SOCIETIES' PROCEEDINGS

THE SCOTTISH OTOLOGICAL AND LARYNGOLOGICAL SOCIETY

President—DR. A. BROWN KELLY.

THE Society held its Summer Meeting in the Western Infirmary, Glasgow, on *Saturday, June 11th*, 1938. The Meeting was a joint one with the Otological and Laryngological Sections of the Royal Society of Medicine, which Sections had been holding their Summer Meetings in Glasgow.

CASES AND DISCUSSION

CASE 1.

Case of Œsophago-Mediastinal Fistula.

—DR. A. BROWN KELLY and DR. FERGUS L. HENDERSON.

Dr. Fergus L. Henderson demonstrated a series of lantern slides of radiograms showing a large diverticulum, communicating with the œsophagus, in a child of 4 years and 9 months. This child had had a troublesome cough from birth, and, when a few months old, it was noted that there was an abnormality of the cervical vertebrae which, the parents were told, would not get any worse.

From two years of age, the child had had recurrent attacks of severe pain in the chest and upper abdomen. These set in at irregular intervals, but, particularly after a dinner at which potato was eaten. Sometimes pain aroused the child during the night and kept her awake for hours ; relief was obtained only by drinking warm water. She had occasionally been quite free from discomfort for a long period. The pain and cough were most troublesome during the winter months.

While the child was in the Mearnskirk Hospital, examination of the neck showed a cervico-dorsal kyphosis, suggesting a congenital lesion of the cervical spine. X-ray examination revealed a synostosis of the 2nd, 3rd, 4th and 5th cervical vertebrae. There was nothing to indicate that this condition was tubercular. The X-ray films of the chest showed an unusual shadow to the right of the vertebral column, extending from the level of the first dorsal vertebra to that of the 10th (Fig. 1).

A barium drink went freely into this diverticulum, the entrance

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to which was at the level of the 7th dorsal vertebra (Fig. 2.) A rubber tube passed to the stomach showed the diverticulum to be situated to the right of the œsophagus (Fig. 3) and posterior to it (Fig. 4). The tube was also passed through the fistula into the diverticulum, where its coils reached from top to bottom of the thorax (Fig. 5). Some of the barium remained in the pouch for over twenty-four hours before passing into the stomach, and apparently caused no inconvenience to the patient. The glands in the roots of both lungs were enlarged, and indicated a tubercular involvement, although no disease of the lung parenchyma could be detected. During the child's residence in Hospital, examination of the stomach washings proved positive for the presence of tubercle bacilli.

In discussing the differential diagnosis, Dr. A. Brown Kelly stated that an œsophagoscopic examination of this girl when four years and eleven months old, revealed nothing abnormal in the upper part of the gullet, but at 17 cm. from the incisors the appearances were such as he had never previously met with. Two œsophagi seemed to lie side by side, with a partition between them which resembled the wall of a normal œsophagus. One could look down the lumen of either. This picture was seen at once, but only for a brief period. It was obtained while the middle of the beak of the endoscope rested on what appeared to be a partition between two œsophagi, but which was in reality the rounded lower edge, or threshold, of a large vertical opening in the right wall of the œsophagus.

The abnormality, based on the endoscopic findings, was at first regarded as a congenital doubling of the œsophagus. A search for literature on the subject brought but little to light, and that dealt largely with the malformation as found in animals. Blasius met with the condition in a newly born infant and a five-years-old child. Kathe reports a case of partial doubling. Wessely states in Denker and Kahler's work that the lumen of the œsophagus may undergo doubling due to a longitudinally placed septum, but that in no case has the doubling been known to extend throughout the whole length of the gullet.

Further consideration of the opening in the right wall of the normal œsophagus, which communicated with the supposed second œsophagus, led to the condition being named an œsophago-œsophageal fistula. This term, however, was found to have been already applied by Ciechanowski to a post-mortem condition he had met with in which the principal features were: One or several small submucous channels in the anterior wall of the œsophagus running parallel with its long axis, and having an opening at each end along which a bristle could be passed. The edges of the openings were quite smooth and the channels were lined with normal

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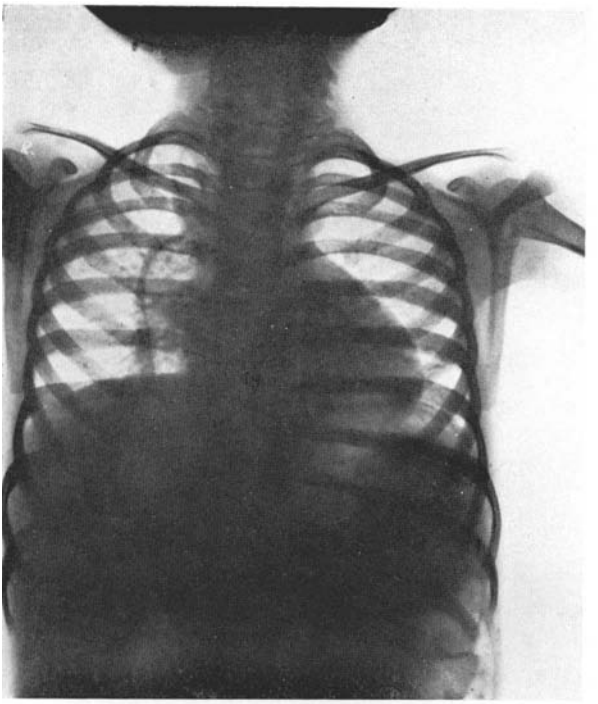


FIG. 1.

