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The Throat Surgeon and the Law

By MUSGRAVE WOODMAN, M.S.

To surgeons alone among the sons of men is the plea of human fallibility disallowed by public opinion. The doctor bears a unique position. He is ever at the call of the patient, no Trades Union fixes his hours, and public opinion looks upon his refusal from sheer fatigue to accept the last of many calls as wilful negligence of duty; while that same opinion holds the refusal of the workman to do more than his allotted day's work merely to be loyalty to his class.

Looking back through the ages, there has been a tendency for non-success to be penalised; this is even more marked in ancient times than it is to-day. Two thousand years B.C. a king of Babylon formulated a code of laws which enacted the privileges, fees and serious liabilities of those venturesome enough to practise medicine and surgery. For instance, the code says that if a doctor has treated a gentleman for a severe wound with a lancet of bronze, and has caused the gentleman to die, his hand shall be cut off. In the times of the Egyptians the unsuccessful surgeon was liable to suffer corporal punishment, while among the Western Goths, if the ministrations of the surgeon resulted in death, he was handed over to the vengeance of the relatives of the deceased.

In the Middle Ages there were numerous examples of prosecutions and fines, which had no other justification than the non-success of the operator. No wonder the advance of science was checked and there was no desire to treat any other than simple cases.

At that time the treatment of a serious case was not attempted by a regular practitioner, or as a famous French advocate said, the position was one of " laisser mourir ". At the end of the last century the position of the medical profession was a very strong one, but since the War, and for various reasons, there is a suggestion that the

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tide is slowly turning in a backward direction. To-day many an action, based mainly on an unsuccessful result, is threatened which has no hope of succeeding in law ; such a threat is advanced for the purpose of escaping fees or obtaining a monetary settlement which is not far removed, in its essential nature, from blackmail.

I would in the first place briefly put before you a summary of the legal position in which the surgeon specialist is placed. Every operation is in the nature of a contract—the surgeon on his part advises a specified operation, agrees to perform it and requests his fee. The patient on his part gives his consent, undergoes the pain and discomfort arising therefrom and pays his fee. If, however, the operation specified and agreed on by the patient has not in fact been performed, but some other or different operation has been carried out, there is breach of contract. It is evident that the patient's consent—if the patient is conscious—must be obtained before any operation, however trivial, is carried out. This applies equally to removing a uterus or puncturing an antrum. If an operation has been advised and agreed upon and during the performance it is seen that a more extensive operation is required than has been assented to, the surgeon will not be held liable, if in order to save the patient's life he exceeds the limits sanctioned ; but the onus will rest on him of proving this. If during the course of the operation it is thought that an important extension may be required, this should be mentioned to the patient before operating.

e.g.—A female, aged 56, had a rodent ulcer which encroached on the lower eyelid. When first seen she was told that it would be necessary to remove her eye in order to cure the disease. This was refused. She was then told to go away and come back when she herself was satisfied that the eye could not be saved. This she did three months later and the eye was removed.

The greatest care must be observed not to do the *wrong* operation. The surgeon should make it an invariable rule to have the notes of the case, or a specially written operation card, in the theatre, to be read immediately before the operation. If, despite these precautions, a mistake should be made the surgeon will be able to prove that he took all possible reasonable care to avoid this.

There is even a danger of acting beyond the generally accepted practice current in the profession at the time. e.g.—Slater *v.* Baker and Stapleton, 1767, where an omission to follow the general rules of the profession in regard to a method of operation was held to be sufficient evidence of negligence to warrant a verdict for the plaintiff.

e.g.—Mr. Baker, who had been senior surgeon at St. Bartholomew's Hospital for twenty years was sued by Slater, who alleged that he had employed him as a surgeon to cure his leg which had been broken and set, and that Baker had ignorantly and unskilfully broken it again

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and disunited the callus after it was formed, by a procedure contrary to the rule of the profession, and that plaintiff had not been told beforehand what was to be done.

The fact that the surgeon is acting without fee, as in hospital, does not alter the law on the subject. The surgeon, even if he is acting gratuitously, is liable for lack of reasonable skill, because his licence implies skill in surgery.

