SCHEINMANN showed a patient with carcinoma of the pharynx and larynx. The case had improved under treatment with pyoktanin and electrolysis.

ROSENTHAL showed a patient who had a bleeding into the mouth proceeding from a wound of the left tonsil, and which was treated by chloride of iron. No cause for it could be found.

SCHOETZ had observed such bleeding in patients suffering from cirrhosis of the liver.

KATZENSTEIN had seen them in malignant tumours and phthisis.

TREITEL had seen them in gouty patients.

LEWIN showed (1) a patient with specific ulcers of the tongue, and defect of the epiglottis; (2) a tracheotome used by him with good results for thirty years.

B. FRAENKEL showed a specimen of specific tumour of the epiglottis.

SCHOETZ did not believe that tracheotomes are practical instruments.

P. HEYMANN showed a patient, twenty years old, with luxation of the right arytenoid cartilage.

B. FRAENKEL had observed a similar case.

LEWIN had observed a tumour between the vocal bands, which was formed by the cricoid cartilage.

SCHEINMANN showed an incrusted foreign body removed from the nose.

HEYMANN showed a specimen of bullous dilatation of the ductus naso-lacrymalis.

CHOLEWA showed a nasal chisel.

SCHEIER showed a specimen from a patient, thirty years old, who died after a fall from a height, thirteen days after the accident, which caused luxation of the vertebral column of the neck. On the posterior wall was a decubital ulcer, produced by pressure of the vertebræ. *Michael.*

BRITISH LARYNGOLOGICAL AND RHINOLOGICAL ASSOCIATION,

Meeting held on June 19th, 1891.

Dr. DUNDAS GRANT, *Vice-President for England*, IN THE CHAIR.

Dr. SANDFORD, in the absence of the Hon. Sec., having read the minutes of the previous meeting, and these having been declared to be correct, a letter was read from Dr. Macintyre expressing his regret at not being able to be present.

The following gentlemen were unanimously elected Fellows of the Association:—FREDERICK AUGUSTUS SMITH, M.D., Portland House, Cheltenham; ARTHUR G. ROOT, M.D., Albany Medical College, Albany, N.Y., U.S.A.; JOHN WILLIAM REES, M.R.C.S, L.R.C.P., Throat Hospital, Golden Square, London, W.

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

ALTERATION OF RULE.

In the absence of Dr. GEORGE STOKER, Mr. LENNOX BROWNE brought forward the following proposed alteration in and addition to the present rule, viz. :—

> "That papers and communications announced on the official programmes of the Association shall not be separately published until they have first appeared in the official journal of the Association. This rule shall not affect or prevent a *résumé* or report of the proceedings appearing at any time in any journal that may send a reporter to the meeting."

He observed that they had received a very liberal offer for the publication of their transactions, and their publication could not fail to excite greater interest on the part of Fellows since it could be the means of disseminating a knowledge of the work that was being done, not only to those Fellows who could not always be present, but generally would thus tend to and advance the interests of the Association. He urged, therefore, that it would be only proper for them to exercise that small amount of self-denial which would be involved by refraining from publishing papers read at their meetings in any other journal until they had first appeared in the JOURNAL OF LARYNGOLOGY, which was now recognised as their Official Journal. He thought that such a course would commend itself to them as being loyal to their publisher. The resolution was seconded by Dr. BARCLAY BARON.

The PRESIDENT, in reply to questions, further explained the object of the motion, and added that it was understood that the JOURNAL OF LARYNGOLOGY would publish a report of the proceedings as early as possible. It was, after all, only a question of reciprocity as between the Association and their publisher.

The proposal was then agreed to unanimously.

Mr. LENNOX BROWNE then moved to alter Rule 18 as to the formation of a quorum, so that three members of Council would suffice instead of four. He explained that there being so few metropolitan members it was sometimes difficult to get together the requisite number of members to carry on the business.

This motion was also agreed to.

It was proposed by Mr. Lennox Browne, and carried unanimously,

> "That Messrs. Coutts and Co., 59, Strand, London, W.C., be authorized to honour the signature of the hon. sec. of the Association for the time being—the hon. sec. at present being Dr. George Stoker. That Messrs. Coutts and Co. shall be advised of any change in the secretaryship of the Association, and are empowered to charge a commission of one guinea per annum, commencing in June, 1892."

The SECRETARY then read various correspondence.

Mr. LENNOX BROWNE suggested that the ballot should not be declared until the end of the meeting. He regretted that the name of the President did not figure on the programme, and also that the fact that

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

the President's address was to be delivered had not been made more conspicuous.

The meeting agreed to declare the result of the election as the last item of business on the programme.

At this juncture, Dr. Hunter Mackenzie, the President, having arrived, took his seat in the Presidential chair. He apologized for the delay in his arrival, but explained that he had been present in good time in the afternoon, but though he had waited some time, only three provincial members had put in an appearance, and he had been compelled to adjourn the meeting in consequence. He observed that he thought the London members were singularly wanting in courtesy in not having attended.

Mr. LENNOX BROWNE pointed out that it was sometimes more difficult for them to be punctual for the very reason that they were London members. He suggested that probably many members like himself had expected the meeting to take place at three o'clock as heretofore, not having remarked the change in the hour. To overcome the difficulty of officers being elected who might be supposed to at once resume their duties, he moved that the report of the scrutineers as to the result of the ballot be made the last item on the business of the meeting.

