aspect of

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the arytænoid region and the posterior part of the vocal cord; and secondly, the enlargement of the lymphatic glands in the immediate vicinity of the ulcers.

The first specimen demonstrated was a larynx removed from a woman, aged 23, at an autopsy made on 18th July 1898.

The larynx presented an ulcer on the posterior third of the left vocal cord (see Fig. 1), the edges of which were ragged but not thickened; at a corresponding spot on the right cord there appeared to be scar tissue.

The lymphatic glands on both sides of the neck were considerably enlarged, both the deep as well as the superficial cervical glands, and more so on the left than on the right side. The tracheal and bronchial and the anterior and posterior mediastinal glands were enlarged and obstructing the divisions of the bronchi leading to the upper parts of the lungs. Of the abdominal glands, the aortic were considerably enlarged, and to a lesser degree those situated along the greater curvature of the stomach and in the hilum of the liver; the mesenteric glands were not much enlarged. The axillary glands were not increased; the inguinal were enlarged. The spleen contained several whitish nodules. The liver was fatty but free from growths. The lungs were œdematous; evidence of tuberculosis was looked for, but none was found.

The second specimen demonstrated was a microscopic section cut vertically through the posterior third of the left vocal cord of a larynx removed from a man, aged 31, at an autopsy made on 16th May 1900.

The larynx presented a deep ulcer dipping below the level of the posterior part of the left vocal cord (see Fig. 2). There was a shallower ulcer at a corresponding spot in the right vocal cord.

The lymphatic glands of the neck on both sides were greatly enlarged; so also were the axillary glands. The inguinal and other lymphatic glands were not affected.

The anterior mediastinum contained a mass of growth. The posterior mediastinal glands were enlarged. The right lung was bound down by adhesions, and had been invaded from its root by the growth; the main right bronchus was almost occluded. The left lung presented evidence of old tuberculosis. The liver and spleen showed no naked-eye evidence of lymph-adenomatous infiltration.

The post-mortem examinations illustrated how in similar cases respiratory obstruction, although apparently laryngeal, might be mediastinal in origin.

The microscopic examination of the lymphatic glands showed in the first specimen the histological structure of lymphadenoma, and in the second specimen all three structures characteristic of lymphadenoma, lymphosarcoma, and tuberculous lymphadenitis.

Hodgkin's disease, so far as could be ascertained, began in the glands of the neck in at least 50 per cent. of the cases recorded. The mouth, the tonsils, the pharynx and the naso-pharynx had all been suggested as possible sites of infection. Ulceration of the larynx as a point of entrance of the infecting agent, so far as he (Dr Jobson Horne)

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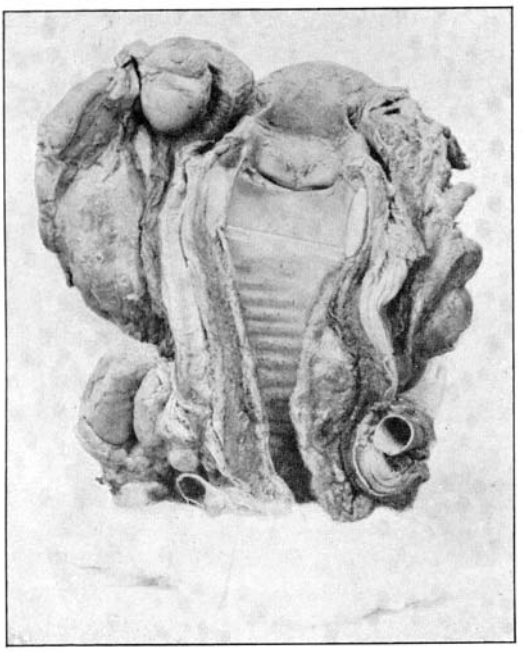


FIG. 1.—From a larynx showing the ulcer in the posterior third of the left vocal cord and the enlargement of the adjacent lymphatic glands.

