SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

December 7, 1923.

President—Mr H. J. BANKS-DAVIS, M.B., F.R.C.P.

Dr Haslinger's Directoscope with Demonstration—Dr RUSS WOOD.—The Directoscope is described and illustrated in the *Journal of Laryngology and Otology*, March 1924, p. 141.

DISCUSSION.

Mr H. J. BANKS-DAVIS (President) exhibited an instrument, Struycken's Direkotoscope, probably the first of its kind, which enabled one to see the larynx easily in certain cases. He also showed a recent pattern, made like Hill's œsophagoscope, with a slit down the side. This was Seifert's supposed improvement on the instrument Dr Russ Wood had just demonstrated.

Sir WILLIAM MILLIGAN asked whether Dr Russ Wood obtained better results with the "directoscope" than with the old Kirstein instrument.

Dr W. HILL said he had used some of these instruments, and the same result was obtained if a similar shape of spatula was used. The present apparatus was self-retaining, and was not so complicated as the Killian nor so expensive.

Mr J. F. O'MALLEY said the two cases on which he used the instrument were edentulous patients, hence it was very easy. He thought it would be a very handy instrument.

Dr W. H. KELSON said it would be interesting to know what patients thought of these devices. Twenty years ago the Kirstein instrument was shown at the Laryngological Society, and was tried by many, but patients did not like it, and he thought that was the reason its use was largely dropped in favour of other methods.

Dr DAN M'KENZIE said he had heard there were excellent possibilities for the use of this instrument, and patients did not seem to mind it at all. He asked a friend if the extension caused damage to the wall, and he said it did not.

Dr RUSS WOOD (in reply) said that the use of the instrument was contra-indicated in post-cricoid growths, as there was much hæmorrhage afterwards. Patients could be examined with it either sitting up or lying down.

Tuberculosis of Nasal Bones—C. A. SCOTT RIDOUT, M.S.—Male, aged 42, in February 1923, had a semi-fluctuating area over the nasal bones: when incised there was very little pus but bare carious

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bone was felt. Later, a mass of granulations was noticed in right nasal cavity, apparently attached to the anterior and upper aspect of the septum nasi. Pathological examination on three separate occasions was made and report gave the opinion that the lesion was tuberculous. Wassermann: negative. Treatment: iodide of potash without any apparent result and curetting on one or two occasions. Right otorrhœa of moderate amount has come on since onset of nasal condition and aural granulations have been cauterised.

Patient seems to be slowly improving.

The opinion of the Section is desired as to further treatment.

Dr CAVENAGH said that at present he had under his care a boy, aged 14, with a tuberculous past and a two months' history of nasal obstruction and a tender fluctuating swelling over the bridge of the nose. There was marked photophobia in the right eye, with irido-cyclitis. The upper region of the nose was full of the typical granulations found in these cases. He hesitated to adopt surgical procedures, as he thought plastic surgery would be required afterwards. He therefore tried a short exposure to violet rays twice a week. At the end of a fortnight there was definite improvement. Now, five weeks later, there was much less swelling and nasal obstruction and no tenderness or photophobia.

He asked why iodide of potassium was used in this case, as the Wassermann was negative, and the condition was evidently tuberculous.

Dr STRANDBERG said that cases of lupus vulgaris on the side of the nose could be treated with the Finsen light, as there was an affection of the bony nose as well. If there was no bone disease, he would prefer electric cauterisation, placing a small electrode in the nose, and a larger one elsewhere on the body. The patient should then be well in a few weeks.

Mr H. J. BANKS-DAVIS (President) said that the use of iodide of potassium in tuberculous cases was often disastrous, especially in the larynx; there was breaking down of the granuloma, and an aggravation of the disease.

Mr RIDOUT replied that at first he thought the case was syphilitic, and even when the Wassermann was reported to be negative he thought so, as the microscopical sections were not characteristic. He did not want to do anything drastic, for fear the man might lose his work, and it was very difficult to secure Finsen treatment. He was slowly improving, and he allowed the man to go back to light work, in which he was in the open air.