Negligence in law is omitting to discharge the duty which the law imposes in a particular case, or to exercise such skill and care as is usual and reasonable in the circumstances. The difference between civil negligence and criminal negligence is merely one of degree. In order to establish criminal negligence evidence must be shown that the degre of negligence was so gross as to amount to recklessness, and it must be of such a nature and such a degree as to convince a jury that it ought to be punished. Negligence for non-attendance is not a good ground for action.

There are two essentials required of the surgeon in treating his case: (1) skill, and (2) care. The degree of skill expected will vary according to the status of the practitioner. Lord Justice Tindal, in 1832, stated that every member who enters a learned profession undertakes to bring to it the exercise of a reasonable degree of care and skill; he does not undertake if he is an attorney that at all events he shall gain his case; nor does a surgeon undertake that he will perform a cure, nor to use the highest *possible* skill. There may be persons who have a higher education and greater advantages than he has, but he undertakes to bring a fair and reasonable and competent degree of skill. In other words, the degree of skill that can reasonably be expected depends upon the man the patient employs and agrees to pay for. There are in law three degrees of skill: the skill expected from an unqualified man, that expected from the qualified man or general practitioner, and that required from a specialist. The degree of care required is only of the degree which would be displayed by another practitioner of the same grade doing similar work.

The surgeon is responsible for an injury to a patient proved to be due to want of proper skill in his assistant, for he is bound to avoid introducing into his practice persons not of competent skill. A surgeon will not be held responsible for the negligence of nurses or attendants, who in their own sphere of duties must be held liable, such as the introduction of hot-water bottles into the bed of the patient.

A medical man must keep secret all things affecting his patient which may come to his knowledge in the course of his practice. Secrecy is an essential condition of the contract between a medical man and his employers, and every breach of secrecy affords a relevant ground for an action for damages.

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e.g.—Kitson *v.* Playfair, 1896. Dr. Playfair had communicated certain information to relatives. He was held guilty of the implied covenant of secrecy, and damages were assessed at £12,000.

Not only is there the danger of transmitting information to relatives without the consent of the principal, but a far greater danger exists when an employer sends one of his workmen and pays the consultation fee, and then asks what you really think about his condition. The only safe way is to examine the patient in the presence of such an employer, or if the latter should not be present, inform him that you have given full information to the patient himself, and he will no doubt tell him all there is to know about the condition.

Let us now turn from the legal aspect of the subject to the more practical side. There are certain special matters in which throat surgeons may find themselves in difficulties.

Many doctors have recently been arrested for being drunk in charge of a car. Now there are many obvious reasons why a small quantity of alcohol tends to have a serious effect on a practitioner. The rush of practice, irregular meals, a whisky and soda taken on an empty stomach instead of food, may lead to trouble. Further there is the added danger that the smell of ether after an operation is readily mistaken by a constable for alcohol.

e.g.—A surgeon was arrested and taken to the police station for being drunk in charge of a car. His breath was said to smell of alcohol. The defence was that not only had he not taken any alcohol that night, but that he was a life-long total abstainer, and that the smell in his breath was due to ether. The prosecution failed.

The knowledge of the use and abuses of radium is widely in the public mind to-day. For this reason we must remember the effect of necrosis of bone, which may result from injudicious exposure to the effects of the radium rays. We must also remember the possible danger to special senses, such as the eye. Lastly, we must recollect the burning effect of a lost tube of radium in whatever part of the body it may rest for a prolonged time.

It is not our business to extract teeth, but only to remove teeth when they are dropped into the lungs, but we may dislodge one when applying a gag into the mouth, and if we drop it into the lung ourselves, less mercy will be shown to us than to the dentist whose duty it was intentionally to remove it.

e.g.—A dentist in removing a tooth dropped it into the lung of a small boy aged 5. This was with great difficulty removed under an anæsthetic. The parents had already instituted legal proceedings against the dentist, who had no defence, as he had failed to put a mop at the back of the throat—a well-recognised necessary precaution.

