SOCIETIES' PROCEEDINGS

SCOTTISH OTOLARYNGOLOGICAL SOCIETY

THE sixty-sixth meeting of the Scottish Otolaryngological Society was held in the Ear, Nose and Throat Hospital, Glasgow, on Saturday, May 30th, 1953, with the president, Dr. R. J. Watson, in the chair. Drs. K. McLay and P. V. Wadsworth were elected Members of the Society.

A demonstration of the Peep-show method of testing hearing in young children was given by Dr. E. A. M. Connal.

Cases were shown as follows:

DR. R. J. WATSON.

(1) Mrs. A.L., aged 51, attended on account of a protrusion of the left eye, associated with some pain and limitation of upward movement. Fields and discs were normal. A firm non-tender mass was present in the upper medial part of the left orbit. Left side of nose clear, but a small polypus was present in the right side. History of previous removal of polypi and curettage of left ethmoids. Modified Howarth operation revealed a little sterile pus in left frontal sinus. Floor of the sinus absent and replaced by very thickened orbital periosteum. Fronto-nasal duct reconstituted and tube left *in situ* for 10 days. Uninterrupted recovery and progress.

(2) W.W., aged 16, admitted on account of right-sided headache, slight proptosis, and a temperature of 100° F., with a pulse rate of 64. Treated by distaquaine penicillin which lowered temperature to 96·8° F., and pulse rate to 40. Right antrum opaque to X-ray. Caldwell-Luc approach revealed thickened mucosa, and a little mucoid discharge. Pulse rate improved to 62, and remained at that level.

Discussion centred around the possible cause of the slow pulse. DR. BROWNLIE SMITH thought that there might have been a thrombophlebitis, which had been arrested by penicillin. DR. LAND noted a gross sinus arrhythmia, and suggested that there had been a relatively small disturbance of the intra-orbital circulation. DR. MCKINLAY'S view was that the boy had had a partial heart block.

(3) P.M., aged 5, gave a history of left-sided nasal obstruction and epistaxis. A deep cherry-red mass seen just above middle turbinate, biopsy of which was reported as "brain tissue". Since then, there has been a slight leak of cerebro-spinal fluid, but no intracranial complications in spite of at least one severe cold.

DRS. WADSWORTH, LAND, HARPER and HOWIE all stressed the urgent need for attempting a repair of the dura mater.

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DR. J. FULTON CHRISTIE.

(1) T.B., aged 38, gave a year's history of severe frontal headaches and a thick yellow discharge from the left side of his nose. The headaches ceased, but reappeared two months before admission when a large fluctuant pulsating swelling, 4 in. × 4 in., appeared over the anterior part of the left parietal bone. Exploratory operation by Mr. Schorstein evacuating pus from below the parietal bone. Dura thickened yellow and shaggy, lying a centimetre and a half from the inner table. Exploration showed the dura to be adherent to the posterior wall of the left frontal sinus. Two months later the left frontal sinus was opened when a small erosion of the posterior wall was found.

(2) Two cases of *acoustic neuroma* successfully operated on by Mr. Paterson. One, aged 60, is awaiting a sling operation, while the other, aged 22, has had a facio-hypoglossal anastomosis. The former had no radiological enlargement of the internal acoustic meatus, and DR. MCNAUGHTAN stressed in discussion that too much reliance should never be placed on the radiological findings in a case of suspected acoustic neuroma. The important diagnostic feature was, he said, loss of sensation in the distribution of the trigeminal nerve.

DR. GAVIN YOUNG and DR. J. FULTON CHRISTIE.

A.H., aged 28, showed an *ulceration of the left ala nasi* spreading over roof to the septum which was not perforated. W.R. negative. Repeated biopsies inconclusive and suggested chronic non-specific inflammation. Treated by various antibiotics locally and generally without effect. Improvement obtained by radiotherapy, and now is awaiting prosthesis and possible surgical repair.

DR. BROWNLIE SMITH thought that this was a case of Leishmaniasis, and suggested that the sections be re-examined for Leishman-Donovan bodies. DR. LUMSDEN supported this view, especially as the patient gave a history of having been in S. Italy.

DR. I. P. MUNRO.