Mr. J. M. REES then read the notes of the following three cases (for Dr. Norris Wolfenden), the patients being shown in an adjoining room:—

CASE I.—*A Mixed Case of Syphilis and Tubercle.*—J. W., female, teacher in good circumstances, aged thirty-six, with atresia of the naso-pharynx and superficial ulceration of the soft palate, swollen and ulcerated epiglottis, and distorted glottis. Throat symptoms commenced with slight pain and ulceration of soft palate nine years ago. Four years ago she first came to the Throat Hospital presenting a membranous web between the vocal cords and aphonia, but no ulceration. The posterior fauces alone were then adherent to the pharynx. The web was destroyed by the galvano-cautery, and voice restored. The patient was not seen again for three years, during which time she had had several severe attacks of ulceration. There was at the time of her first visit to the hospital no sign of phthisis, and no history of syphilis could be obtained. Now, the palate was adherent to the posterior wall of the pharynx, so that the naso-pharynx is almost entirely cut off from the oro-pharynx, save for a perforation the size of a pea, situated a little to the left of the uvula. Her condition when she came to the Throat Hospital, Golden Square, on Oct. 10, 1890, was: Atresia of the naso-pharynx as described, but with a superficial, irregular, ill-defined ulceration of the soft palate, the area of which would be equal to that of a florin, and covered with grey granulations and mucous secretion, and at times with a thin grey filmy membrane, which scraped off easily, leaving a bleeding and rather nodular surface underneath; an uniformly enlarged epiglottis with a similar ulceration along its apex; no enlargement of arytenoids or ary-epiglottic folds, but a very curious state of the glottis. The right vocal cord had been destroyed, and, as a substitute, the right ventricular band had become stretched and altered to simulate a vocal cord, being anteriorly in

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

the exact position of the anterior portion of the vocal cord, but as it proceeded backwards it became wider, and curved, so that it attached itself to the right side of the left arytenoid, but somewhat above the level of the left vocal cord. This altered ventricular band became so pale, glistening and fibrous-like, that at first sight it might easily be mistaken for a mis-shapen cord. The voice was excellent and clear, though not strong. At this time there was no rise of temperature, no expectoration, or spitting of blood, no enlarged glands under the jaw, but a certain amount of discomfort in swallowing, and at times odynphagia. The ulceration has been most intractable, not responding in the least degree to any form of treatment—iodoform, iodide of potassium, or iodide of iron.

Daily curetting, scarifications and the application of lactic acid have produced no apparent beneficial change. Patient in March became an in-patient for three weeks, and all local applications energetically applied failed. Bacilli were found in specimens scraped from the palate and epiglottis. No nightly rise of temperature was observed.

June 14.—For the first time patient coughed up about an egg-cupful of blood. Coughs a good deal of a morning lately. Fresh-formed ulceration is to be seen, with but little accompanying swelling, on the right ary-epiglottic fold. Crepitations now are to be heard at the left apex, with slight tubular breathing and bronchophony; very limited. Her history of syphilis was vague, but the state of the palate, epiglottis, and distortion of the glottis, made matters plain. The ulcerations on the epiglottis on its laryngeal surface were typical of tubercle, and bacilli were found in specimens scraped from the surface. It is curious that her discomfort and pain in swallowing was not greater; but pain she only complained of after the parts had been subjected to irritation. Possibly the combination of the two diseases might be credited for this alleviation.

CASE II.—*Case of Multiple Papilloma in a Child.* The child, aged ten and a half, has been under treatment since November, 1890, for this condition, the growths springing from the surfaces and edges of both vocal cords, and the anterior surface of the arytenoids and the ventricular bands, and a large mass of growth springing from the inter-arytenoid commissure. Three warts have lately appeared on the right hand. The history of the child's condition reveals that she has never had a voice. There are no signs of congenital syphilis, the child being robust in appearance. There are no post-nasal growths present. She has on two occasions been to large general hospitals without the condition being recognised. The growths have been removed by operation with the ordinary Mackenzie forceps on several occasions by Mr. Rees. Though the larynx has been once quite clear of growth, and the voice restored, the growths have recurred, so as to almost defy treatment. There has never been any dyspnœa. All kinds of local medication (lactic acid, iron, zinc, &c.) have been tried without result. The growths are probably congenital in origin. The coincidence of warts on the hand with laryngeal growths is interesting as showing the predisposition to papillomatous growths in more than one situation in the body. A case of this kind had previously been mentioned to the society as occurring in Dr. Wolfenden's

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

practice, where an aural polypus, papilloma of the uvula and laryngeal papilloma, existed simultaneously in an adult man.

CASE III.—*Complete Atresia of Naso-Pharynx.* The patient was a married woman, aged thirty-nine, and though a very indistinct history of syphilis (such as loss of hair and some throat trouble) could be obtained, there was no doubt as to the nature of the condition. The whole of the soft palate and the uvula throughout its whole length were completely attached to the pharynx, leaving no aperture of communication from the pharynx into the naso-pharynx. This fleshy curtain was of a fair degree of thickness. She had been under treatment for three years when she came with atresia (complete) of the naso-pharynx, and which had supervened six years after the first onset of ulceration in the pharynx. During these three years there had been several severe attacks of ulceration of the posterior wall of the pharynx, which had yielded to large doses of iodide of potash and cauterization.

Dr. SANDFORD read the notes of the following case :—*Foreign Body lodged at Base of the Tongue for several Years.*

J. L., aged forty-seven, consulted me in December last. He complained of increasing difficulty of articulation, some difficulty in swallowing, and of a swelling in the right submaxillary region. He suffered extreme pain from time to time when the swelling, he said, appeared to become inflamed, and he then obtained considerable relief from local applications, such as poultices, etc., under medical advice. Of late the trouble had become unbearable, and the patient had lost considerably in weight and general health. Externally the right submaxillary gland was swollen, and extremely hard, red, and glazed.

On examining the interior of the mouth, I noticed the tongue to move with great difficulty at the right side, and, on raising it, a thickened, ulcerated patch appeared at its base on a level with the position of the last tooth. Most of the teeth were absent. The ulcerated surface was soft to touch, but bled profusely. The whole presented an extremely malignant appearance. On searching with the finger I felt some unusually hard substance at the base of the ulcer, and with some difficulty I extracted by means of a forceps a white, chalky body, which afterwards proved to be a tooth covered over with deposit, which had evidently been *in situ* for a long time, and had burrowed its way downwards between the jaw and the tongue. On enquiry, the patient informed me that he recollected having been on a severe drinking bout several years previously, shortly before his throat trouble commenced, and to have had some "disputes" with a comrade, during which the tooth, he thinks, might have been dislodged from its socket, and found a resting-place beneath the tongue. As to the nature of the ulcer and swelling, I give a guarded diagnosis, but every abnormal condition gradually disappeared under treatment after the removal of the cause of irritation, and in a month the patient was quite well.