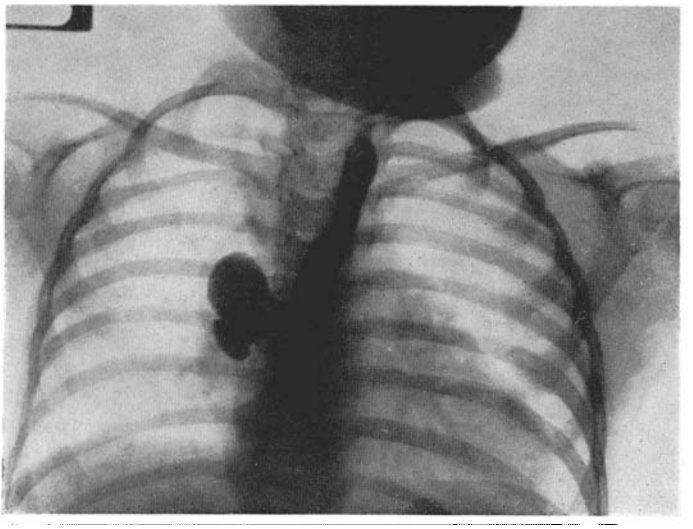


FIG. 2.

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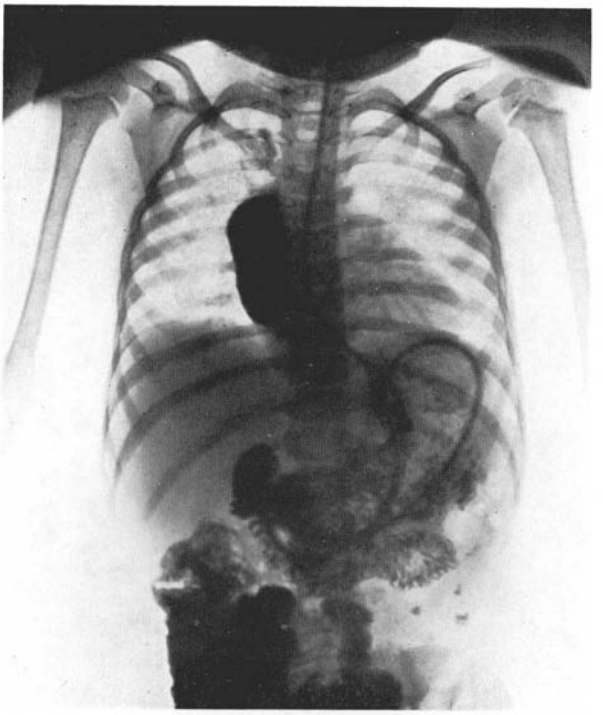


FIG. 3.

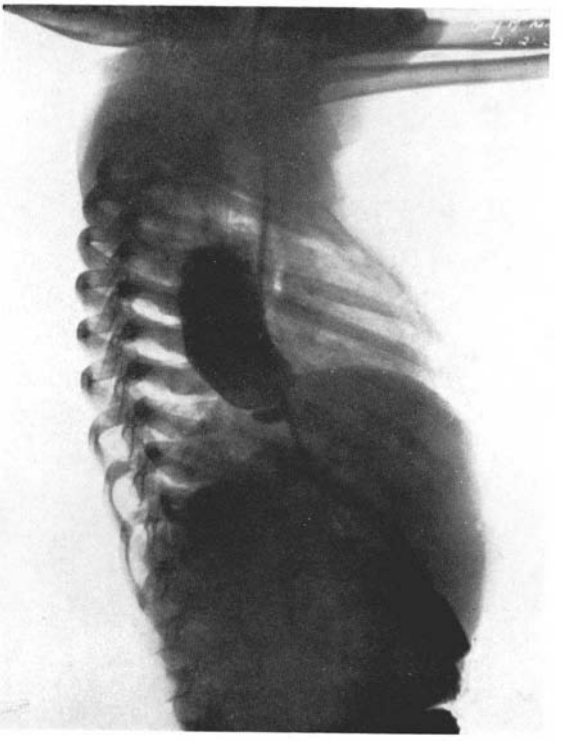


FIG. 4.

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epithelium. This condition was not pathological but due to a developmental disturbance.

Dr. Fergus Henderson had in the meantime demonstrated by barium meals and coiled tube tests that nothing like a second œsophagus was present, but that a large open space lay to the right of the normal œsophagus, extending far laterally and from the level of the neck above, to the diaphragm below.

The best view of this region obtainable in the cadaver is from behind, after removal of the vertebral column. It is then apparent that an inflammatory affection of the mediastinum or a neighbouring organ may readily involve the œsophagus, especially the uncovered right side, as has taken place in this case.

There are two ways in which an œsophago-mediastinal fistula may be produced. A tuberculous process in the mediastinum such as that demonstrated by X-rays in this patient, may extend to the œsophagus and give rise to adhesions and strands. These subsequently contract and draw part of the œsophageal wall outwards, thus producing a traction diverticulum. If the axis of the diverticulum is directed downwards, food is liable to be caught, and gradually causes distension, so that the tent-like shape becomes rounded, and the type of diverticulum is changed from traction to pressure-traction. Continued pressure, the stagnation of retained food, and, possibly, the lodgment of a foreign body, lead to ulceration, rupture of the diverticulum and a fistula.

The other mode of origin is for tubercular ulceration to develop on the outer surface of the œsophagus in the mediastinum, perforate the wall and thus establish a communication between the œsophageal lumen and the mediastinum.

Lastly, we have to consider how far the clinical history of the case is in accordance with the suggested diagnosis. While still an infant it was noticed that her neck was short, and her head tilted to one side. These abnormalities still exist, and are associated with a synostosis extending between the 1st and 6th cervical vertebrae; the 6th, in addition, being eroded. It is impossible to say to what extent these changes were respectively antenatal and postnatal, or to determine the part they played, if any, in the production of the fistula. A communication between the œsophagus and mediastinum would seem to have been established before the patient was two years old, because from that age onwards she has been subject to the attacks of severe pain in the chest and upper abdomen to which Dr. Fergus Henderson has referred.