I.W., aged 16, a case of *juvenile angiofibroma of the nasopharynx* treated by X-ray therapy with marked regression in the size of the tumour.

MR. VENTERS mentioned one case which responded to monthly injections of sodium morrhuate for 8 to 9 months. DR. LUMSDEN quoted a similar case who had been free for two years since deep X-radiation. DR. HOWIE had treated a case by diathermy needles passed through the nose.

DR. F. T. LAND.

(1) J.C., aged 12, had had severe right-sided epistaxis for a year. Large *capillary angioma* of right inferior turbinate. Treated initially by cautery and diathermy, and later by radiotherapy with an applicator.

(2) M.K., aged 6, previously shown to the Society, had *multiple papillomata of the larynx* treated by an intralaryngeal radon applicator and later by X-radiation. This has resulted in a disappearance of the papillomata from the larynx, but there is still a mass in the subglottic region.

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DR. WATSON mentioned another case, also previously shown, who had developed a complete laryngeal stenosis following deep X-ray therapy. DR. LUMSDEN suggested that the remaining subglottic papillomata be removed in stages. He had found this successful in one case who had had irradiation, and in whom no recurrence followed such a removal. DR. BIRRELL discussed the problem of a spread further down the trachea below the tracheotomy tube. He found the easiest way of removing these was to use Henckel's forceps through a split aural speculum in the tracheostome. DR. MUNRO had used local stilboestrol in three cases with no effect. MR. VENTERS had had successes with 25 per cent. podophyllin locally, the papillomata disappearing in a week.

DR. M. JOELS.

Three children, aged 8-14, each with *congenital œsophageal stenosis*, who had been treated by repeated dilatation, and who had been taught to pass gum-elastic bougies on themselves, demonstrated their abilities. Once they could pass a No. 18 bougie, Dr. Joels said, they could eat almost anything except, perhaps, fruit. When the children could swallow a No. 20 bougie, they had no difficulty, even with this.

DR. G. C. MCKINLAY.

M.A., aged 29, suffered from renal tuberculosis for which she had received 60 gm. of streptomycin in two months. Vestibular symptoms appeared during treatment and deafness was noted three months after treatment was completed and slowly increased in severity over the subsequent eighteen months, when the speech threshold was down to 55 Db. She wears a hearing aid, and has learned lip reading.

DR. HOWIE was satisfied that the bulk of deafness was in connection with tuberculous meningitis, and that the danger of streptomycin causing deafness had been over-stressed. DR. CHRISTIE supported this view, and mentioned that in one sanatorium, where tuberculous meningitis is not dealt with, no case of deafness resulting from streptomycin has occurred. DR. WALKER quoted a series of 134 cases of tuberculous meningitis, of whom 56 had died, 48 were alive and well, 12 were alive but totally deaf, and a further two were partially deaf. Since the abolition of di-hydro-streptomycin, no case of deafness has been encountered.

Other cases were shown by Drs. F. T. Land. G. C. McKinlay, R. J. Watson and Gavin Young.

THE sixty-seventh meeting of the Scottish Otolaryngological Society was held in the Royal Infirmary, Dundee, on Saturday, November 28th, 1953. The following office-bearers were elected: President, R. B. Lumsden; Vice-President, M. J. Gibson; Secretary and Treasurer, J. Fulton Christie; Assistant Secretary, J. F. Birrell; Members of the Council, R. J. Watson, E. A. M. Connal, I. M. Farquharson, I. S. Thomson and D. Brown Kelly.

J. P. Fraser and A. M. Mann were elected members of the Society.

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A demonstration of hearing tests including the estimation of hearing loss in young children by activity tests and the technique of speech audiometry was given by Dr. J. F. O. Mitchell.

Clinical cases were shown as follows:

DR. M. J. GIBSON. *Intrinsic intra-epithelial carcinoma of larynx.*

(1) J.F., aged 62, reported with a history of variable hoarseness of some nine months' duration. There was no pain and no dysphagia. The larynx showed diffuse thickening of both cords, with an increase in the hyperplasia in the posterior third of the left cord. Movement was free. Biopsy from the posterior third of the left cord showed an intra-epithelial carcinoma with no evidence of invasion. Treated by deep X-ray therapy. Present appearance is that of a chronic laryngitis.