Injury to Lingual Nerves in Guillotine Removal of the Tonsil—DAN M'KENZIE, M.D.—In 1918, the patient, then a girl of 15, had her tonsils removed by the guillotine method. On recovery from the anæsthetic she noticed that the left side of the tongue was numb, and on examination I found it to be insensitive over the distribution of the left lingual nerve.

Since then some improvement has taken place. The tongue is less anæsthetic, but the sense of temperature has not returned as

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she still occasionally burns the tongue with hot food. On examination I find that she can now feel light touches over the affected surface, but they are said to be less distinct than on the right side.

Dr P. WATSON-WILLIAMS asked what was the precise condition of the tonsils in this case. Sometimes the tonsillar hypertrophy extended down to join the lymphoid aggregations at the base of the tongue, and this made it difficult to engage with the guillotine in the ordinary way, and this might lead to injury of the pillars.

Mr DAWSON said that less had been removed on the affected side than on the other. One did notice that after removal of tonsils patients sometimes complained of neuralgia or of a painful sensation in the tongue.

Dr DAN M'KENZIE (in reply) said that he had not heard of or seen this accident before. He agreed that on the left side there was now some tonsil tissue showing, but that appeared frequently after total removal of the tonsil. Immediately after the operation the patient complained of anæsthesia. He did not know what the injury to the nerve could have been. He did not think it could have been divided.

Defect in the Vomerine Part of the Nasal Septum associated with Bifid Uvula—DAN M'KENZIE, M.D.—Male, aged 37, shows an absence of about one-third of the posterior part of the nasal septum. The defect is widest below near the floor of the nose, the posterior edge of the septum curving up to the usual position in the roof. The defect exposes to endoscopic view the posterior ends of the middle and inferior turbinals from the opposite side of the nose. The uvula is slightly bifid, and both abnormalities are obviously connected developmentally.

Mr J. F. O'MALLEY said he thought this was an exceptionally rare condition. Apparently the septum had undergone arrest, and the palate had proceeded to completion, except for the bifid uvula. He thought the posterior border of the septum seen now was not the same as seen in a person whose posterior border was formed by the vomer. It looked as if the greater part of the vomer was absent in this case, and that arrest of development had taken place at about the third month of fœtal life.

Dr DAN M'KENZIE (in reply) said that Dr Brown Kelly had written a long article on the subject published in the *Journal of Laryngology* for 1910. In this case there was no submucous cleft of the palate. Sir Arthur Keith had shown him a similar condition in the gorilla.

Nasal Septum Clamps—DAN M'KENZIE, M.D.—The clamps are used instead of packing after submucous resection. They cause very little discomfort, and seem sufficient to prevent hæmatoma.

Dr P. WATSON-WILLIAMS asked whether the patient could breathe through the nose with this instrument in position. He had used fine wire clamps (Brüning's), but he had found them of little advantage owing to the swelling of the nasal mucosa after operation on the septum causing difficulty in breathing through the nose. He, therefore, preferred the old plan of

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packing with a piece of rubber glove loosely filled with gauze; it was so easy to remove them without discomfort: in fact they sometimes removed themselves unless one took the precaution of tying them together in front.

Mr J. F. O'MALLEY said that in some cases, where there was excessive swelling as a result of trauma, there was a danger that the resultant pressure might jeopardise the life of the flap. On that account he had given up using rubber splints.

Sir WILLIAM MILLIGAN asked whether it was considered really necessary to pack the nose after submucous operations. At the Manchester Royal Infirmary he had tried a series of twenty cases in which packing was done with the finger of a rubber glove with gauze in it, well glycerined; and twenty other cases where no packing whatever was used. He found the last twenty gave as good results, and the patients were very much more comfortable than the others were. One of the points in packing was to prevent the formation of a hæmatoma; and he had concluded that if, when replacing the flap, one did not sew it up at all, a hæmatoma was very unlikely to form, but that a couple of stitches and close approximation of the edges facilitated such formation. He, therefore, seldom packed the nose now, and he obtained quite as good results as when he had packed.

Mr A. R. TWEEDIE said that he had for some two years given up using any dressing or application after these operations. He had never seen any untoward complications, and had found patients much more comfortable as a result of this omission.