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I have never known legal trouble to arise from a portion of the tonsil being left behind, but doubtless it is a matter for the future, although there have been serious complaints about regurgitation in the nose where extensive scarring has resulted from dissection of the tonsils.

It is unnecessary accidentally to remove the uvula when taking out the tonsils.

e.g.—A case recorded in Ulster in 1927, in which the uvula was accidentally removed by a surgeon in an operation on a child. The father instituted proceedings against the surgeon, who had the case decided in his favour only when no less than four Irish surgeons stated that it was quite a usual thing in their practice for a small piece of the uvula to be nipped off.

A particular difficulty comes to the throat surgeon from the possibility of leaving ribbon gauze packing in the flaps between the septum, in the antrum, or high up in the nose. These may possibly drop into the lung or remain *in situ*, and the most meticulous care must be exercised to obviate this accident.

For instance, a swab in the mouth or pharynx should always have a piece of silk thread leading out of the mouth, and gauze in the nose should always have the end hanging out over the lip sufficiently far to prevent it being drawn accidentally into the nose. Lastly a careful search should be made between the flaps of the septum or in the antrum to see that no foreign body remains.

The septum operation, well known for its difficulties, leads to two risks: (1) Depression at the junction of the cartilaginous and the bony portion of the bridge, and (2) perforation.

Men do not quite realise perhaps how much the exact appearance of the nose means to women, or what attention they pay to the slightest depression, and every precaution is worth while taking to prevent this from happening. Should it occur, by no means make the mistake of making light of the disfigurement, even if it is not evident to you. Treat it in all seriousness, and say that if the patient is not quite satisfied with the shape of her nose, you will be prepared to make it into any shape she wishes by the grafting of cartilage, and to do this without further fee.

In the second place perforation may have to be taken seriously, and it is always a mistake if your patient is dissatisfied and drifts into the hands of somebody else, who possibly quite unintentionally, calls attention to the fact that the septum has been perforated. The patient may have been unaware of this, and that innocent remark might start the process of a legal action.

I do not hesitate to say that the danger of damage to the facial nerve is the greatest anxiety the surgeon operating on the mastoid has in front of him. In case of any operation beyond the simple

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mastoid the patient should be warned of the possibility, however remote, of danger to the facial nerve occurring. I have known complete paralysis of the facial nerve remain for eighteen months in a case in which the nerve was not cut, but severe inflammatory reaction ensued after the operation, and recovery began to take place only at the end of that time.

In all cases of surgical diathermy it is wise to employ a skilled electrician, whether medical or otherwise, to control the machine, and thus relieve the surgeon of the responsibility for any serious variation in the intensity of the current which might prove dangerous to the patient. The surgeon is responsible if during the course of the operation the electrode touches a part not under treatment and a burn should result. For instance, in diathermy to the tonsil a burn on the edge of the mouth would be actionable. The surgeon is responsible that the pad of the indifferent electrode is in firm and even contact with the patient; failure to observe this point may result in a severe electric burn. The law in regard to the relative position of the surgeon and the anæsthetist is not clearly defined. The patient or his doctor chooses the surgeon, but the surgeon selects his own anæsthetist, and the latter is in some respect at least the " agent " of the operator. The surgeon is therefore liable to the patient for the skill and carefulness of the anæsthetist. The anæsthetist, as a qualified man of special training, is responsible for his own actions in administering the anæsthetic. The law holds the surgeon ultimately responsible for everything that goes on in the operating theatre, but fortunately I can find no recorded case in England of a successful action for a death under anæsthesia.

In this connection I would recall to you a famous case in France fifty years ago :

A man died under chloroform, which he insisted on having for a trivial operation. An action was brought and the Judge fined both surgeon and anæsthetist 50 francs each. Velpeau gave evidence on appeal :—

" You have in your hands the future of surgery. The matter interests the public more than the surgeons. If you condemn the surgeon who has used chloroform, none of us henceforth will consent to use it. It is left to you to maintain the abolition of pain or to invent it anew."

Closely allied to the anæsthetic is the question of explosions, which have been only too numerous during late years. It is well known that a naked cautery point or a diathermy spark will ignite an ether vapour, but it is not generally recognised that most explosions take place from a faultily constructed electric bulb introduced into the mouth or bronchus.