DR. HALL asked whether in view of the present appearances Dr. Gibson would consider doing a laryngofissure. DR. GIBSON thought that if there were still a neoplastic lesion, the arytenoid would be involved, and he felt a hemilaryngectomy might be necessary. DR. FARQUHARSON suggested that this was a case of keratosis where neoplastic changes were taking place. PROF. LENDRUM demonstrated the slides from the sections, stating that he could not find any extra-epithelial extension. He compared the picture with that found in Bowen's disease of the skin.

(2) Mrs. F., aged 28. *Tuberculosis of the antrum.*

This case has been fully reported in *Journal of Laryngology and Otology*, 1954, **68**, 170.

DR. PRAIN demonstrated the slides of sections from the tumour in the cheek and the antral mucosa. In reply to Dr. Collins, Dr. Gibson said there was no disease of bone.

DR. M. J. GIBSON and DR. G. O. CLARK. *Unilateral deafness for diagnosis.*

E.C., aged 15, became suddenly totally deaf four years ago, but in six hours the hearing in the left ear returned. She has remained totally deaf in the right ear since. Complete ear, nose and throat and neurological examinations negative apart from total deafness in the right ear. Caloric tests in both ears were entirely normal.

DR. HOWIE thought it rather odd that both cochlear centres had been involved while the vestibular systems were not. MR. VENTERS suggested that the girl had a congenital deafness of the right ear without being aware of it, and that the deafness in the left ear had been of a temporary nature.

DR. M. J. GIBSON and DR. J. MOWAT. *Hoarseness for diagnosis.*

Mrs. H.B., aged 29, became hoarse after a bout of influenza. Examination showed a uniform swelling of the epiglottis covered with an intact mucosa. The arytenoids were swollen, pale and œdematous. Chest X-ray and W.R. negative. Biopsy from the epiglottis "suggestive of tuberculosis". Biopsy repeated, and was reported "characteristic of tuberculosis". Meantime a

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guinea pig which had been inoculated remained healthy. A course of streptomycin and P.A.S. given. Some improvement after one month, but since then the condition has remained unchanged. A further biopsy showed similar appearances to other two, but no acid-fast bacilli have been found.

DR. HALL said that in spite of the guinea-pig inoculation, he would support the diagnosis of tuberculosis. He had seen a similar case which eventually proved to be tuberculous. DR. PARK described the appearances of the three sections. The absence of response to streptomycin, and the failure of the guinea pig to die made one doubt the histological diagnosis, and the possibility of sarcoidosis had to be considered. DR. YOUNG thought one might call this lupus of the larynx.

DR. A. G. GIBB. *Transpalatal approaches to nasopharynx.*

(1) G.R., aged 41, showing the result of the C. P. Wilson transpalatal approach to remove a respiratory papilloma of the nasopharynx of four months' duration.

(2) J.W., aged 2½, a case of bilateral congenital choanal atresia relieved in the first instance by forcing No. 4 Eustachian catheters through the obstructions, and later by acrylic-covered metal tubes. Nasopharynx approached by Ruddy's technique and bony occlusions removed. The openings were maintained by regular bouginage.

(3) Four cases illustrating the *permeatal subcortical mastoid operation* for chronic suppurative otitis media. DR. GIBB said that he had learned this method from Mr. Venters, and that he felt his own results, in 45 cases, were comparable with those obtained by any other approach. The advantage of this method was that the infected area is rapidly reached, and tissues not involved in the diseased process are spared. He stressed the importance of minimal interference with the cavity after the packs had been removed at the first dressing.

(4) T.B., aged 43, complained of hoarseness for six months. Laryngoscopy showed inter-arytenoid heaping-up, and biopsy from this area is reported as *"heterotopic ossification with bone marrow formation"*.

DR. J. F. O. MITCHELL.

E.M., aged 42. *Bilateral Fenestration Operation.*

DR. MITCHELL commented on the effect of performing the second fenestration under antihistamine cover which, according to his patient, reduced the post-operative vertigo. An aspergillus fumagatus infection of one of the cavities was treated by topical application of "Mycil".

Other cases were shown by Drs. Gibson, Gibb, Mowat and Mitchell.

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