CLINICAL RECORDS

HÆMANGIOMA OF THE TYMPANIC CAVITY.

By J. ARNOLD JONES, F.R.C.S.E.

IN June 1922, I was consulted by a lady of over sixty years of age for a discharge from the left ear of some months' duration. For the last three or four weeks she had had slight earache at times. On examination a large polypus bathed in pus was discovered presenting in the left external canal. There was no mastoid tenderness. Under general anæsthesia a large aural polypus was removed. The pathologist reported:—"A fibrous polypus growing rapidly in parts, possibly going on to sarcoma." The patient was instructed to perform a daily antiseptic toilet on the ear, and she returned home.

I heard nothing more until November 1926, when I was again consulted. This time aural discharge and more pain were complained of, and again a large polypus presented in the left external canal. There was no mastoid tenderness. A radical mastoid operation was advised and performed. Before removing the polypus its origin was traced to the inner tympanic wall, and after removal considerable and annoying hæmorrhage took place from this situation. The drum and ossicles were almost totally destroyed, and the mastoid antrum and cells contained pus. A complete radical operation was performed.

The patient's recovery was uneventful, and she had a dry, clean cavity lined with epithelium within three months. The pathologist, Dr Loveday, this time gave the following report:—

"The larger section (fig. 1) shows at the base a hæmangioma with a fibrous connective tissue growth superficial to it and probably of inflammatory origin which is covered by squamous epithelium. The hæmangioma is ill-defined, as is usual, and the blood spaces are large. At one part the appearance is suspicious, though there is no definite evidence of the hæmangioma being malignant.

"One of the smaller sections (fig. 2) shows hæmangiomatous tissue without any fibrous connective growth, and the other shows fibrous tissue with distended glands and no structure of hæmangioma. There is no evidence of any epithelioma."

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I wrote to the patient a month ago regarding her ear, and she replied that she had had no trouble of any kind since the operation.

I can find no other case of hæmangioma of the tympanic cavity recorded in literature. Richman and Fischer have recorded a case each of hæmangioma of the drum; Calabresi a case of fibromyoangio endothelioma of the middle ear; Beck a case of angio-endothelioma of the middle ear; Urbantschitsch cases of angio-sarcoma of the middle ear.

REFERENCES.—J. C. Beck, "Angio-endothelioma of the Middle Ear," report of case, *Illinois Med. Journ.*, 1906, ix., 137-40. F. Richman, "Report of a case of Vascular Tumour of the Membrana Tympani," *Laryngoscope*, 1928, xxxviii., 94-97. J. Fischer, "Hamangiektatischer Tumor des Trommelfells," *Zeitschr. f. Hals-, Nasen- u. Ohrenheilk.*, 1925, v., 221-32. A. Calabresi, "Fibromixoangioendotelioma primitive dell' orecchio medio," *L'ospedale Maggiore*, 1919, n.s., vii., 17-18 (biblio.) E. Urbantschitsch, Angiosarkoma des Mittelohres, Schrumpfung durch kontinuierliche Einwirkung von frischem Zitronensaft," *Zeitschr. f. Ohrenheilk.*, 1913, lxvii., 365.

A LARYNGEAL DERMOID CYST.

By W. STIRK ADAMS.

(*From the Throat and Ear Department, The General Hospital, Birmingham.*)

THE patient, a well-built, healthy woman, aged 49, was first examined at the hospital on 17th April 1928. She was suffering from a severe degree of huskiness, and told me she had lost her voice fifteen years before in an attack of "laryngitis" and that it had never completely returned. She had been an in-patient at a sanatorium for a month fifteen years ago, and had attended an Anti-Tuberculosis Centre every six months since. She was said to have had in 1923 some hoarseness for two months, with swelling of the epiglottis and arytenoids.

In 1925 she had six months' Carbon Arc Light treatment, after which the laryngologist reported (January 1926):—

"There is swelling of the left ventricular band, incorporating the left aryepiglottic fold and arytenoid. Right free. Cervical glands enlarged and hard." She has been examined at the Centre half-yearly since then, the laryngeal condition remaining unchanged. Last examination 30.12.27. Her general health appears to have remained fairly good with no signs of active pulmonary tuberculosis. Tubercle bacilli have not been found in her sputum.

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FIG. 1.

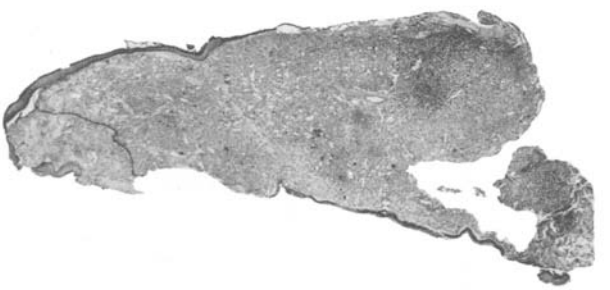
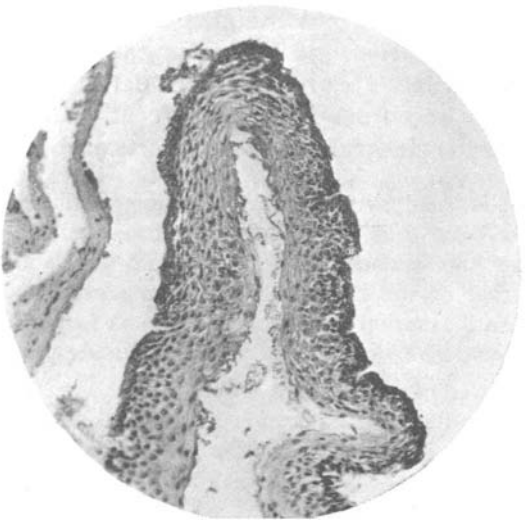


FIG. 2.