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Dr. Morgan, an expert on explosives, last year demonstrated that ether vapour, when heavily concentrated, is relatively non-inflammable, but when very greatly diluted with air, it becomes highly explosive, and that finally the presence of oxygen converts a simple explosion into a detonation.

In the more serious explosions the flame appears to flash up the anæsthetic tube connected with the apparatus, which in turn is blown up to the ceiling. These explosions are so dangerous to the patient and even more so to the surgeon, that every precaution must be taken in practice to render them impossible. It is the legal duty of surgeon and anæsthetist to take every known precaution against explosions.

Whatever may be the trend of public opinion towards the work and the activities of the medical profession, the Law, as it at present stands—" takes full and even generous cognizance of the anxieties and difficulties inseparable from medical practice. In its dealings with medicine, as with other arduous and honourable callings, it embodies those principles of fair play, justice and humanity, by which Englishmen are governed in their public and private affairs."

CASES

Nodular Swelling involving the whole of the Right Vocal Cord : Case for Diagnosis.—E. BROUGHTON BARNES.

Miss C., aged 43. Husky for seven months. First seen five weeks ago.

The whole right cord is involved in a pinkish nodular sessile mass, extending far down into the subglottic space. No limitation of movement. Sputum, negative for T.B. (two examinations). Wassermann reaction negative.

The swelling on the cord appears to be slightly less marked as a result of rest and inhalation for five weeks.

DISCUSSION.

HAROLD BARWELL remarked that the sputum was said to be innocent of tubercle bacilli, but no mention was made of a further examination of the chest. Absence of the bacilli on examination of the sputum did not necessarily negative phthisis, and he asked whether the lungs had been skiagraphed. This was probably a case of tuberculous laryngitis.

LIONEL COLLEDGE agreed with Mr. Barwell that this was probably a case of tuberculosis; the diagnosis rested between tubercle and papilloma, with the possibility that it might be malignant. The possibility of malignancy in a woman was apt to be ignored, yet about 10 per cent of the cases of intrinsic cancer of the cords were in women. The swelling was fairly movable, so he held the first view. In the

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absence of chest signs the best way was to remove a piece for diagnosis. Should it be malignant, he recommended removing half the larynx rather obliquely, not by the classical division of the larynx into two.

L. GRAHAM BROWN reminded members that the origin of this trouble dated back to two years ago, and during one period the patient had complete aphonia for three weeks; she had been accustomed to shouting to her deaf parents. In view of this long period he regarded the condition as innocent, an infiltration of the mucosa causing a polypus or a papillomatous condition.

DOUGLAS GUTHRIE said that the patient worked in a factory which had a dusty atmosphere, and this, coupled with the fact that she had to shout to her deaf parents, suggested a chronic inflammatory lesion, though the strictly unilateral nature of the redness was suggestive of tuberculosis.

E. BROUGHTON BARNES, in reply, said that he had never had a case of intrinsic carcinoma of the cord in a woman, and he did not think that the condition was malignant in this case.

Carcinoma of the Larynx.—HERBERT TILLEY.

Nearly twenty years ago laryngo-fissure was performed by the exhibitor and the case is shown to-day as an example of the good speaking voice which may follow this operation.

Stenosis of Glottis following Tuberculosis of Larynx.

—F. C. ORMEROD.

N.W., female, aged 30. Attended hospital April 1928 with early pulmonary tuberculosis. Nodular infiltration of epiglottis and swelling of ventricular bands. Appearance suggestive of lupus. Later became obviously more active and ulcerated. Larynx treated by Sir James Dundas-Grant by repeated galvano-cautery puncture and, on several occasions, excision of portions of the epiglottis, ventricular bands, and lingual tonsil, until only the vocal cords remain. Infiltration of the vocal cords and subglottic region resulted in cohesion of cords and narrowing of glottis, despite vigorous attempts to prevent it.

In April 1930 dyspnœa had become established and tracheotomy was performed. Appearance of glottis has improved and aperture widened.