Sir MORELL MACKENZIE related that he had once removed a foreign body from the throat which had been *in situ* for fourteen years. The foreign body in question was a pin originally about two inches long, but the piece removed was only about half an inch long, the other portion

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

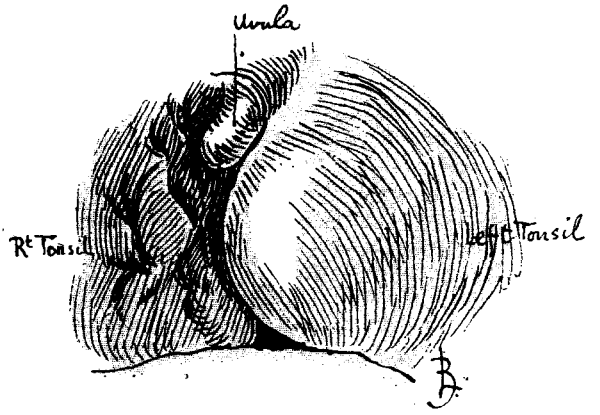
having corroded away, and the part that was left being curiously thickened in an irregular way by the action of the tissues on the metal. The patient was a lady who lived at the Cape of Good Hope. There had been many attempts made to remove the pin, all of which had been unsuccessful. It was in the right hyoid fossa, only the extremity being visible. The pin had been pushed almost vertically downwards along the side of the larynx, and only the small black point presented. He managed to get hold of and removed it, and at first a good deal of inflammation resulted. The patient ultimately went away quite well.

Mr. WINGRAVE asked whether there was a tooth missing in Dr. Sandford's case?

Dr. SANDFORD, in reply, said there were indeed several.

Mr. LENNOX BROWNE then read notes of a *Case of Lymphadenoma of the Tonsil*, the patient, who was present, having been previously examined by the Fellows.

Rachel H., aged forty-eight, married, residing at Cardiff, was admitted on June 4, 1891, into the Central London Throat, Nose, and Ear Hospital, complaining of difficulty of swallowing, of two years' duration. Personal history: She is a woman of somewhat full habit, stout and flabby, of pale complexion and somewhat bluish lips — in fact, of very œdematous appearance. She has "never experienced a day's illness in her life" till twenty-seven months ago, when present illness commenced with the expectoration of large quantities of phlegm, and slight difficulty in swallowing. These symptoms, with vocal and articulative weakness, gradually increased. She has never suffered with bleeding, either from nose or uterus. There has been no loss of flesh, but her paleness has markedly increased during the past twelve months, coincidently with the



increase of the size of the swelling. Family history: Father died, aged sixty, of a decline. Mother died, aged sixty, of a disease exactly like what the patient has now. Had four brothers and sisters, who died at different ages from decline. She has borne six children, who are all living and healthy.

State on admission: She speaks as if her mouth were full of food,

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

and articulation is almost obscure; the swallowing is extremely painful and difficult, which condition has increased rapidly during the last five weeks. Cannot swallow solids at all. There is neither cough nor pain, except when taking food. She is troubled with slight dyspnœa on exertion. On examination: There is a large roseate, tense and slimy mass to be seen occupying the situation of the left tonsil, and extending into the faucial aperture considerably beyond the middle line, and displacing the uvula. It is resilient, only slightly painful on manipulation, and does not fluctuate. The right tonsil is almost equally prominent, but deeply furrowed, and has more the appearance of an ordinary hypertrophied gland, whilst the left looks almost as if it were the subject of inflammatory œdema. The uvula is compressed and pushed forward, as well as displaced, to the right of the median line. The tongue is protruded sluggishly, but straight, and is not much swollen. Hearing, taste, and smell: Normal. Heart: Slightly dilated; action regular. Lungs: Normal. Thyroid gland is apparently atrophied. Lymphatics: There are several enlarged and painless glands to be felt in the neck and left axilla. Spleen is not enlarged. Urine: Normal. Blood: Hæmoglobin, 9 per cent.; red corpuscles, 4,000,000 per c.m.m.: white corpuscles, 1 in 200. No pigment spots anywhere.

June 8. Mr. Lennox Browne removed the greater portion of the enlarged right tonsil with the wire *écraseur*, with the result that in forty-eight hours she could swallow with great comfort, and speak more clearly, and expressed herself as feeling better than she had done for many months.

June 15. Examination showed that only the anterior portion of the right swollen tonsil had been removed, for another large mass was seen to be fungating from the posterior of the fauces. This was easily snared with the *écraseur*, and removed. The left side was then attacked, and several large pieces were evulsed by means of the wire loop and curetting. The whole mass from the two sides weighed nearly 400 grains.

Mr. WINGRAVE then read the pathological report on the growth in question, which was as follows:—

Microscopical Examination by Mr. Wyatt Wingrave, of the tissue removed, showed that it is composed almost entirely of small round cells, the protoplasm of which is very scanty as compared with the size of the nucleus, a characteristic of lymphoid cells: these are embedded for the most part in a homogeneous matrix. In parts the characteristic tonsil arrangement and structure is visible.

Nature: Histologically it belongs to the "lymphoid" group of tissues.

The author of the case remarked that the disease was of sufficient rarity to merit exhibition. This was only the fourth or fifth case he had witnessed, in a constant hospital experience of over twenty-five years. The improvement of the patient's health and complexion were very marked, and were evidently the result of the operation, for internal treatment, consisting of a mixture of iron and arsenic and pills of iodoform, had not been pursued long enough to account for the benefit experienced. At present there seems to be no disposition to recurrence.

Dr. DUNDAS GRANT observed that it was a very interesting case

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

and it showed very clearly the advantage of attending regularly the meetings of the Association. He had had the advantage of seeing this case when the patient first came for treatment, and thanks to his having heard Dr. Frank's valuable and interesting paper, he had been enabled to diagnose it to his own satisfaction and to that of Mr. Lennox Browne, who afterwards confirmed the diagnosis. These cases were rare, and it was easy to overlook their nature. One met more often with lympho-sarcoma of one tonsil, but the bilateral enlargement, together with the presence of other enlarged glands in the body, helped one in arriving at a diagnosis of Hodgkin's disease.