She is said to have had pneumonia three or four times. Repeatedly in the past, there has been suspicion as to the state of her lungs.

It is noteworthy that while the barium suspension gains easy access to the mediastinum through the fistula, it seems to be slowly

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but completely expelled; traces have been visible many hours after administration. This thorough emptying and a non-irritating diet may have helped to protect her up to the present from fatal septic complications.

LITERATURE

BLASIUS. *Observata anatomica* etc., 1677.
CIECHANOWSKI, S. and GLINSKI, L. K. *Virchows Archiv*, 1910, Bd. 199, S. 420.
KATHE, H. *Ibid.* 1907, Bd. 190, S. 78.

DISCUSSION

PROFESSOR BLACKLOCK said they were rather fortunate in Glasgow in having such an authority and enthusiast as Dr. Brown Kelly to stimulate the lagging pathologist to take a little more interest in the œsophagus. The case under discussion was very puzzling, and the condition may have arisen as a result of tuberculous mediastinal glands. The largest lymphatic glands in the body are found on the right side of the bifurcation of the trachea. He had seen enlarged caseous glands in this region become adherent to the œsophagus and occasionally perforating that structure, forming in the first instance small ulcers. The ulcerative process continues; food enters the small cavity and thus a rather irregular diverticulum is formed. The few diverticula of this nature which Professor Blacklock had seen at autopsy had been of small size, none being larger than the tip of the little finger, and all had been in children over five years, or in adults.

According to the history of the present case the lesion in the œsophagus was of over two years' duration. This to him would rather rule out the possibility of the condition being of the nature of a traction diverticulum, because two years ago the child would be rather young to produce a dense fibrosis in tuberculous mediastinal glands sufficient to cause a traction diverticulum.

He (Professor Blacklock) felt that some light might be thrown on the present case if a snip from the wall of the abnormal pouch could be obtained and examined histologically.

Dr. CONNAL asked about the use of the word "ruptured" in this connection. He said he always had the idea that a rupture at that level of the œsophagus invariably led to a mediastinitis and death.

Dr. BROWN KELLY (in reply) said the only objection he had to Professor Blacklock's contention was that perforation of the wall of the œsophagus was very rarely met with *post mortem*.

With regard to Dr. Connal's question, Dr. Brown Kelly also was surprised that the child had not developed a mediastinitis; this severe pain may be a prodromal symptom.

CASE 2.

Case of Hyperpyrexia, with elevations of temperature to 116 degrees.—DR. GAVIN YOUNG.

C.R., female, 26, seen in Mr. Mill Renton's ward 10.5.38, complaining of sickness and abdominal pain, with occasional elevations

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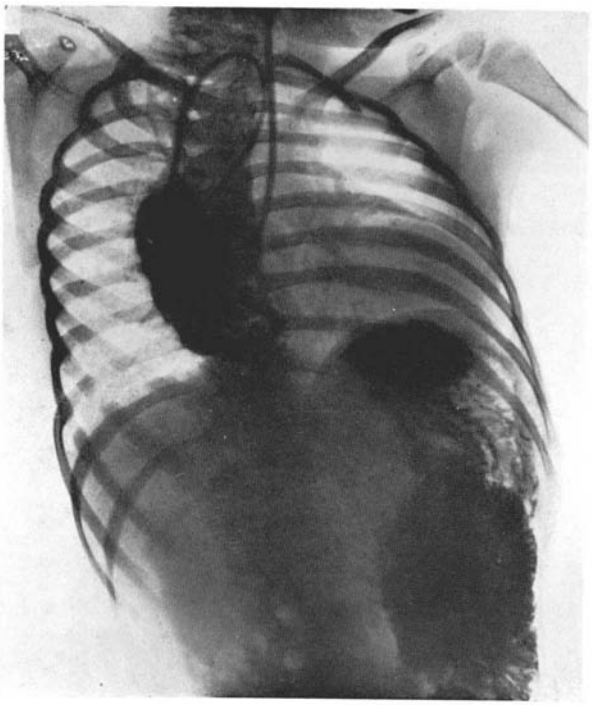


FIG. 5.

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of temperature to 112°. Two thermometers were broken, as they were unable to record the temperature.

There was a history of tuberculosis at the age of 4; and of an abdominal operation, probably appendicectomy, at the age of 20; treatment without operation for an ear condition had taken place for several years.

On *examination*, a hard, rounded bony swelling was felt in the region of the right mastoid process. The tympanic membrane was not seen owing to swelling of the posterior meatal wall. There was purulent discharge in the meatus and the patient was hard of hearing. *X-ray examination* revealed "large well-defined opacity in the right mastoid region, behind the greater wing of the sphenoid. This has the appearance of a subdural abscess."

Transferred to the Ear, Nose and Throat Department 11.5.38. Mastoid operation. The mastoid process appeared to be replaced by a bony process with a hard cortex and an internal structure of the consistence of hard cheese which was homogeneous and exceedingly vascular. In spite of extensive excavation, no antrum was defined, and the aditus was recognized only by following up a seeker introduced from the tympanic cavity. No pus was found in the mastoid. Bone was sent for pathological examination, but was reported on as non-malignant. Professor Shaw Dunn later suggested osteoma.

14.5.38.—Professor Ballantyne examined the eyes—congestion of discs, no hæmorrhages, no evidence of tuberculosis.

Dr. T. N. Fraser, neurologist, reported that save for twitching of the right side of the face, and general weakness, there was no definite abnormality of nervous system.

16.5.38.—Further removal of bone, with exposure of the lateral sinus and middle fossa dura, both apparently perfectly healthy.