Dr W. H. KELSON said he put one stitch in at the anterior inferior angle of the flap. By that means one secured a little space for leakage of blood, and no hæmatoma formed. Patients preferred not to have packing.

Mr RIDOUT said he considered that hæmatoma was very rare after these operations, and he could see no reason for clamping. A little vaseline, or gauze, he thought ample.

Mr MUECKE said he thought clamps were likely to cause sloughing. He said he had tested fifty cases, one series with packing, another with nothing in at all, another with a lightly-packed finger stall, and still another with so-called clamps. In consequence he now employed a little oiled silk rolled over gauze, made, at the time, the exact size necessary. The object was not to keep the septum straight in the mid-line—the operation should do that—but to prevent hæmatoma. The patients in two cases out of ten, if nothing were left in, would get hæmatoma, and the thickening would last a long time. He never sewed up. It was well to put a hook in and make a hole in one membrane three-fourths of the way back as a drain, and then the result was excellent. With the clamps it was impossible to affect the upper part. The oiled silk drained the secretion away and in a short time the nose looked normal.

Dr W. HILL said that there might be hæmorrhage after operating on the septum, and that he always felt safer about a case if he packed, especially if there had been bleeding at the time. He put in a rubber or paper compress and he could then go home more contented, as he was less likely to be summoned urgently to the case.

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Mr CYRIL HORSFORD said that his invariable practice was to use Lake's splints, not only to keep the flap in excellent position, but especially if there had been a tearing of the flap, which could not be helped sometimes when there was a sharp-edged spur. The splint should not be too large. Most of the pain was due to blocking of the middle meatus from pressure of the splint or plug which was too high up. He anchored the splint by a suture in front, because one splint got away and passed into the stomach and out in the fæces. Their removal is painless and bloodless.

Mr A. J. M. WRIGHT said that one of his patients, before he (the speaker) had begun to tie splints or plugs in front of the nostril, inhaled them, and he had to extract them from the bifurcation of the trachea through the tracheotomy wound.

Dr DAN M'KENZIE (in reply) said that the clamps would not cause sloughing of the flaps unless the screwing were done tightly. The clamps were never closed absolutely, and he had found them work very well. Sometimes bleeding from the septum was a very serious matter, and when the packing was removed a day or two afterwards the bleeding was occasionally so bad that re-packing had been required. That had not happened when he had used the clamps.

Tumour of the Larynx—F. J. CLEMINSON, M.Ch.—Female, aged 20, on 6th November complained of hoarseness of five months' duration. She said that she had had a cough every winter for some years. There are some signs in the upper lobe of the right lung pointing to active or quiescent disease. Her sputum is being examined.

The larynx shows two small fleshy tumours, pinkish in colour. The larger and more posterior is apparently growing from the right ventricular band, and, at its anterior end, it partially overlaps a smaller mass, which seems to be growing backwards from the region of the commissure.

Mr T. B. LAYTON said he had the feeling that this was tubercle, but not an ordinary case. He thought the lower anterior lip, which he first considered was a soft fibroma of the anterior commissure, was a little piece coming from the right ventricle beneath the false cord and that there was some swelling and ulceration of the false cord.

Dr JOBSON HORNE said it was not typical tubercle; he thought it was simple papilloma and had nothing to do with the lungs.

Mr CLEMINSON replied that he proposed to remove the tumour and would report to the Section what it actually was.

Enlarged Tonsils complicated by a Venous Nævus of the Palate—ELEANOR LOWRY, M.B., B.S.—Boy, aged 6, was brought to hospital on account of enlargement of the tonsils, glands in the neck, and cough.

The tonsils are much enlarged, and the glands of both cervical and

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right inguinal regions slightly enlarged. There is a venous nævus of the palate, extending over the uvula, right anterior pillar, and both alveolar margins.

The patient is anæmic, his blood count being as follows: Red blood corpuscles, 5,140,000; white cells, 21,400; hæmoglobin, 80 per cent.; colour index, 0.8; polymorphonuclears, 84 per cent.; large lymphocytes, 3 per cent.; small lymphocytes, 4 per cent.; transitional, 2 per cent.; eosinophils, 1.5 per cent.; basophils, 0.5 per cent.

Nothing abnormal was found in the heart or lungs.