Mr. LENNOX BROWNE then read an account of his second case, one of *Angioma of the Larynx, with traumatism.*

Mr. C. A. C., aged forty, residing at Windsor, first came to me on May 29, 1891. He complained of hoarseness, effort, and fatigue of the voice, which had existed for two and a half years. He believed that it originated after exposure to the influence of a dense London fog.

Replying to questions, he admitted that he had suffered pain low down on the left side of the throat quite recently, especially in swallowing, and that after talking for a short time, he had some gasping for breath.

I found considerable swelling and hyperæmia of the left side of the larynx, with what appeared to be some superficial ulceration of the pharyngeal aspect of the ary-epiglottic fold. This was covered with muco-purulent secretion, which did not disappear on spraying.

On enquiry of the patient, he told me that he had not seen any other throat specialist since he was first attacked, and my attention was not, therefore, directed to the possibility of traumatism as a cause of his trouble.

His general condition excluded any idea from my mind of either cancer or phthisis, and although the history was by no means confirmatory, there appeared some probability that the laryngeal lesion might be syphilitic. I accordingly prescribed some biniodide of mercury, and a diluted iodide compress to be worn over the larynx every night.

My attention had been so occupied with the condition I have described, and the swelling was so considerable, that I had not perhaps examined all the other parts of the larynx so completely as I should have done. However, my gratification to discover on the patient's second visit, a week later, that all sign of ulceration and inflammatory swelling had disappeared, except that the left cord was congested, was tempered by a surprise in the shape of finding a small, round, smooth growth, of a bright pink colour, at the anterior insertion of the vocal cords. On my telling him of this, the patient voluntarily confessed that he had not been loyal in his information to me on his former visit, for that he had suppressed the fact that he had quite recently seen another specialist on account of this growth, and had undergone eleven or twelve sittings for the purpose of its removal by the forceps. His last visit to this gentleman had been made less than a week before his first one to me ; and on that occasion the forceps had been used six times. He had been informed that the growth was twice caught, but could not be removed, and finally

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

that, as the operation was admitted by the operator to be beyond his skill, he was recommended by him to a friend "over the way." The patient described the pain experienced at the last sitting as considerable, in fact as a regular "twister."

It was clear to me, therefore, that the condition I had seen a week before was due to traumatism, and this having been now reduced, I proceeded to at once remove the growth. This I was fortunate in effecting on the first introduction of a Gibb's snare into the larynx, which did not appear to require cocainization, with the result of an immediate improvement of the voice, which increases each day; so that at the date of his third visit to me—June 17—it is almost normal.

Remarks.—I have not brought forward this case with the object of vaunting my own skill at the expense of another, but to illustrate a few points of some practical importance.

1. The danger of unguarded instruments for endo-laryngeal operations, which I have insisted on for the last fifteen years, and in which view I am glad to have been recently supported by Dr. Stoker and other Fellows of this Association. This danger is of course proportionate to the lack of experience and skill of the operator; but with guarded instruments, even if the growth is not removed, there is no fear of injury to normal tissues.

2. That while a growth in the anterior commissure of the larynx is, for obvious reasons, more difficult to seize with the forceps than in almost any other situation, it is absolutely one of the most favourable positions for the use of the snare, especially if the operator, having got the loop well in position, draws it forward on to the angle of the thyroid and presses the larynx from the outside—so as to make a good *point d'appui.*

3. The importance of microscopic examination of every intra-laryngeal growth on removal. In this case I should have judged from microscopic appearance that the little tumour was a smooth-surfaced papilloma or myxoma, whereas it turned out to be a thrombosed pile or angioma.

Lastly, the case affords an example of what is daily experienced in consulting practice, the extent to which one may be deceived by giving credence to the evidence of patients. Confessing myself, therefore, as misled by this patient's first mis-statement, that he had not recently been in other hands, I should offer the account of his previous treatment with much more reserve did it not bear internal evidence that it is the only reasonable explanation, in the light of after events, of the laryngeal condition as I first witnessed it.

Microscopical Examination of the removed Tumour by Mr. V. H. Wyatt Wingrave.—The size of the tumour is that of a small pea; it is of pink colour, and appears to have been sessile, as it has a clean cut and comparatively broad base. The surface is everywhere covered (excepting the base) with stratified, squamous, epithelial cells, on a well-defined basement membrane.

Below this, on one side, is seen an abundance of fusiform nucleated cells—visceral muscle-fibres; on the other, fine reticular connective tissue, showing slight mucoid changes, arranged very loosely, and con-

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

taining numerous spaces lined with epithelioid cells—evidently vascular channels or dilated capillaries—the walls being extremely thin.

Beneath this, and towards the centre of the tumour, the tissue becomes more dense, and the nucleated cells fewer, until a dense, non-nucleated laminated mass is seen, obviously non-vascularized fibrin, in the midst of which is some yellowish substance, evidently disintegrating blood. Scattered about the field are numerous masses of pigment, and several smaller vascular channels containing fibrin.

No gland substance is seen, and no evidence of a neoplastic process.

Nature of Tumour.—Judging from the larger quantities of pigment (*extra-cellular*), and the vascular evidences, it is highly probable that it is a "thrombosed pile or angioma," and that the fibro-myxomatous changes are secondary.

Histologically, it is purely innocent.