27.5.38.—Wassermann reaction negative. Lumbar puncture—at the time of sending in this note, no full report, but nothing of much importance.

Since time of admission to Ear, Nose and Throat Department, the temperature has risen every day or so, suddenly, to heights varying from 112°, at which point two thermometers have given way, to 116° the full height of another thermometer.

Discussion

Dr. Brown Kelly said he had a case in which the temperature apparently rose to 108° and 109°. The patient was a girl who gave a lot of trouble and they found that she had been rubbing the thermometer as hard as she could. The treatment was discharge from hospital.

Mr. Peters said it might be useful to take the temperature with four thermometers at the same time! This is a certain method of

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excluding malingering. He remembered a case of hyperpyrexia in which the temperature went up to 112° every night and, although there were no recognizable signs at that time, five days later pneumonia declared its presence, the temperature fell and the patient recovered. Mr. Peters suggested that it would be wise to exclude the possibility of a latent broncho-pneumonia; that could only be excluded by a radiographic examination.

Dr. HENDERSON said the case appeared to him to be one of some disturbance of the temperature centre. Her tongue was so clean that it was not likely to be a case of septic absorption.

Mr. E. D. D. DAVIS said that during the War a number of cases of extensive cerebral cortical hæmorrhage following bullet wounds had temperatures of 108° or more before death. He had one soldier under his care who had a piece of shrapnel in his optic thalmus, and he died with a high temperature.

Dr. GAVIN YOUNG (in reply) said that every possible care was taken of any hot water bag or anything like that. The temperature was taken in the ordinary way and the mercury just broke up in the mouth. She had been observed in Mr. Mill Renton's ward also and she certainly showed some unusual neurological features. It was pointed out by one of the neurologists there that she had right-sided facial twitchings. Sometimes she looked almost as if she had right-sided facial paresis. Dr. Gavin Young had not seen such a massive osteoma before, or anything like it, and he was prepared to find that it was probably malignant. He had hoped that the case would be provocative of some discussion. He was quite sure there were no artefacts about the case.

In reply to Mr. Peters, the patient had her chest X-rayed and there was nothing to be made out. She had her temperature taken in both armpits, with separate thermometers, and there was a degree of difference between the two sides. This was tested by changing the thermometers.

CASE 3.

Recurrent nasal Polypi, with clinical suspicion of malignancy, treated with radium.—DR. GAVIN YOUNG.

A.B., male, 42, complaining of nasal stuffiness and post-nasal discharge: several operations previously for removal of polypi, last operation, 1931, on antrum and ethmoid.

On *examination*, left naris full of polypi.

5.11.37.—Proof puncture. left, positive: polypus removed. Biopsy—no definite evidence of malignancy reported.

15.11.37.—Caldwell-Luc operation—polypi in the antrum, well marked on the antro-nasal wall: there was much bleeding, and the cavity was packed with proflavine, and drained. Examination of polypus as before.

23.11.37.—Antrum and ethmoid thoroughly exenterated, three tubes of radium were packed into the cavity for seventy-two hours, giving 450 mgm. hours.

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CASE 4.

Hypersensitive Inferior Turbinals treated with Radium.
—DR. GAVIN YOUNG.

I.B., female, aged 15, complaining of sore throats and almost complete nasal obstruction. Unhealthy tonsils and a large pad of adenoids were found. Also inferior turbinals of the type usual in hypersensitiveness, a very marked case.

25.11.37.—Radium was inserted in left inferior turbinal (2 needles 20 mm. long, 3 mgm.) for twenty-four hours.

29.11.37.—Tonsils and adenoids removed.

21.2.38.—This period was allowed for observation of the action of the radium on the left side. Then the right inferior turbinal was similarly treated.

DISCUSSION

Dr. BROWN KELLY asked Dr. Gavin Young what he meant by " hypersensitive " inferior turbinals: was it a vasomotor condition or some other ?

Dr. GAVIN YOUNG (in reply) said he really meant what is commonly called the allergic type of nasal mucosa. He had said " hypersensitive " out of deference to Dr. Adam.

Dr. ADAM said they need not ask him to define allergy. He would be very glad if any one there could do so. Tzanek has collected different definitions of allergy and Dr. Adam thought that everyone present at the meeting could give a different one. He had examined this case and considered that treatment had succeeded on the left side and failed on the right. He thought radium rather a dangerous treatment. He was interested to see what the effect of exercise would be on the turbinal so induced the patient to run along the corridor and on examination afterwards found that the right turbinal had contracted, leaving the nostril free. Dr. Adam recommended deep cautery puncture, a proper amount of vitamins in the diet and plenty of outdoor exercise.

CASE 5.

Nasal Plastic Treatment following Submucous Resection.—DR. GAVIN YOUNG.

G.G., male, aged 17, referred as an old patient of the Royal Hospital for Sick Children, where he had undergone an operation for cleft palate and hare lip. He now required submucous resection for a very severe deviation of the septum.

1.11.37.—Submucous resection, which was so radical that the nose collapsed, causing complete occlusion of the right nostril.

16.12.37.—Outer ala of right naris propped up by piece of costal cartilage.

10.3.38.—New columella formed by piece of costal cartilage.

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Discussion

Dr. Capps took it that Dr. Gavin Young had not yet finished with this case.

Dr. Gavin Young said, in reply, that the patient was in the hands of the surgeon at the Sick Children's Hospital.

Cases 6-8.

Three Cases of Facial Injury, each with Fracture of Lower Orbital Rim and Anterior Wall of Antrum.—X-ray Films shown.—Dr. Gavin Young.

Case 6.—Treated by W. S. Syme.

M.F.G., aged 23, Egyptian student. 20.1.38.—Blow from compatriot on left cheek : area of depression over cheek.