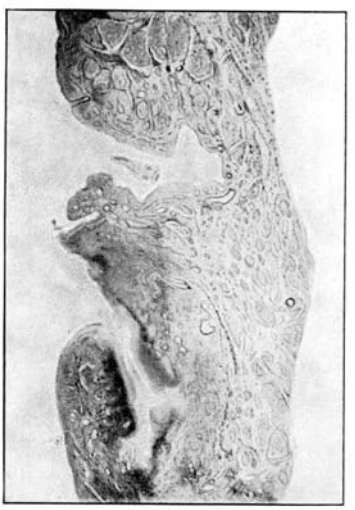


FIG. 2.—Microscopic section cut vertically through the posterior third of the left vocal cord of the larynx (Specimen 2). The section includes the ventricular band, the ventricle, and the vocal cord. An ulcer can be seen dipping below the level of the cord.

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knew from an investigation of the literature when he first published his cases thirty years ago, had escaped notice. The cases he had demonstrated, he considered, were evidence that Hodgkin's disease concerned the laryngologist.

Sir JAMES DUNDAS-GRANT said that there was a remarkable resemblance between his case and those to which Dr. Jobson Horne had referred, except that instead of an ulcer below the vocal cord there had been, in his case, a cavity lined wlth columnar epithelial cells. He pointed out the number of lymphatic swellings in the lingual tonsil. He thought at first there was tuberculosis, but he found nothing to confirm that opinion. The red corpuscles were reduced to four millions, and the whites, instead of being only 7000, were 45,000. Only 2 per cent. were polymorphonuclear neutrophils, 0·6 per cent. were eosinophils, and 94·7 per cent. lymphocytes. Apparently this count was characteristic of lymphatic or splenic leukæmia, whereas in Hodgkin's disease there was no change in the corpuscles, but there was enlargement of the spleen and lymphatic glands. The disease had begun in this patient long before there was any laryngeal manifestation, so that there was no proof here that the original port of entrance was the larynx.

Specimen of Tumour removed from Tonsil.*—N. ASHERSON, F.R.C.S.

Female, aged 40, complained of a lump in the throat. Depending from the right supra-tonsillar recess was a bi-lobed, pendulous, whitish, firm and lobulated tumour. It was not friable, and each lobe was the size of a walnut. The mass was freely movable on its pedicle, which was extremely slender, and the mass was easily snared off.

Report on section by Dr Scott Williamson: "Tonsillar tissue containing many keratin cystic crypts. Contains a simple capsulated abscess-like area, lined with epithelium."

Endothelioma of the Tonsil, with Vincent's Organism.—N. ASHERSON, F.R.C.S.

Patient, male, aged 21, complained of a swelling in the throat with slight soreness, of a few weeks' duration; otherwise he was in good health. The right tonsil was very much enlarged, reaching to the mid-line. The free surface presented a deep ulcerated cleft, extending laterally into the tonsillar substance. It was hard on palpation, and bled easily on handling. By retracting the tonsil forward, the fissure could be viewed. From the upper pole of the anterior pillar dilated vessels coursed over the surface of the mass, which was limited to the tonsil substance, and did not involve the faucial pillars. The tonsil could be moved about freely in its bed. The left tonsil was merely enlarged and not ulcerated. No clinical evidence of syphilis in mouth, pharynx, or larynx. At the angle of the

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jaw, in the right side of the neck, was a mass of enlarged glands, the size of a golf ball, painless, globular and freely movable.

Wassermann reaction, negative; swab from right tonsil revealed Vincent's organism, confirmed by second swab taken one week later.

At the same time, as the appearance of the tonsil suggested a neoplasm, a part of the edge was removed for microscopic examination. This was reported upon as "certainly not a neoplasm." Mercury and iodides internally produced no effect, and three weeks later the tonsils were removed. The dissection was easily performed; there were no adhesions and no involvement of the pillars and there was little bleeding. No ligatures were found necessary for the tonsil bed.

The right tonsil was still enlarged, with the fissure present, but the ulceration was healed. The mass was firm and somewhat nodular. The capsule was normal.

Report on section by Dr Scott Williamson: "Certainly a new growth, probably an endothelioma." There were no clinical signs of lymphadenoma; the microscopic section showed no typical giant cells or eosinophilia, often found in the latter condition.