Sir MORELL MACKENZIE congratulated Mr. Browne on his success, and suggested that this might in part have been due to the fact that the growth when removed by him was possibly only hanging by a pedicle as the result of the preceding operations. The last attempt at removal had taken place only a week previously. Moreover, it was very rare that any accident occurred as the result of the use of the forceps. He himself had used them many hundreds—he might even say thousands—of times, and Mr. Browne had seen him use them many hundred times, and he was not aware that any injury had ever been done to any part of the larynx by him. He had used at one time a pair of tube forceps, but he had discontinued their use on account of the possibility of some part of the instrument becoming detached and falling down the trachea. It had happened to him once that a blade became thus detached, and since then he had entirely given up the employment of that instrument. He remarked that the previous operator in Mr. Browne's case appeared to have introduced the forceps no less than six times on one occasion, adding that he personally made it an invariable rule never to introduce the forceps more than once at a sitting. He admitted that there was great temptation to transgress this rule because it was so disappointing to the patient and to the surgeon to stop when the first introduction of the forceps had failed, and the patient being naturally anxious to have something accomplished urged the operator to make another trial. Nevertheless, it was a feeling that ought to be resisted. The case Mr. Browne had reported, however, was interesting, independently of the question of treatment, for growths of its peculiar structure were rare in the larynx. He had only met with five cases.

Dr. DUNDAS GRANT was not prepared to be quite so exclusive in the use of any instrument as either of the eminent speakers who had preceded him. One must be selective. There were cases in which the guarded instrument was sufficient, and in such cases it was their duty to make use of it. At the same time they ought not to discard the forceps altogether. It was sometimes necessary. He had found himself able to remove growths by means of the forceps after the snare had failed even in highly skilled hands. It was, therefore, only right to remember that there was a field of usefulness for the forceps. At the same time those who valued

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

the safety of their patients rather than their own capacity for manipulation would agree that the statement as to the better practice of using guarded instruments was a valuable one. It was, after all, only natural that the operator should have a leaning towards the instrument which he had been in the habit of using, but he ought to have an open mind in selecting the instrument for use in particular cases. He admitted, however, that with a growth at the anterior commissure of the cords no attempt should be made with anything but the snare for its removal. He used a Gibb's snare as modified by Dr. Bond so as to present either transversely or antero-posteriorly. There were, however, cases in which the forceps were equally to be preferred, and he instanced the case of a projecting body on one of the cords, which could be better removed by this instrument than by any other means. The idea of using the large forceps had been carried still further by Gouguenheim, of Paris, and the principle upon which this operator proceeded seemed to be irresistible. Dr. Grant pointed out that the forceps employed by Gouguenheim were very much heavier than Mackenzie's, but the cutting portion was an inch or an inch and a half in length, and the blades met each other with the most perfect coaptation. The beauty of these forceps was that there was a considerable amount of scope above and below the level of the growth. If they used a pair of the ordinary Mackenzie forceps below the level of the growth they caught the growth between the shanks of the instrument and did not effect its removal, whereas with Gouguenheim s forceps, having so much more vertical length to come and go upon, they would be pretty well sure of catching it. He was personally in favour of a judicious eclectism in the choice of instruments.

Dr. WARDEN mentioned a case of his own about two years since of papillomatous growth just underneath the left vocal cord. This growth always eluded the grasp of the forceps. He tried several times, adopting the plan suggested by Sir Morell Mackenzie of never trying twice at the same sitting. After four or five unsuccessful trials, it occurred to him to try that old-fashioned instrument, the horse-hair (bristle) probang, and with this he was enabled at once to achieve his object.

Sir MORELL MACKENZIE said he himself had made use of the probang, especially in children, and he had occasionally found it very useful. He pointed out that with a large instrument there was a possibility of injuring something, but still the importance of getting the growth away was so great that the risk sometimes had to be incurred.

Mr. WINGRAVE, in reference to Sir Morell Mackenzie's suggestion that the growth was possibly hanging by a thread, said that microscopical examination showed that there was a clean cut at the base, without any pre-existing ulcerative process.

Mr. LENNOX BROWNE, in reply, said that Sir Morell Mackenzie's generous suggestion as to what had been done by the previous operator did not account for the almost acute inflammation and swelling and distinct ulceration of the left side of the larynx, when the case was first seen a week after the first operation, and which subsided and healed so quickly as to clearly prove its traumatic origin. Certainly the growth was as cleanly cut off as possible, and there was no sign of any partial

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

removal previously. In this he was corroborated by Mr. Wingrave, who knew nothing whatever of the nature of the case when he made his examination. He confirmed the practical utility of the plan adopted by Dr. Warden. They all knew that Voltolini used a sponge, and he himself had used a large cotton-wool probang—the wool well secured in the same way. He added that it was ten or fifteen years since he had first had a Gibb's snare which would turn in any direction, and he thought Dr. Grant must be mistaken in believing that there was any novelty in such an arrangement (as that with which Dr. Grant has credited Dr. Bond).

Dr. DUNDAS GRANT then read the notes of the following three cases :—

CASE I.—*A Case of Tubercular Laryngitis of the Proliferative Type, Simulating Papilloma.* Thanks to the kindness of a medical friend, I am enabled to narrate to you the history of a case of tubercular laryngitis, of the type specified in the title of my communication, and to show you the parts involved, as removed on *post-mortem* examination.

Ernest U., a Frenchman, aged twenty-eight, came under my friend's care with dyspnœa and other symptoms of laryngitis, on the 1st of last May. His previous history, as given by himself was, that six years ago, after drinking some iced beer, he was attacked with what he understood to be laryngitis, for which he was treated in the *clinique* of Dr. Fauvel, the renowned Parisian specialist ; ever since then his voice has been hoarse, and he has suffered from frequent cough, with the hawking of mucus. For the last three years, however, he has had no treatment for his larynx. There was no specific history, and beyond the fact that his mother died of pleurisy, nothing suggestive of a family tendency to tubercle.

On the night preceding his application for treatment, he was suddenly attacked with dyspnœa, became blue in the face, and had great pain in the throat. In the morning, when he first came under observation, he had undergone some degree of improvement, but he had much stridor, with difficulty in phonation and considerable dyspnœa.

On examination, his fauces were seen to be reddened, his epiglottis to be red and rather œdematous, his aryteno-epiglottidean folds very markedly so, and his vocal cords red, œdematous, and thickened, with much mucus adhering to them. The cords did not meet on phonation, and ulcers were observed on the right cord and right aryteno-epiglottidean fold. Examination of the chest showed some slight bronchitis, but no evidence of tubercle.