21.1.38.—The antrum opened in the canine fossa, and was found to be full of blood clot. The anterior wall was replaced and held in position by stout rubber tubing doubled up. The tubing was removed ten days later.

Case 7.—Treated by Gavin Young following the above technique.

A.B., male, aged 27, injury received on 14.4.38, during execution of duty as referee, exactly as in the preceding case. Antrum found to be full of blood clot.

Case 8.—C. McC., male, aged 42, injuries received 30.4.38 in gang fight. On the left side of the face. There was a fracture of the nasal bones, the left ascending nasal process of maxilla, and the left orbital rim. Seen in the Department of Ophthalmology, suffering from orbital abscess, with complete loss of vision. The abscess was incised externally in the Eye Department, and the patient was transferred to the Ear, Nose and Throat Department. The antrum was opened through the canine fossa, old-standing disease was found in antral mucosa which was removed ; the ascending process of the maxilla was fractured in two places forming a sequestrum ; it was removed.

21.5.38.—Patient left hospital.

Discussion

Dr. Gavin Young said that Case 8 had practically lost all vision in the left eye. He could see only light and darkness. He had a very bad orbital abscess which was evacuated through the cheek before he was sent to the Ear, Nose and Throat Department, and then he had the antrum cleared out. Dr. Young understood that the outlook for his eyesight was not very good.

Case 9.

Case of Atrophic Rhinitis.—Dr. James Adam.

Mary McK., aged 15 when first seen in 1933. The disease had lasted a lifetime. The nose was packed with stinking crusts, the

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turbinals reduced to stumps, and the facies typical. It was the worst case of the disease among 170 cases he had seen. Pus was found in both sphenoidal sinuses and in both ethmoids and these cavities were opened. The antral walls were thickened, as usual; but the antra were doubtful on proof puncture, and were not opened.

B. Diph. reported as usual, but found to be diphtheroids, in pure culture.

Implants of cartilage and of fascia have done little to narrow the nasal airway, but there are now no crusts or fœtor. The patient douches twice weekly.

Discussion

Dr. Brown Kelly asked Dr. Adam in what period he had had 170 cases of atrophic rhinitis. He remarked that cases of atrophic rhinitis submitted to the Society should be told not to wash their noses before coming, otherwise a true estimate of the disease could not be formed.

Dr. Adam (in reply) thought it would be about thirty years. It appeared to him that atrophic rhinitis seemed to be increasing. He thought the routine treatment of tonsils and adenoids helped to keep down sinusitis in children, also sinusitis in children was being more looked after than it used to be. One did not get atrophic rhinitis without sinusitis. The ethmoid was always involved, and often the sphenoid. Dr. Adam had just heard that day that in America they were using instillation of œstrin into the nose and they say they get very good results with it. But the cases won't recover unless one treats the sinusitis. Why this problem has lingered is that a surgeon naturally hesitates to take something more out of a nose which is already too empty, but the one thing to do is to deal with the ethmoid and, if necessary, with the sphenoid and antrum. Dr. Adam thought there were a great many cases of chronic maxillary sinusitis in which the radical operation could be avoided if they made an infraturbinal opening and cleared out the ethmoid cells.

Dr. Brown Kelly thought there would be differences of opinion as regards that.

Dr. Adam said he had had differences of opinion with himself, but now he was pretty sure.

Mr. Livingstone said that the chemists had found that œstrin applied to mucous membrane stimulated the glands and the whole of the Department in Montreal were using this solution, spraying the nose after the crusts had been removed. Apparently at the end of a week the crusts ceased forming and the patients themselves had no ozoena. It did not cure the condition, but the glands were very much increased. He had been very much impressed with the cases he had seen.

Mr. E. D. D. Davis said he would like to hear more about this question of sinusitis. He had investigated a large number of cases and everything had been done to discover a sinusitis, with a negative result. He thought atrophic rhinitis was a more difficult question

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than that of sinusitis. It was a curious thing that at about the age of twenty-five the crusting frequently disappeared. It may be that they developed an immunity. Mr. Davis had asked many of his colleagues if they had been able to find sinusitis associated with atrophic rhinitis, and they had all said " No, it is very unusual ".

Dr. ADAM said there was one other factor in atrophic rhinitis, that of avitaminosis. Most of these patients had a very defective diet and it was important that they should have vitamins A, B, C and D. In the extra case he showed, the right nostril was clear. He opened the ethmoid on the right side, which was now well. The man did not douche. On the left side Dr. Adam discovered, after opening up the ethmoid, that he had missed a sphenoidal sinusitis. This remained to be dealt with. The right nostril was now well, the left had improved, but until the left sphenoid was treated the trouble in the left nostril would not clear up. The success with the right nostril where all the sinusitis had been stopped, the comparative failure on the left, where the sphenoidal sinusitis remained, was very definite evidence that sinusitis was at the back of the problem of atrophic rhinitis.

CASE 10.

Malignant Disease of the External Meatus of the right ear, slowly extending to base of Skull and involving Nerves VIII to XII.—DR. JAMES ADAM.

This case was shown to the Society six years ago.

Mrs. M., now aged 71. Deafness in the right ear began in 1922. First seen in 1923 : there was a small growth in the floor of the meatus through which bare bone could be felt. M.T. unruptured. Biopsy negative as to malignancy. Exploratory mastoid : nothing abnormal found.

Hearing.	R.	L.
C.V.	2 in. (?)	
W.V.		10 ft.
Weber to right.		

Not seen again for six years.

1930.—Difficulty in swallowing, altered voice, bleeding growth in middle ear. Right cord fixed, tongue protruded to right : tinnitus, no pain.

Although microscope revealed no malignancy, 25 mgm. Ra. with 0.5 Pt. screen was put in the meatus for thirty hours.