The points of note are: (1) The presence of Vincent's organism. (2) The growth was limited within the tonsillar capsule. (3) The first section was negative. (4) The diagnosis was made microscopically from a section of the removed tonsil.

The case recorded by Norman Patterson (*Proc. Roy. Soc. Med.*, 1930, xxiii., 1151, Sect. Laryng. 45) seems to be a late stage of this condition. These two cases are the only records I can trace of endothelioma of the tonsil.

The enlarged glands were removed by operation. A recurrence in the lower cervical glands on the same side was treated by radium (2400 mgm. hrs.) and this dispersed the mass completely. A skiagram suggests enlargement of the mediastinal glands. The microscopic section "does not correspond to a sarcoma or an epithelioma."

Sir JAMES DUNDAS-GRANT said that he had had a girl patient with what appeared to be a typical Vincent's organism infection; it was present in quantity. Eventually lymphosarcoma of the tonsil developed and the patient died. Vincent's organism being associated, in early stages, with such conditions, was it something more than an accidental coincidence?

Colloid Cyst of the Thyro-glossal Tract. Specimen dissected out.*—N. ASHERSON, F.R.C.S.

Female, aged 18, noticed a lump in the neck, now present for three years. It was not painful, and did not vary in size. There was a globular cystic swelling, $\frac{3}{4}$ in. in diameter, over the middle of the prominence of the thyroid cartilage. It could be moved from side to

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side, but was adherent on its deep aspect. A thickened cord could be palpated running up the mid-line of the neck to the hyoid bone, to which it appeared to be adherent. It displayed the characteristic physical sign of the thyro-glossal cyst, that of becoming more prominent and moving upwards when the tongue was protruded. This movement was very much more obvious on palpating the tumour while the tongue was being protruded. The base of the tongue (foramen cæcum) was normal and the thyroid gland appeared to be present, and presented no pathological enlargement. At operation, the lower end of the cyst was adherent to but separate from the upper border of the thyroid isthmus, and also to the prominence of the thyroid cartilage. It was dissected off, and while its lower end was soft and cystic, it had a solid pedicle running upwards from its upper border. This was followed to the hyoid bone. The track led deep to this bone in the mid-line. The middle part of the hyoid bone was removed, and the tumour, pedicle, and attached hyoid bone came away. The pedicle was adherent to the deep surface of the hyoid bone, as shown in the specimen. The track appeared to end at this point, where it obtained attachment to the deep surface of the hyoid. Recovery uneventful. The specimen shows a colloid cyst at the lower end of the thyro-glossal tract, but the condition may also be looked upon as a colloid goitre at the lower end of the pyramidal lobe of the thyroid. A section revealed the structure of a colloid goitre. Dr. Scott Williamson looks upon it as an attenuated isthmus with a colloid cyst in it. Clinically the case was indistinguishable from one of simple thyro-glossal cyst.

Sir JAMES DUNDAS-GRANT asked whether the tract passed up deep to the hyoid bone, or in front of it. A distinguished anatomist insisted that, on embryological grounds, the duct should pass in front of the hyoid bone. In a case of the kind under his (Sir James's) care he dissected the tube out after having passed an electrolytic needle through its whole course. He found it went up behind the hyoid bone to the foramen cæcum. There was no recurrence.

Mr. ASHERSON (in reply) said there was no doubt that clinically the growth was a thyro-glossal cyst and he expected to have to follow it up to the foramen cæcum. There was a cord which went behind the hyoid bone and stopped there. He had expected to find fluid in the cyst, but it turned out to be a colloid goitre. He wondered whether it was colloid goitre in the pyramidal lobe of the thyroid, or in the thyro-glossal tract.

Epithelioma of Left Vocal Cord.—E. WATSON-WILLIAMS, M.C., F.R.C.S.

J. S., male, aged 68, began to notice hoarseness five and a half months ago; it was quite painless, came on rather suddenly, and has become a little worse, but not much. No difficulty in swallowing, no cough, no expectoration. Patient thought the hoarseness was due to

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cold weather, but it did not clear up in the spring, and on 4th June 1931 he sought advice. The left vocal cord is replaced in its middle two-fourths by a snow-white, nodular, almost spiky neoplasm, which projects somewhat above the surface and into the opening of the glottis; the cord is quite mobile, but the portion in front of and behind the neoplasm is bright red; there is no ulceration, and both ends of the cord appear free from infiltration. No glands palpable. There are several foul stumps of teeth.