A 20 per cent. solution of nitrate of silver was applied to the larynx, and he had a good night's rest, his stridor next morning having diminished, and his face having lost its cyanotic tint, and the appearance of the larynx giving evidence of a lessening of the œdema.

On the 3rd of May the œdema was much less marked, and there could be seen springing from the right vocal cord a pedunculated growth, which disappeared on inspiration and came up between the vocal cords on expiration, so as to prevent any apposition of the vibrating edges during attempts at the production of vocal sound. The breathing on the previous night was rather worse, but improved on his sitting up.

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

My friend endeavoured on the 12th of May to remove the growth by means of laryngeal forceps. The larynx, however, was extremely intolerant, and the removal was postponed till, by daily application of cocaine, it should become more used to operative interference. Up till the 16th he was fairly easy, the œdema having practically disappeared, and the growth being easily seen. The œdema, however, then returned in the neighbourhood of the cords; the patient had, in the afternoon, an attack of dyspnœa, became blue in the face, sweated profusely, and had retraction of the chest walls on inspiration. His condition was almost immediately improved by the inhalation of carbolized steam, and he became fairly comfortable, although he had still considerable laryngeal stridor.

On laryngoscopic examination the cords and the whole of the mucous membrane were seen to be red. This condition continued; the growth did not enlarge to any noticeable extent, but there was considerable ulceration of both vocal cords, and of the ary-epiglottidean folds. The ulcers were of irregular shape, had yellow bases, and did not seem to be deep.

On the 2nd of June I had the opportunity of seeing the case, and of noting, in addition to the appearances above described, a sessile tumour of considerable size in the inter-arytenoid space above the level of the vocal cords. I ventured to diagnose the case as one of that form of tubercular laryngitis in which the outgrowths simulate benign neoplasms like papillomata, and to suggest that tubercle must be present in the lungs. I succeeded, in my hurried attempt, in detaching a small portion of the growth, but not sufficient for microscopical examination, or to give any relief to the patient.

An examination of the lungs was made by a physician of eminence, but he could find no definite evidence of tubercle of these organs.

Early in the morning of June 6th, the patient, who had still great dyspnœa, had an attack in which syncope seemed the chief factor rather than asphyxia, and he died in spite of the performance of laryngotomy.

On *post-mortem* examination the larynx presented the appearance which I now show you:—

On opening from behind the laryngotomy wound is first seen; above this and to the right is a small pedunculated mass, evidently hanging from what is left of the right vocal cord. Above this is an irregular mass of tuberculous tissue, extending as high as the ary-epiglottic fold, forming a large cushion, and occupying the whole of the right supra-glottic region, replacing the ventricular bands, and involving the sacculus. There is a similar mass on the left side, in a similar position, but no pedunculation. Just in front of the left arytenoid cartilage is a large ulcerated cavity, extending deeply to the thyroid cartilage. There is perichondritis of the cricoid cartilage on its inner surface. The ary-epiglottic folds are infiltrated and extremely thickened, the left showing signs of active ulceration. Everywhere there is evidence of great œdema, but there are no fistulous tracks. The posterior commissure was greatly involved, as is shown by microscopic examination. The epiglottis is unaffected.

The case illustrated several interesting points in connection with

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

tuberculosis of the larynx—(1st) its *imitative character*. In this instance the clinical appearance suggested simple papilloma, for which it might easily have been mistaken. Gouguenheim read before the International Congress of Laryngology at Paris in 1889, a very instructive paper on the relation of papilloma and tuberculosis of the larynx, to which I was to a considerable degree indebted for being able to diagnose, *intra vitum*, the nature of this case. I have seen two cases in which tuberculosis imitated carcinoma of the larynx so exactly as to lead to unfortunate operations by experienced laryngologists. (2nd) The degree to which the *physical signs in the thorax are masked by the co-existing laryngeal disease.*

In the discussion on Dr. Grant's case of tuberculosis of the larynx, Dr. SNOW agreed that when there was extensive laryngeal disease, it was very difficult to make out the presence of disease in the lung, and the lung mischief was consequently often found, *post-mortem*, to be much more extensive than had been supposed.

Mr. LENNOX BROWNE said the author was to be commended for bringing the subject before them, because it had not unfrequently been said that laryngoscopists never saw further than the throat, and in cases of laryngeal phthisis, overlooked the pulmonary disease. The author's frank acknowledgment of the difficulty often experienced in detecting the extent of the lung changes when the larynx was greatly involved, was a sufficient answer to this charge, and his experience would be confirmed by all laryngologists. The fair retort that chest physicians often neglected the larynx, was one which could not be so easily explained away.

Sir MORELL MACKENZIE was glad the author's remarks had been confirmed. He pointed out that in cases of tubercular aphonia, due to tubercular ulceration, they could not get vocal resonance, and this was felt to be such a great disadvantage by Dr. Stone, that he had invented a kind of musical instrument by which the patient was enabled to produce a sound for the purpose.

CASE II.—*A Case of Fibro-Sarcoma of the Palate removed by operation.* Mrs. N., aged forty-six, was sent to me by Dr. Sunderland, of Bexley Heath, on the 6th April, 1891, for my opinion concerning a tumour in her palate. The patient was a hearty, well-developed lady of active business habits, and was in the enjoyment of first-rate general health. She complained that at times, when she got hot and tired, her tongue seemed to swell and to come in contact with her tonsils and uvula. This first came on two years ago, and the symptoms then lasted with some severity for a short period, but diminished until they again became very prominent a few days previous to her coming under my observation.

On examination there was seen to be a general, and not very pronounced, bulging of the right half of the soft palate, which was noticeably hampered in its movements during phonation and nasal respiration, and a projection of the right tonsil. On palpation an ovoid tumour of dense consistence could be felt in the region described, and apparently continuous with the tonsil. The post-nasal space was singularly free, and the finger could with ease be passed up to both posterior nares. There was no ulceration, and the mucous membrane was pretty freely movable over the tumour. There were no enlarged glands.