1931.—Growth shrunken, less discharge, less difficulty with saliva ; palate rather insensitive to touch but no curtain sign. The shoulder movements were carried out without difficulty.

Later.—Great pain in the ear was relieved by anæsthesine. The facial ridge was bare. Blood picture normal.

1932.—Pain gone, but still some tinnitus : Weber not lateralized ; atrophy of right sternomastoid and trapezius, and of right half of tongue ; no dysphagia ; no facial palsy.

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1938.—Facial ridge necrotic, no facial palsy; other nerves as stated, but patient moves shoulder well and swallows well. General health excellent.

Discussion

Dr. Adam asked for suggestions with regard to this case. It seemed to him that it was malignant. The only comparable case in his experience was one of the hypopharynx in a woman in which the malignant disease lasted fifteen years before she died. J. S. Fraser saw the present case six or eight years ago and he could not throw any light on it. He thought of the possibility of agranulocytosis, but the blood picture was quite normal.

Dr. Brown Kelly thought it seemed rather extraordinary to have so extensive an involvement of the cranial nerves due to a growth such as was present in this case.

Case II.

Dr. W. S. Syme.

J.E., female, aged 17 years. Complaining of nasal discharge, and crusting of both nostrils. Tracheotomy performed two years ago in Mearnskirk Hospital. Tubercular history. Operation on right eye three years ago.

Lupus of anterior inferior turbinals.

18.11.32.—Diathermy. 22.12.32.—Local condition and general condition very satisfactory. Sunlight recommended.

16.2.34.—Left inferior turbinal curetted and lactic acid, 20 per cent., applied.

5.5.35.—Diathermy to nose.

17.1.36.—Scar tissue in left nostril excised; one stitch inserted and tube placed in nostril.

24.5.38.—No further trouble. Right nostril clear, left contracted.

Suggestions were asked with regard to further plastic.

Discussion

Dr. W. S. Syme wondered if it would be possible to break down the scar tissue again and try to line the nostril with a skin graft on stent.

Dr. Ewart Martin strongly advised leaving this case alone. He said that they, unfortunately, saw a number of lupus cases. They found that healing at first took place superficially and that the final healing did not take place for some months or years later, so therefore, if any plastic operation were undertaken before five years had elapsed, there would be a possibility of the scars breaking down and the disease recommencing.

Mr. Capps remarked that this patient still had several areas of infection and she had some bad teeth in the right jaw. He thought nothing would ever be done with the scar tissue.

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CASE 12.

Case for Diagnosis.—DR. W. S. SYME.

J.H., male, aged 30 years. Complaining of regurgitation through the nose for two years, with shortness of breath, choking sensation at night, and sore throats.

Septic tonsils and thickening of palate and uvula. X-ray of sinuses showed both antra positive. Lavage was negative.

8.3.38.—Ether was given for removal of the tonsils; but the patient became very cyanosed and operation was not possible.

11.3.38.—Chloroform for the examination of nasopharynx and hypopharynx. No growth found but palate and uvula and epiglottis were much swollen; non-inflammatory. (?) Simple hyperplastic pharyngitis. (?) Cause.

Adrenalin spray had no effect, and potassium iodide was prescribed. *Wassermann negative.*

11.4.38.—Feels much better but still shows the thickening of palate and epiglottis.

DISCUSSION

Dr. BROWN KELLY said there was very considerable thickening involving the uvula but not extending much into the palate. The epiglottis was very much thickened: redness and ulceration were absent. The case reminded him of a condition called sclerotic hyperplasia of the throat, which involves the uvula and soft palate and may extend to the epiglottis and arytenoids. It was described in Thomson and Negus's book. It is very rare, and clears up slowly. The cause is unknown and Dr. Brown Kelly thought that local treatment was of no use.

Dr. W. S. SYME said the patient was very much better than he had been three or four months ago.

CASE 13.

DR. W. S. SYME.

Female aged 40 years.

14.5.35.—Complaining of spitting of blood. X-ray of the chest showed no tubercular disease apart from calcified foci at the left hilum; sharp angulation of œsophagus at the level of manubrium.

24.5.35.—The œsophagus was narrow eight inches from the teeth.

28.6.35.—Bronchoscopy and œsophagoscopy; no abnormality was found.

20.8.37.—On two or three occasions in the past four and a half years has spat up blood following bad cough which ended with bringing up calcium.

21.8.37.—X-ray as before.

1.9.37.—X-ray as before.

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28.3.38.—X-ray as before.

5.4.38.—Left bronchus very close to calcified masses at left hilum—probably actual calcification of bronchus.

22.8.37.—Bronchoscopy. Left bronchus 9 inches from teeth, on the posterior wall just below the carina there was a granular area ; probably simple, bleeding easily. Right bronchus normal.

24.9.37-26.11.37.—Has been free from symptoms.

25.3.38.—Further attack with calcium. He bled on Sunday, and coughed calcium up on Monday night ; occasional pain.

Pathological report.—" Decalcification of material fails to reveal an organized structure. It is not bone. Chemically it consists of calcium phosphate and calcium carbonate. There is a trace of magnesium—possibly come from calcified hilar lymphatic gland after ulceration through the bronchus."

4.4.38.—Bronchoscopy showed no change since the last examination.

30.5.38.—Bronchoscopy. (?) Lipiodol examination.

Discussion

Dr. W. S. Syme said that on several occasions this patient brought up portions of calcium about the size of a hazel nut. It usually started with a little coughing, some bleeding and then this calcium or stone was coughed up. Bronchoscopy has not been of much help. There was an X-ray with the patient. There was not been much change in the X-ray appearance. There was no sign of any tuberculous disease in the lungs ; all that was to be seen was a large mass of what was described as calcified glands near the hilum of the left lung and the suggestion made by the pathologist who examined the calcium was that the stones had gradually worked through into the bronchus. But whether that was a feasible suggestion or not, Dr. Syme was unable to say.