Patient also developed lupus of nose, treated by galvano-cautery; lupus of face, treated by light; and tuberculous ulceration of the whole of the margin of the tongue, treated by surgical diathermy.

Condition of lungs has improved.

DISCUSSION.

Sir ST CLAIR THOMSON said that tuberculosis was such a kaleidoscopic disease that it was difficult to generalise confidently on the

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subject. Lupus and tuberculosis had the same basis pathologically, but clinically they were entirely different diseases. One met with people with an atrophied epiglottis who never knew that there was anything the matter with it; they could recover under many forms of treatment, as well as under no treatment, and might last a lifetime. Lupus never killed a patient, except by becoming tuberculous. The present patient's condition evidently started as lupus, and had now become tuberculous. The true lupus case had no tubercle bacilli in the sputum, or only a few scattered ones. Between the two states was a "lupoid" stage. In this, the disease tended to infiltrate, not to ulcerate, and the bacilli were scanty. In the middle-aged and elderly this might go on for years and then be cured spontaneously. In the spontaneous healing, lupus might cause stenosis, but tuberculosis might cause stenosis when it was getting active. One was apt to use the galvano-cautery too long and too frequently. He had obtained the best results by using it only once a month, and his average number of applications was from three to eight. It was seldom successful if this number did not suffice.

The present patient had not been sent to a sanatorium. All cases of lupus did better under sanatorium régime, whether they had cautery applications or not; and they there had vocal rest, as well as general bodily rest. He had had many patients of the kind. One was a surgeon, in whose larynx no tubercle bacilli were found during the two years in which he had tuberculosis; bacilli were discovered only just before he died. The larynx filled up, and he, Sir St Clair, begged to be allowed to do tracheotomy, but the patient refused. With complete rest the stenosis often disappeared.

Mr. Ormerod had said that he would like to have his (the speaker's) opinion on tracheotomy as a curative measure. It was the best curative measure for stenosis of the larynx, but one could do harm to unsuitable cases. Here, also, sanatorium treatment was of much help. In consultation with a physician one knew whether the disease was being arrested. When that was so, tracheotomy might be carried out.

F. C. Ormerod, in reply, said that in over nine years' work at Brompton Hospital, tracheotomy had never before been necessary for dyspnœa. He had had another case of the kind shortly afterwards, and he brought this one forward in order to receive opinions on the value of earlier tracheotomy in such cases.

Cystic Carcinoma of Trachea.—V. E. Negus.

The patient, a man aged 47 years, first seen on March 13th, 1932, was referred to the exhibitor by Mr. T. D. Deighton.

History.—Hoarseness and dyspnœa, with inspiratory and expiratory stridor, began eighteen months previously, and had been marked for the last two months.

On examination.—A smooth, round swelling projected from the posterior wall below the glottis. Direct laryngoscopy showed that it apparently arose from the cricoid cartilage; it practically filled

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the trachea. It had a perfectly smooth surface and was cystic. Tracheotomy was performed on March 17th with local anæsthetic.

Operation (27.3.32).—The thyroid and cricoid cartilages were split, and it was seen that the cystic swelling came from the posterior and lateral tracheal walls, extending up to, but not actually involving the cricoid. The neoplasm occupied the depth of rather more than two tracheal rings and their inter-spaces. The mucous membrane was incised longitudinally and stripped off easily, the appearance resembling that of a mixed salivary tumour. There was a broad base stretching across rather more than half the trachea, and when the posterior wall was reached dissection became difficult because of adhesions. The cyst was opened, and thick gelatinous contents escaped. The cyst wall was then removed piece by piece, care being taken not to enter the œsophagus. The larynx and trachea were then closed, a tracheotomy cannula being left in.

The patient breathed well the same day with the tracheotomy tube corked, and on 31st March the cannula was removed.

Microscopical examination.—The cyst wall was carcinoma, probably derived from mucous glands. The carcinomatous cells were set in some dense fibrous tissue, and were arranged in a glandular manner, with very little stroma. They were cubical and columnar, and were all very similar in staining characteristics; a few showed mitotic figures.