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On examination a large, rounded swelling was found to be present in the right aryepiglottic fold, overhanging and obscuring the view of the right half of the larynx. On palpation through the mouth with the index finger fluctuation was detected in the swelling, and the diagnosis appeared to be a chronic abscess, originating from a necrosis of the right half of the thyroid cartilage or from the arytenoid. My colleague, Dr Hardy, after a lengthy clinical examination could discover no evidence of tuberculosis in the chest and X-ray of the chest showed lung and hilar fields clear.



The wall of the cyst. × 50.

On 20th May 1928, owing to increasing huskiness and some dyspnœa, she was admitted under the care of Mr Musgrave Woodman. Direct laryngoscopy under an anæsthetic was performed, and the cystic swelling opened. At operation the cyst was opened from the pharynx, and was found to be full of caseous material, which was evacuated.

The patient left hospital a week later in good health apart from some soreness of the throat on the right side. On 20th September Mr Woodman notes:—"Swelling on right false cord coming up again. Recommended for external operation on the larynx."

On 11th November she was readmitted to the General Hospital, stating that her hoarseness became worse two months

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after the previous operation, and had been getting worse ever since. At operation an incision was made as for "window" operation on the right side of the larynx. When dissecting through the deeper structures a cyst containing much caseous material was opened. The cyst was large and extended downwards and backwards between the right side of the thyroid cartilage and the hyoid bone. The caseous material was all removed, and the cyst wall dissected out, without opening into the pharynx. Ten days after operation, the patient's voice was regarded as almost normal.

The patient reported in November 1929, a year after the second operation. She told me that she had been perfectly well since the operation, and her voice had remained normal. On laryngoscopy no abnormality was detected. Both cords moved equally and freely. Dr F. W. M. Lamb, Assistant Pathologist to the General Hospital, reports as follows:—

"The cyst is lined by squamous epithelium exhibiting the typical lowest layer of basal cells and showing the usual tendency to become flattened near the surface. The epithelium is exactly similar in character to that of the interior of the larynx or that covering the epiglottis. (An illustration of such a cyst is to be found in Henke and Lubarsch's *Special Pathological Anatomy and Histology*.)

"The outer wall of the structure is fibrous and there is some evidence of organisation and cellular infiltration in certain areas, but there is no indication of any specific inflammation such as tubercle. The only other tissue present in the wall is a small focus of lymphoid tissue.

"The appearances are those of a congenital laryngeal cyst, analogous to the remnants of branchial or thyroglossal structures found in the neck, but as the lining is squamous epithelium, the latter site is best regarded as excluded, although Louys and Salomon have apparently envisaged the possibility. Other origins which have been suggested are: from the appendix of the ventricle (Schneider), or from some cutting off of epithelial rudiments of the larynx during development (Kahler)."

The chief points of interest in this case are the difficulty in diagnosis (which was not finally resolved until the cyst wall was examined microscopically), the variation in the symptoms at different periods and the very long clinical history.

The diagnostic difficulty was not lessened by the presence of enlarged hard cervical glands at the right side of the thyroid cartilage, which were calcified to X-ray.

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The variation in the symptoms, I consider, must be regarded as due to variation in the size of the cyst, probably partly explained by attacks of inflammation in its wall. No history of spontaneous rupture could be obtained.

In the report of my colleague in January 1926, a swelling of the left half of the larynx was recorded. I have observed no lesion on the left side.

From the relation of the cyst, beneath the deep cervical fascia and extending into the larynx between the hyoid and the thyroid cartilages, it appears to be a closed extension of the laryngeal ventricle, analogous to the laryngeal air sacs so well described by Bland-Sutton in *Tumours Innocent and Malignant*, 4th Edition, p. 608.

SOCIETIES' PROCEEDINGS

SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY

THIRTIETH MEETING, GLASGOW

November 30, 1929

President—Dr JOHN L. HOWIE

CASE 1. **Persistent Alveolar Fistula after Antral Operation**—R. P. MATHERS, M.B.—Tooth extracted December 1927. Three weeks later pain over left antrum. Pus expelled from nose on blowing through mouth. Seen April 1928. Caldwell-Luc. Mucosa polypoid. Fistula. Three attempts at closing: not successful.

Dr LOGAN TURNER said he had seen the patient, and suggested to Dr Mathers that he should enlarge the opening, remove some more bone from the alveolus, and refashion the flaps.

Dr DOUGLAS GUTHRIE showed a radiogram from a case under the care of Dr C. E. Scott, who was unable to attend the meeting. In this patient removal of an upper bicuspid tooth was followed by a gush of pus from the antrum and a fistula persisted until the radical operation was performed, which resulted in cure. Personally Dr Guthrie suggested to Dr Mathers that in his case the fistula should be freely opened through a vertical incision in the canine fossa, sufficient bone being removed to convert the tubular channel into a gutter. Should this fail, the plastic operation might be tried, but it was essential that the flap should be lined with mucous membrane or skin, and not raw on one surface. This could be accomplished

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