Treatment proposed: Preliminary dental clearance, laryngo-fissure and removal of the affected half of the larynx. It may be necessary to remove the arytenoid.

Dr. P. WATSON-WILLIAMS said he did not doubt that this was epithelioma, or some form of malignant growth. That was also Professor Portmann's view. It was a question whether removal should be preceded by a biopsy. He would take a biopsy immediately before operation by laryngo-fissure.

Osseous New Growth of Ethmoid.—W. H. JEWELL, O.B.E., M.D.

A. F., male, aged 27. The condition began four years ago while he was in India serving in the army, from which he has been discharged on account of his disability. No history of injury. There is a fixed, hard swelling on the right side of the face, which crosses from the nasal bone like a wing over the anterior surface of the maxillary antrum, with two prominent ridges, one passing along the infra-orbital margin, the other obliquely downwards.

There is pain at times lasting two or three days, originating from the swelling and continued over the right cheek, temple, forehead and head to the opposite temple.

Wassermann reaction negative.

Translucency is obscured over the tumour, but the rest of the antrum is clear.

Sir JAMES DUNDAS-GRANT said that the skiagraphic findings were somewhat disconcerting, but he considered the swelling to be bony, like leontiasis. Pain in the region supplied by the superior maxillary nerve could sometimes be relieved by the injection into the antrum of a very weak solution of novocain.

Mr. BELL TAWSE said he thought that this was a bony tumour, and he would have advised leaving it alone, except for the intolerable neuralgic pain which demanded that something should be done. The infra-orbital nerve seemed to be involved. An external incision would enable the tumour to be investigated and dealt with if advisable. Removal of the tumour might involve the orbital margin, and consequent damage to the eye. If any injection were decided on he thought it should be alcohol.

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Dr. JOBSON HORNE suggested the administration of iodide of potassium, beginning with small doses.

Mr. JEWELL (in reply) said he thought the tumour was a bony growth. Something had to be done because of the severe pain. He had thought of making a Moure's incision, turning the cheek back, cutting the bone out, and trying to leave the orbit free. He did not think the injection of novocain would do much good, as the man was incapacitated by the pain, which was increasing.

Some growths of this kind were seen among natives on the West Coast of Africa. This man had served in foreign parts, in Africa as well as in India.

POSTSCRIPT, 16.6.31.—The bony tumour has been removed.

Mr Herbert Tilley showed three specimens illustrating the relationship between a certain type of accident and this age of mechanisation. (1) A "Baby Austin" Model impacted in the Gullet. (2) A Model of an Aeroplane impacted in the Gullet. (3) A Fountain-pen Clip in the right Bronchus.

All these foreign bodies were removed successfully within a few hours of the accident.

ABSTRACTS

EAR.

Are the Terms "Otitis Media" and "Mastoiditis" correct ones in view of our present-day knowledge of the pathology of these conditions? A. LINCK. (*Arch. Ohr., u.s.w., Heilk.*, 1931, Band cxxix., pp. 181-206.)

A plea for a more accurate terminology in otological literature! From a strictly anatomical point of view, an otitis media should mean an inflammation of the middle-ear cavity alone. This we know to be incorrect, an acute otitis media in practically all cases being an inflammation of the mucous lining of the middle ear, plus an inflammation of the mucous lining of an extensive pneumatic cell system reaching various and often remote parts of the temporal bone. It would be better to speak of *acute otitis* and *paraotitis*. When we come to chronic otitis media the discrepancy is still more marked. In many cases the pathological changes are confined to the regions behind the middle ear, a marginal perforation simply providing an outlet.

By "mastoiditis" we indicate a condition in which bone destruction has complicated an inflammation of the mucous lining of pneumatic cells in the mastoid process, and in which this bone destruction has become manifest clinically. If the inflammation in the mastoid process

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