A few normal glands were seen in the section.

The carcinomatous nature of the neoplasm, and the impossibility of removing it completely with a surrounding area of healthy tissue, made it necessary to insert radium; this was done on April 25th. Four needles, each 3·3 cm. long, containing two milligrammes of radium element as sulphate screened by 0·5 mm. of platinum were sewn into a rubber tube of sufficient size to fill the trachea. They were left in for six days, the tracheotomy cannula being inserted temporarily. The patient left hospital on May 7th, breathing comfortably.

He now has no sign of swelling in the posterior part of the trachea, but there is some scar-tissue projecting from the anterior wall in the side of the incision. The right vocal cord does not move at all, but the glottis opens widely.

The case is exhibited not as showing a cure of carcinoma but because of the rarity of the condition.

Discussion.

F. Holt Diggle asked what led Mr. Negus to treat this case externally; did the size of the growth seem to contra-indicate an attempt to remove it endoscopically?

V. E. Negus, in reply, said he opened the larynx in this case because it seemed impossible to remove the growth in any other way.

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The tumour had a wide base, and it arose not only from the posterior wall of the trachea, but was on the lateral walls of the trachea, and occupied about three-fourths of the tracheal lumen, so that there was left only a small chink. He could not see the downward extent of it, and in the upward direction it was thought to come up to the cricoid cartilage, but it came short of that. To have removed it from above by the direct method would have meant an incomplete operation. After low tracheotomy and by direct laryngoscopy he felt it was not a chondroma, but was cystic.

Nasopharyngeal Fibroma.—F. J. CLEMINSON.

Male, aged 20. First seen June 1929. Lower edge of tumour visible, and palate pushed forwards and downwards. One year's history of increasing nasal obstruction. In July part of the tumour was removed after ligature of the base, and a fortnight later the palate was divided and the remainder of the growth removed as completely as possible. It was attached to the spheno-ethmoidal region and round the upper part of the left Eustachian cushion. In August the palate was sutured but broke down partially and was sutured again in November, in its posterior part only. A year later the tumour had recurred and was removed by a snare. For eighteen days recurrent hæmorrhage was dealt with by packing. On two subsequent occasions (June 1931), under avertin anæsthesia, remains of the growth were treated by diathermy. Patient was last seen in May of this year when there seemed to be no recurrence. Section showed typical nasopharyngeal fibroma.

Pharyngeal Tumour.—E. COWPER TAMPLIN.

Patient, female, aged 52. Firm tumour growing from soft palate, lateral pharyngeal wall, and posterior faucial pillar on the right side. First noticed by patient four months ago. No glands palpable. Sometimes discomfort in right side of neck, extending into ear.

DISCUSSION.

C. A. SCOTT RIDOUT said he thought this growth might be removed by diathermy. He regarded it as a sarcoma, and if it proved to be so, the base should be irradiated. He had had a case in which the growth was outside the tonsil, and he put in a 50 mg. tube of radium, but the tube slipped down the œsophagus, and he had to remove it by gastrostomy.

HERBERT TILLEY remarked that some five years ago he had to deal with a similar lesion in a woman aged 32, on the same side as in the present patient. He put radon seeds in it, and the tumour disappeared completely. Last spring the patient returned with a hard and fixed mass of glands behind the ramus of the jaw, coupled with

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intense neuralgic pains in the corresponding occipito-parietal region. There was no recurrence of the primary nasopharyngeal lesion.

E. D. D. DAVIS said he had inserted radium in two cases of fibroma with no benefit, indeed, the condition had been made worse.

Sir ST CLAIR THOMSON said that Gordon New, of the Mayo Clinic, claimed that " radium is the treatment of choice " for fibroma of the nasopharynx.

H. V. FORSTER said that he would like to mention the only instance of a nasopharyngeal fibroma which he himself had been called upon to treat.

Professor Regaud's opinion as to the probability of success from radium was obtained, but was not very hopeful. Nevertheless, as a quantity had already been secured for the case, radium was tried, but there was no early result. Treatment by diathermy puncture was then decided upon, but in such a vascular growth coagulation was difficult to obtain unless a rubber collar is passed on to the electrode to act like a cork against bleeding when carrying out the puncture.