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

The situation and growth of this circumscribed tumour suggested the probability of its being a fibro-adenoma, but the age of the patient, and the fact of its extending into the tonsillar region, left a possibility—in view of Mr. Stephen Paget's observations and deductions (St. Bartholomew's Hospital Reports) of its being sarcomatous in nature. In the former case the removal would be a simple matter, in the latter the difficulties might be considerable.

I advised operation, and—*in utrâque fortunâ paratus*—hoping for the more propitious of the two conditions, carried it out on the 10th of April with the assistance of Mr. Percy Jakins and Dr. Sunderland. The latter administered chloroform by means of Junkers' bottle and bellows, with a catheter attached. The layers of the soft palate were snipped through with scissors, and an opening was thus made through which I was able to introduce my finger so as to explore the tumour more accurately. I found that it was a firm, rounded, circumscribed mass, and that by means of my finger nail I could loosen it from its bed of connective tissue. It extended downwards externally to the tonsil, pushing that body inwards, but without invading its substance. On all sides, except the outer one, it was easily liberated, but it was there more firmly attached to the inner surface of the lower jaw. A free use of the finger-nail, and a very limited application of curved blunt-pointed scissors, enabled me to break down the adhesions without difficulty. The capsule of the tumour was slightly torn, but on careful examination it was ascertained that none was left behind. The tumour was then easily shelled out, and was found to be oval in shape and of the size of a bantam's egg. The posterior layer of the palate was left whole, and the hæmorrhage during the operation was quite insignificant.

The after-treatment consisted in the use of antiseptic mouth-washes, especially after food. Dr. Sunderland, who then took charge of the case, informed me that for a few days after the operation she was troubled with much coughing, owing in all probability to the blood inhaled during the chloroform narcosis, and that she had considerable pain on swallowing, but this soon passed off. Her temperature at noon for the first few days was 100°, 102°, 101°, 100°, and on the fifth day 98·4°. She had some swelling on the right side of the neck, close to the angle of the jaw, and could hardly separate the teeth, but these conditions speedily disappeared, and on the 30th of April, Sunderland examined the throat and observed that the position of the tumour was marked only by a few granulations.

The patient came to show herself to me on her way back to Guernsey. She then professed herself as perfectly well and comfortable, able to open her mouth and to swallow without difficulty. There was a small granulation at the situation of the wound but no trace of tumour could be felt.

The tumour, which weighed 470 grains, was invested with a firm capsule, and appeared to consist of irregularly massed fibrous tissue.

Mr. Wingrave kindly made a microscopical examination of the growth (a section of which is exhibited), and reported it to consist chiefly of fibrous tissue, with a few cells suggestive of sarcoma, and here and there a disposition of cells in imperfect gland-like formation. He considered it practically non-malignant.

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

CASE III.—*Subsequent History of a Case of Intrinsic Cancer of the Larynx treated by Thyrotomy.* The case of which I have now to give you the final report is that of a man whom I brought before the Association at the meeting on the 28th of November, 1890. The history of this case was reported in the proceedings of the Association in the JOURNAL OF LARYNGOLOGY for last January, and subsequently in the "British Medical Journal" of March 28th, 1891.

Briefly, he was referred to my care on August 23rd, 1890, by Dr. Gordon Holmes, who had made a diagnosis of carcinoma, in which my colleagues and I quite concurred. He had been hoarse for eight months, the voice gradually dwindling to a mere whisper, and he had latterly a pain running up to the left ear, apart from functional use of the larynx. There was a slight fulness of the left half of the larynx, and on laryngoscopic examination there was seen an ulcerated nodular mass occupying the whole area of the left vocal cord, extending also to the ventricular band. *The cord itself was completely immobile.* There was a slightly enlarged gland behind the thyro-hyoid space. I removed a small portion of the growth by means of forceps, and Mr. Wingrave promptly prepared a section which confirmed the diagnosis of epithelioma.

On the 27th of August I opened the larynx in the manner described in my previous communication, and removed the soft parts from the interior of *both* sides of the larynx. He made an excellent recovery from the operation, and left the hospital on the 22nd of September. Laryngoscopic examination showed on the right side an arrangement of the mucous membrane singularly like a vocal cord, and moving on phonation. The left side was occupied by a cushion-like fulness, covered with a healthy-looking mucous membrane. The glandular enlargement was certainly no greater (later it almost disappeared).

As I said in my report in the "British Medical Journal," the question of recurrence could only be answered by further observation. Unfortunately, though hardly unexpectedly, the evidence of the return of the growth was not much longer delayed, for, after having resumed his business avocation, the patient soon found that the production of his hoarse, but audible, voice became difficult and painful. He "caught a cold," and had a croupiness in his breathing. The tissues of the interior of the larynx were swollen, but, as looked at from above, no ulceration was visible, except below the anterior commissure. At this spot we had frequently seen a little mucus accumulate, and I, therefore, removed the silver-wire stitch I had left to retain the alæ in conjunction. Strange to say, the right half of the larynx appeared the most severely affected, and on that side a lymphatic gland at the level of the thyro-hyoid space became distinctly enlarged. On May 6th I introduced a tracheotomy-tube through the tissues previously traversed by Hahn's canula; but, although his breathing was improved, no form of tube was found to be comfortable, and the patient sank more from pain and exhaustion than from any mechanical trouble arising from the growth.

On *post-mortem* examination the body was noted as thin, but not remarkably emaciated. In the middle line of the neck was the opening communicating with the larynx (continuity upwards of the

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

tracheotomy wound), from which some small fungating masses projected. On removal of the larynx, numerous hard lymphatic glands were discovered in front of, behind and beneath both sterno-mastoids—one particularly large one close to the right side of the hyoid bone—and several others scattered about the supra-clavicular regions. The larynx contained abundant evidence of new growth. On division of the cricoid cartilage posteriorly on the middle line, two symmetrical fungoid masses were seen almost filling the larynx, extending from the situation of the ventricular bands as far down as the bottom of the tracheotomy wound. The cricoid cartilage is only slightly involved by the growth, but the thyroid to a very great extent, especially the right ala. On the right side of the root of the epiglottis is a hole of the diameter of a goose quill, which is the upper opening of a sinus leading to the new growth. There is considerable thickening of the remaining soft tissues, but the epiglottis is evidently not involved. The largest (thyro-hyoid) lymphatic gland was found on section to be infiltrated with epithelioma. The others were free from that disease. The thyroid gland was uniformly enlarged, and very firm, but although its condition suggested clinically that it was infiltrated with malignant disease, the microscope showed that its enlargement was due to chronic inflammatory changes. The other organs were normal.