Case 14.

Closed Sphenoidal and Ethmoidal Sinusitis with Orbital Cellulitis.—Dr. T. O. Howie.

D.D., male, aged 17 years, clerk. Admitted to the Victoria Infirmary 18.5.38.

Complaint.—There was severe pain behind both eyes and swelling round the right eye.

History.—There was sudden onset of pain behind the left eye on 14.5.38. Two days later the pain had become " unbearable ". His nose bled and a considerable quantity of blood passed into his nasopharynx. The pain developed into a generalized headache and then seemed to leave the left eye and pass behind the right. Photophobia was extreme.

Examination.—There is marked photophobia. There is a

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swelling of the tissues round the right eye, of a cellulitic nature. The right eye is proptosed and fixed, with some displacement of the globe outwards. There is a small localized area of tenderness on the inner wall of the orbit immediately above the inner canthus. Ocular tension is normal. There is almost complete ptosis of the right upper eyelid. There is no evidence of facial sepsis. Both nasal cavities show no abnormality on anterior and posterior rhinoscopy.

X-ray examination.—Both ethmoidal areas and both sphenoidal sinuses are dull.

Further progress.—23.5.38. With menthol inhalations, hot fomentations, and prontosil, the swelling gradually decreased and to-day blood-stained mucopus has appeared post-nasally. The photophobia is passing off. There is some movement in the upper lid. Slight movement of the bulb takes place in all directions except outwards. Swelling has almost entirely gone. There is still slight exophthalmos.

30.5.38.—There is some anæsthesia of the right cornea. The IIIrd, Vth and VIth cranial nerves still show some involvement. There is some congestion and fullness of the veins in both fundi.

Temperature.—The temperature on admission was 99·4° F., and gradually dropped to normal.

Suggestions would be welcomed from members as to the line of treatment which should be followed. Is there probably a defect in the bony wall of the sphenoid sinuses which is leading to an early toxic effect on the oculomotor nerves? Should the sinuses be explored externally?

X-ray films shown.

Discussion

Dr. Howie said the only other thing which he might mention was that the patient was slightly blind in that eye. He had had an optic neuritis in conjunction with the other ocular palsies. The patient was really brought forward in order to get opinions as to what line of treatment should be followed. Should they let well alone or should they explore with a view to giving better drainage? If the patient gets another attack will there be a risk of cavernous sinus thrombosis?

Dr. Derek Brown Kelly asked if Dr. Proetz's displacement method would help in this case, with a view to improving the drainage.

Dr. Proetz said he had not seen the case so could not be of much help.

Case 15.

Case for Diagnosis.—Dr. Derek Brown Kelly.

S.F., aged 37, attended the Victoria Infirmary on 11.1.38 complaining of pain in and foul discharge from the site of a dental extraction in the upper jaw on the left side.

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Examination revealed a sequestrum, which was removed and healing readily occurred. A small ulcer with grey coloured base was observed on the left side of the soft palate. This has extended until now it is about the size of a threepenny bit. The edges are raised, red and indurated; the appearances suggest a gumma. The tongue presents a curious "hairy" surface. Glands not obviously involved. Wassermann reaction negative on two occasions.

The ulcer has been cauterized with silver nitrate, and potassium iodide administered over several weeks. A piece from the growing edge had been taken for pathological examination.

Discussion

Dr. Gavin Young suggested that it might be worth while having the antrum on the same side X-rayed in this case. He thought this might be a process through from the antrum.

Dr. Brown Kelly said a little piece had been removed from the ulcer on the left side. The man had in addition one or two tiny ulcers which resembled chronic recurring aphthae, but might be unrelated to the chief ulcer. In the *British Medical Journal* every now and then there is an enquiry with regard to the treatment of these little ulcers in the mouth, which are very painful and reappear over a period of years. It is difficult to do much for them. They have also been appropriately termed neurotic ulcers.

Dr. Derek Brown Kelly said the ulcer on the left side of the soft palate had grown a great deal larger and become extremely painful during the last month. Since the billet had been printed, a biopsy had been performed. The section showed proliferation of the external epithelium, multilayered, with thickening and in-dipping of epithelial process and an occasional island of epithelium: no cell nests and no marked malignant change, but early malignancy or a pre-cancerous condition might be entertained.

Dr. G. B. Brand had seen this case once or twice and there was no doubt that the ulcer was steadily growing. It was suggested that a piece should be removed for biopsy. It was very like a simple aphthous condition to begin with.

Dr. Connal called attention to the very marked condition of pyorrhœa that the man was affected with and suggested that attention to his teeth might have a beneficial effect.

Dr. Derek Brown Kelly (in reply) said that, with regard to the teeth, the condition started with a dental extraction. Whether this had any connection with the ulcer he did not know, but the patient had several teeth removed from the upper jaw on that side and a sequestrum formed afterwards. At that time the ulcer was just a small pin-head. It looked very like thrush. They had not considered touching the rest of the teeth just at the moment.

Case 16.

Tumours of Vocal Cords.—Dr. Derek Brown Kelly.

G.F., aged 48, has been hoarse for eight years. Several endo-laryngeal operations have been carried out.

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There are irregular elevations on the anterior thirds of both cords. The right cord, in addition, shows generalized swelling, injection, and has a ragged appearance along the edge.

A pathological report will be available.

Discussion

Dr. G. B. Brand said that when they first saw this case it looked very like the ordinary cancer of the vocal cord, but a piece was removed and it was found to be non-malignant—thickening of the epithelium and nothing more : this was in 1934. They had taken bits off the cords several times.