Progress in reducing the growth was eventually secured by this method from the front, but as swelling of the lateral pharyngeal wall with apparent extension of the growth in this direction had increased, deep X-ray therapy was begun, and fortunately the combined effect of this with the diathermy puncture resulted in cure.

The case was described in the *Journal of Laryngology and Otology* 1931, xlvi., No. 6.

F. J. CLEMINSON (replying for Mr. Tamplin) said the object of bringing the case was to ask for suggestions as to treatment; the exhibitor's view was that it was sarcoma, and he proposed to dissect it out with the diathermy knife, followed by the application of radium.

Mixed Parotid Tumour.—F. J. CLEMINSON.

Male, aged 43. In 1919 a mixed parotid tumour was removed at University College Hospital. First seen by exhibitor in June 1923 for a painless swelling in the throat. The fauces on the left side were enormously distended by a tumour of soft elastic consistency thought to be of tonsillar origin. 150 mg. of radium bromide for twelve hours round periphery had no marked result, so in August 1923 the tumour was removed by dissection and found to be of the size and shape of a small pear with the small end downwards. It was encapsuled and had no connection with the tonsil. Sections were said to show " soft fibroma ", but were unfortunately lost. In January 1931 a tumour was found in the fauces and left side of palate. At operation it was seen to be continuous with the deep aspect of the parotid gland and was only partially removed. There was also some swelling of the deep part of the parotid which was treated two weeks later with radium, and a marked diminution in size and hardness resulted. Since then the parotid has been treated three times by insertion of radium and once by surface irradiation (radium).

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The condition has been almost stationary for the last seven months, but when patient was seen a week ago some weakness of the left facial muscles was observed.

DISCUSSION.

WALTER HOWARTH said that these cases were interesting, not only because of their rarity, but also on account of their appearance in the parotid gland and in the palate. The most accepted theory of their appearance in the palate was that of Cohnheim. He had had a similar case in which, twenty-five years previously, a parotid tumour had been removed by Sir Percy Sargent, who asked him to see the palatal swelling. It seemed likely that the palatal tumour would shell out, but at the operation it was found to be attached firmly to the internal pterygoid plate. Not being satisfied with the removal, he inserted six radon seeds in this region. The case remained well for four years, when a tumour appeared in the parotid region, somewhat similar to that in Mr. Cleminson's case. It was not possible to say whether the radon had driven the cells deeper into the parotid and caused the neoplasm or whether it was an entirely separate growth. He thought that in Mr. Cleminson's case the proper treatment was by radium.

Two cases of lachrymal obstruction following an antral operation (Skiagrams shown).—EDWARD D. D. DAVIS.

(1) A woman, aged 27, was sent to the exhibitor by an ophthalmic surgeon for a report on the condition of the nose. The right lachrymal sac was distended and, on pressure, purulent fluid regurgitated into the eye, and the ophthalmic surgeon had found the naso-lachrymal duct to be obstructed. Fifteen months before, an intranasal antral operation had been performed, and the patient stated that when she recovered from the anæsthetic her eye repeatedly filled with blood and that since the operation the eye was always full of tears. She also had attacks of suppuration of the sac.

The skiagram has been reinforced by the injection of lipiodol into the lachrymal sac and shows the retention of the lipiodol in the sac and above the intranasal antral operation opening. This opening apparently has been made above and below the attachment of the inferior turbinal.

(2) This patient, a woman aged 65, complained of " watering " of the eye since an antral operation ten years ago. There was no distension of the sac and no regurgitation of tears on compression of the sac, but there was some conjunctivitis.

A reinforced skiagram shows the retention of lipiodol in the sac and nasolachrymal duct, but the lipiodol has flowed into the floor of the nose.

Again the intranasal antral operation opening had apparently been made above and below the inferior turbinal.

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These are the only two cases of lachrymal obstruction following an antral operation ever seen by the exhibitor.