Satisfactory as this case is from the point of view of mere operative *technique*, the ultimate result is not of a kind to encourage operation even in such a comparatively favourable case. In this instance, the temporary freedom from the presence of the disease was bought at a decidedly too great sacrifice when we recall the duration of life enjoyed by some who have been treated by simple tracheotomy. I may recall to you a case illustrating this in my own practice, and which I brought before this Association on March 27th, 1889. I performed tracheotomy for her on the 26th of July, 1886, on account of dyspnœa threatening her life, and quite recently I heard of her as being still alive, though with enormous glandular swellings in her neck. Whether a prolongation of such a life is desirable is a difficult question to decide. The matter is narrowed down considerably when we reflect that in a large percentage of laryngeal cancer there is no hesitation possible in refusing operation. In the few remaining cases the question lies between operation, with the great probability of a speedy demise, but with the remote chance of respite or total reprieve, and tracheotomy, with a practically certain prolongation of a life of not inconsiderable discomfort. I hold that we are not justified in discarding extirpatory operations altogether, as long as the alternatives are clearly laid before the patient and his friends. At the same time there will always be cases where, as regards diagnosis, it is justifiable to entertain an amount of doubt—albeit philosophic doubt—and, accepting thyrotomy as being with modern *technique* a comparatively safe operation, I see no reason why it should not be practised for exploratory purposes, further proceedings being determined by the additional information thus obtained, the possibilities having been previously subjected to the judgment of the surgeon and the will of the patient.

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

Sir MORELL MACKENZIE showed *a specimen of a congenital growth in microscopical section removed from a young lady, twenty-two years of age, supposed to have had polypus from birth.* The nurse had removed some solid substance from the nostril when she was born, and she never afterwards was able to breathe through or smell with the nostril on that side. When the young lady came, a few weeks since, he found a large polypus occupying the left nasal passage. He had operated upon her a number of times, and removed a quantity of growth. Much, however, was left, and he therefore subsequently operated again under ether. Dr. Rawes, the demonstrator of physiology at the London Hospital, had made some sections of the growth for him, and he considered the growth to be a fibrous polypus, which had undergone mucoid degeneration. Considerable hæmorrhage had followed the last operation and had continued for two or three days. The interest of the case was partly pathological and partly clinical, on account of the great rarity of congenital growths in the nose. He knew of no other case of the kind on record, and polypi were in any case very rare among young people.

Mr. WINGRAVE asked what was the exact spot from which the growth arose.

Sir MORELL MACKENZIE, in reply, said from the inferior turbinated bone, in fact from the whole of the side of the nose, but not from the septum. It extended right back to the pharynx.

Mr. WINGRAVE said that judging from the histological features one had to consider the possibility of slight variations in development. It might of course have been congenital, but histologically this would not seem to have been the case.

Dr. RAWES observed that there was not much to be said about the structure, except that it was covered on one side by columnar ciliated epithelium. Underneath the basement membrane there was a good deal of adenoid tissue. These were not altered. Below there was a considerable quantity of fibrous tissue, with strangely-coloured cells in it. The structure contained a number of small spaces, which looked as if they had been filled with mucus. These had obviously run together, forming irregular spaces, separated by little shreds and remains of fibrous tissue. In places the tumour was seen to be highly vascular. In one place there was a capillary running through an angle, where it had undergone mucoid degeneration. It had struck him as curious that it should have been so vascular, and yet had degenerated. It was very unusual to find a purely fibrous growth undergoing mucous degeneration.

The result of the ballot was then declared, and the following gentlemen were elected as office bearers for the year 1891-92 :—

President: Mr. LENNOX BROWNE.

Three Vice-Presidents:

England—Dr. WARDEN, Birmingham; Scotland—Dr. J. MAXWELL ROSS, Dumfries; Ireland—Mr. KENDAL FRANKS, Dublin.

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press

Six other Members of Council:

Metropolitan—Mr. MAYO COLLIER; Dr. ORWIN; Mr. HOVELL; Dr. WOLFENDEN. Two Extra Metropolitan—Dr. J. DAVISON, Bournemouth; Dr. BARCLAY BARON, Clifton.

Secretary: Dr. GEORGE STOKER.

The meeting then terminated.

NEW PREPARATIONS.

The Adhesive Electrode.

THIS very ingenious invention is destined to supplant entirely the somewhat defective and often cumbrous electrodes now in general use. No metallic plates, wash leather, or sponges are necessary, with all their disadvantages, these special electrodes being manufactured of some kind of composition which renders them pliable and elastic, besides being exceedingly cleanly. They adhere to the surface of the skin, and conduct a very even current. Their internal resistance, after experiment, is proved to be very much less than that of electrodes now in use. They can be made of any size, even so as to entirely supplant the cumbersome clay electrodes employed in abdominal electricity. With strong currents even, no blistering of the surface results. There is no doubt that these electrodes fill a much felt want in electro-therapeutics, and their great value has already been recognized by eminent physiologists and electricians in this country. We believe that they are obtained in standard sizes, so that uniformity of experiments may be secured. They are cheap, and decidedly preferable to any other kind of electrode. They can be obtained from H. Nehmer and Co., 40, Berners Street, London.

NOTE.

THE Editors trust that the detailed Table of Contents, started this month, and to be continued in future, will be of value to those desirous of looking up abstracts or other papers in the unbound numbers of the Journal for the current year.

Witherby & Co., Printers, 326, High Holborn, London, W.C.

https://doi.org/10.1017/S0022215100013177 Published online by Cambridge University Press