Mr WRIGHT suggested that the nævus should be left alone; he considered the glandular condition was due to enlarged tonsils.

Sir WILLIAM MILLIGAN said he considered the nævus in this case was a very insignificant matter. If treatment were required for it—he did not think it was—electrolysis should be used.

With regard to an operation on the tonsils, he would first like a detailed statement of the blood examination. There was a pallor of the throat and tonsil of this patient which made him think it might be only an accompaniment of a general blood change. If the white cell count was apparently normal, he saw no objection to removing the tonsils in the ordinary way.

Dr JOBSON HORNE asked whether this was not a suitable case for London paste. He would not urge enucleation of the tonsil in this case, for the stretching and tearing of an enucleation might aggravate the condition of the nævus. But sufficient could be punched out to give the patient comfort. After that, with attention to health and the general condition, the tonsils might subside without any other treatment. It was important to investigate the blood, and to inquire as to hæmophilia.

Dr W. HILL agreed that London paste might be tried in this instance. There was an instrument, that of La Force, by which the tonsil was enucleated by a blunt blade, and there was an arrangement for tying a surgical pedicle, with no blood vessels exposed. He had a case in which the coagulation time was fifteen minutes.

Dr GILHESPY said he thought this was a case for dissection. The hæmorrhage could be controlled much better than with the guillotine.

Dr LOWRY replied that she proposed to send the patient into the country for six months; she would then show him again. He had a very large leucocytosis, more than double the normal. There was no lymphocytosis. The red cells were over 5,000,000, the whites over 21,000.

Frontal Sinus Empyema with an Unusual Position for a Fistula—ELEANOR LOWRY, M.B., B.S.—Woman, aged 64, seen on 1st September 1920, with a fistula high up on the forehead slightly to the right of the midline. Six months before, she had severe pain in the frontal region and a swelling which opened, leaving this fistula, from which pus had discharged ever since.

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On examination, a probe only entered for ½ in., going slightly towards the left. No pus could be found in the nose. Skiagrams showed only thickening of the bone, with indefinite outline of the sinuses. The Wassermann reaction was negative.

On operation, the fistula was found to communicate with the left frontal sinus, which was large and extended almost to a line perpendicular to the external angle of the eye. The sinus was filled with pus.

The wound was treated with B.I.P.P. and drained from the external angle. The wound healed, and the patient left the hospital within a fortnight. She has had no further trouble.

Dr T. B. LAYTON congratulated Dr Lowry on the result, and especially on the extreme neatness of the scar. He had had a case with a swelling in the same position, and he had so feared an ugly scar that he made a flap, as suggested by Mr Tilley, and with rather disastrous results, for it retracted, and when some tension was put on it a large piece sloughed. When a large swelling occurred there, how did the pus get under the skin? He understood that, in this case, it had come through the anterior wall of the vertical portion of the frontal sinus. In his own case it had not done so, having come through in the usual place, and then tracking round had formed a swelling. In the case he had spoken of, it would not have been necessary to do anything except make the ordinary incision.

Sir WILLIAM MILLIGAN said that the result was very good in respect to the supra-orbital incision. He had only once seen a fistula in this particular situation, and in that case there was a history of syphilis. He thought it resulted from a form of localised septic diploïtis, a localised and mild infection, probably staphylococcic, and the fistula resulted from a localised abscess. In a paper on the frontal sinus operation by Sir Alexander Ogston, in 1884, the vertical incision was the one recommended, and he agreed with Mr Layton that this incision gave surprisingly little deformity if it healed well. In his (the speaker's) early days he invariably operated in the middle line, and when there was bilateral frontal sinusitis it gave a very good approach. Was there a history of syphilis in this case?

Dr GILHESPY mentioned a recent case in which there was a large swelling over the forehead, and when pressure was made on it, pus came out of the nose. He (Dr Gilhespy) made a vertical incision over the swelling and another under the eyebrow, and found the anterior wall over the frontal sinus eroded over an area equal to that of a shilling. The case shown would have been similar if it had not been operated upon.

Dr LOWRY replied that the Wassermann reaction was negative; in spite of that, however, she gave iodide of potassium for two or three weeks, but the patient became worse.

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