F. HOLT DIGGLE expressed surprise that these cases were not more frequent. Only a few months ago he encountered his first case of the kind, after a Caldwell-Luc operation. A feature of the case was that the floor of the antrum was much below the level of the floor of the nose. He thought that if such a condition were discovered one should make a limited upward opening. He successfully treated the case by West's operation.

Skiagrams of two cases in which roots of teeth had been accidentally forced into the antrum.—EDWARD D. D. DAVIS.

Attention is drawn to the position of the roots.

A Caldwell-Luc operation was performed in each case within three weeks of the accident. In both cases there was a marked dusky red œdema of the mucosa of the antrum. The œdema was so great that the cavity of the antrum was filled and the roots were embedded in the mucosa. An examination by the endoscope some weeks after operation showed the mucosa to be normal, and the result was excellent.

Nasal Obstruction. ? Mycosis.—H. G. BEDFORD RUSSELL.

Patient complains of nasal stuffiness for some years. One operation ten years ago. The brown stain which covers the nasal mucosa is shown on microscopical examination to consist largely of mycelial elements (probably *Aspergillus fumigatus*).

DISCUSSION.

W. SALISBURY SHARPE said that there was no mycelicide in use which equalled iodine. Not only should iodides be given freely internally, but the case should be treated with one of the colloidal preparations of iodine locally, a watch being kept on the microscopical condition of the discharge. Some surgery might be needed to make a clearance.

A. BROWN KELLY said he saw no evidence of the aspergillus in this case. Several years ago Mr. Tilley had described aspergillosis of the antrum but there was little mention in most textbooks of the affection. He (the speaker) had had several cases in which the nose or antrum had been the seat of this disease. It was characterised by the formation of masses of a tough greenish substance which was usually situated high in the nose posteriorly and when removed quickly re-formed. In one specially persistent case in which perchloride of mercury had failed, a cure was effected by hexylresorcinol solution.

Ulceration of Soft Palate.—V. E. NEGUS.

Patient, male, aged 58 years, complains of nasal obstruction and discharge. Submucous resection in March 1931.

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July 1931.—Symptoms became worse, and have continued up to the present.

June 1932.—Posterior end of nasal septum showed some ulceration, and walls of nasopharynx were swollen. Surface of septum roughened on right side ; middle turbinal had a nodular appearance. Wassermann reaction negative.

July 1932.—It was thought that the patient might have a new growth in the antrum, and this was opened by Caldwell-Luc's operation. The right antro-nasal wall was friable, and the soft palate was thickened. Pieces taken from the soft palate and the right antro-nasal wall contained some glands and vessels and fibrous tissue extensively infiltrated with lymphocytes and plasma cells. There was no evidence of malignancy. The report suggested syphilis. Wassermann reaction again taken ; still negative. No response to administration of mercury and iodides.

July 10th, 1932.—Perforation of the soft palate to the nasopharynx, followed by superficial ulceration of a considerable area of the palate. In spite of negative Wassermann reaction and lack of response to mercury and iodides, salvarsan was given, but the patient is becoming worse, and ulceration is extending along the palate.

There has never been any sign of actinomycosis, but numerous Vincent's organisms have been present.

Discussion.

Herbert Tilley said he thought it a mixed tumour containing carcinomatous and salivary gland elements in it. A somewhat similar case had been shown to the section two years ago by Mr. Woolf. The history of Mr. Negus's patient was so long that it could not be a simple epithelioma.

W. Salisbury Sharpe said that as this case did not answer to antisyphilitic remedies, and no microscopical evidence of malignancy could be found, the condition might be granulomatous like that of syphilis, and sometimes antimony succeeded when mercury had failed.

V. E. Negus, in reply, said that the case was sent to him as a new growth in the nasopharynx ; there was swelling in the roof of the soft palate. Sections had been taken on three occasions, but no trace of tumour could be found ; the sections were consistent with syphilis, but the patient had not responded to treatment. He would try antimony. Many injections of arsenic and bismuth had been given without result.

Great enlargement of the Hyoid Bone.—Lionel Colledge.

Patient, male, aged 25. The span is about double the normal width, and the great cornu projects under the skin each side.

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