Dr. Derek Brown Kelly said that since two years ago this patient had been under observation and in the last month the appearances had changed a little. Apart from the thickening on the anterior thirds of both cords, there was now tumefaction and raggedness of the whole of the right cord and some swelling of the right vocal process.

Mr. Tumarkin said that the patient informed him that his general condition is quite good but he (Mr. Tumarkin) had seen a case in the sanatorium to which he is attached, in a man of very similar appearance. Mr. Tumarkin thought it was not tuberculous, and took a piece for section. The report was " No evidence of malignancy." The man was treated with chaulmoogra oil instillations, and has been quite well for a couple of years, so Mr. Tumarkin took it that the laryngeal lesion was certainly tuberculous and not neoplastic.

Case 19.

Specimen and Slide of Tumour of the Left Tonsil of Twenty Years' Duration.—Dr. G. B. Brand.

Dr. Brand stated that the patient was a man of 49 with a history of having had a lump in his throat for twenty years. It apparently gave him very little trouble until lately, when it began to get larger, causing difficulty in swallowing and sudden violent attacks of apnœa due to the growth falling into the glottis. Dr. Brand did his best to keep the patient intact to show at the meeting, but he had been forced to remove the tumour two weeks previously. It was a pedunculated growth attached to the lower pole of the left tonsil. The patient could cough it on to the back of his tongue, but when he inhaled, it dropped into his glottis. There were no glands and there was no pain or difficulty in swallowing, apart from the sudden mechanical blockage. At the removal, he (Dr. Brand) simply dissected the tonsil out and the growth came away intact. Macroscopically it was a fibroma, very pale. The slide showed a very indefinite condition suggestive in parts of fibroma. Dr. Brand asked Professor Blackstock to look at it, and his suggestion was, that it was probably a vestigial remains of one of the branchial clefts which had started to develop.

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Discussion

Dr. Brown Kelly remarked that these pedunculated growths were very rare. He had one of cancer which he showed to this Society years ago, and another, a fibroma.

Case for Diagnosis.—Dr. W. S. Syme.

Dr. Syme said this was a young boy whom he saw two years ago. The patient came with a history of sore throats. He had had his tonsils removed five years before. When seen, he was aged 10, and showed a large swelling in the right tonsillar region, which Dr. Syme thought to be remains or a re-growth of tonsil tissue. Part of it was removed and examined and it was reported as being suspicious of sarcoma. The pathologist made the suggestion that the whole of the growth should be removed with diathermy. A similar report was given of this remaining portion. Dr. Syme saw the patient for some time after that and there was no sign of any recurrence in the original situation, but, about six months after that, he had some granulation tissue on the other fauces, extending up to his uvula. Dr. Syme had it examined and received exactly the same report as for the first specimen. He (Dr. Syme) wondered whether anything could be done in the way of irradiation for this condition. The boy was very young and at the Radium Institute they did not think radium would be suitable. They were of the opinion that it was not a malignant condition. However, for safety, the tissue from that side was also removed, again with diathermy. Dr. Syme asked for opinions upon the slide which was shown that day, as to whether it was definitely a sarcoma or not.

Discussion

Dr. Proetz said that if this was not a sarcoma, what would be the harm in irradiating it? It seemed to him that a tumour such as that ought to respond to irradiation. Was there a reason for not doing it?

Dr. Syme replied that it was suggested that if they irradiated a tumour of that nature in a boy of that age, they might stimulate the growth. One had always thought that growths of a sarcomatous nature were definitely responsive to irradiation.

Case for Diagnosis.—Dr. Connal.

Dr. Connal reported that he first saw this girl three years ago. She was now nine, but at that time she had severe vomiting followed by giddiness and apparent loss of hearing. Her parents now notice that if she is carrying anything and has not the use of her arms to balance with she tends to stagger. She says that she can hear "sometimes". She knows when they knock at the door and on one occasion she said she did not like to hear people talking on the

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wireless. She gets on normally at school. The only thing that puzzles her is dictation. Dr. Connal asked if it was possible that that child could be getting on so well just with lip-reading. He tried her with dropping things behind her and ringing a bell but she did not notice them. She did not blink at all. He tried speaking into a stethoscope into her ear. He could not understand a child of that age getting on so well. He said she played with her companions and there was no abnormality noticeable in her play at all. She was very shy, but she spoke quite well to her parents. She got on well with her reading and picked up new words. She was excellent in all her school subjects with the one exception—dictation.

DISCUSSION

Mr. TUMARKIN said he had a similar case of a child whom he watched for several years. They sent her to a psychotherapist, as they thought she was hysterical, but got no help. That child was exactly the same. She was now thirteen and got on normally in her classes.

ABSTRACTS

EAR

The Study of Psychic Deafness. DOMENICO DELLA CIOPPA. (*Bollettino delle Malattie dell'Orecchio, della Gola e del Naso.* 1938, lvi, 325.)

The author describes the case of a girl of eight years who received a slap on the side of the face from a woman. The blow was not one that could have any material consequences, but the child's father made a great scene with the woman, following which the child was very frightened and suffered from intense tremors. Her speech, hearing and sight were normal until she went to bed at night, when she became very feverish and complained of severe headache and vomited repeatedly. During the night she was worse, she became incontinent, completely deaf in both ears and could articulate only with difficulty.

She remained very ill for several days and then began to recover, but was left with a general lowering of nervous tone, sluggish reflexes and complete bilateral deafness. Her memory was disordered and her conversation consisted of disconnected sentences. At the end of six weeks she had quite recovered except that the deafness remained stationary. On examination her nervous system was found to react normally, except that sensation to touch, heat and pain were lost in the skin of the pinna, the external auditory meatus and in the tympanic membrane. She heard forks of 128, 256, and 512 cycles by bone conduction, but only when vibrating with

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