ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

November 6, 1914.

Dr. G. WILLIAM HILL, *President, in the Chair.*

Fracture-dislocation of Right Great Cornu of Hyoid Bone.—G. William Hill.—This man fell off a bicycle one year ago and contused his neck. Pain for some days on left side. The right cornu was now seen projecting into the right glosso-epiglottic fossa. The man had suffered from laryngitis with hoarseness ever since the accident.

Skiagrams of Frontal Sinuses operated on by Good's Method.—G. William Hill.—Dr. Watson-Williams's metal sounds were seen *in situ*. Good's bone files or rasps for enlarging the frontal ostium were exhibited. Dr. Hill had recently performed Good's type of per-nasal operation for enlarging the frontal ostium on five frontal sinuses, using Good's special bone rasps, which he had just exhibited. The technique appeared to be both easy and safe. It was too early to speak of the permanent results, but the immediate relief was surprisingly good. No doubt in some cases a larger and more direct opening could be obtained by Dr. Watson-Williams's drill and burr, and by other modifications of Ingals's original instruments, which were exhibited many years ago by Dr. Dundas Grant.

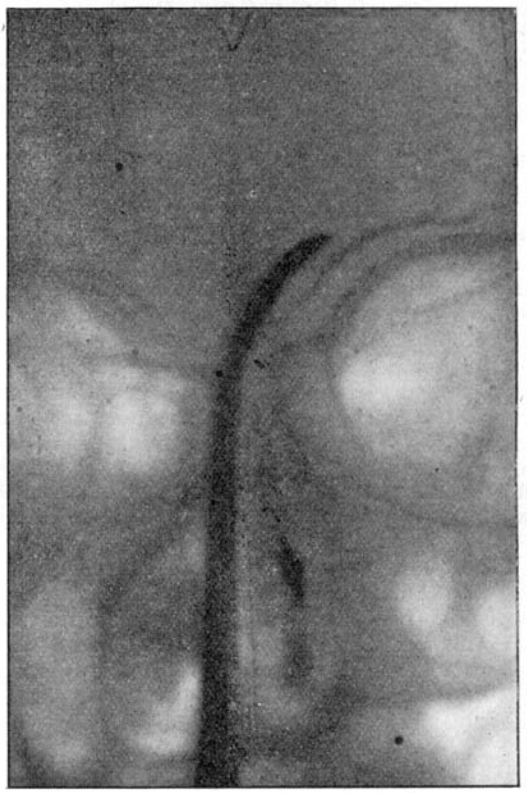
Skiagram of Frontal Region, showing Symmetrical Fronto-ethmoidal Cells extending above Roof of Orbit.—G. William Hill.—In reference to this skiagram, showing accessory fronto-ethmoidal cells extending far outwards between the frontal sinus floor and roof of the orbit, it had been assumed hitherto that the occasional presence of these cells, first described by Sir StClair Thomson under the name "orbito-ethmoidal," could only be ascertained by the Killian technique, and this assumption had been used as an argument for the inadequacy of the Ogston type of operation. The cells, however, could be seen by radiography quite clearly, and could be at least drained by Good's type of operation.

Breaking down of the Inter-frontal Sinus Septum by the Nasal Route so as to ensure Lavage for Double Frontal Sinus Suppuration.—P. Watson-Williams.—Four skiagrams were shown. Dr. Watson-Williams pointed out that the rasp or sound shown passing up one fronto-nasal passage and through the inter-sinus septum to the opposite side appeared to be traversing the sinus septum lower down than was actually the case, this illusion being due to the fact that the head was tilted back, hence everything in a plane posterior to the anterior surface of the sinus of course would appear lower in a skiagram than the corresponding part of the anterior sinus wall.

Dr. DUNDAS GRANT said it was pleasing to him to see the growing tendency towards the treatment of the frontal sinus by the intranasal method. When years ago he uttered an opinion in favour of it, there was a smile on the faces of the listeners. He might claim some priority in regard to the method just described, because at their meeting in

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Sheffield he brought forward an identical frontal sinus bougie, and narrated some cases in which he had found those bougies of considerable benefit. The only change necessary was to have the instruments made more pliable. The rasp was a great addition, and he recently used it in a case with much satisfaction, and he approached closer to guaranteeing a natural sized opening than he had done before. Rasps and burrs, however, were apt to provoke considerable granulation, compared with chisels and other clean-cutting instruments. Mr. Tilley had stated how



Skiagram showing the author's small frontal sinus rasp passed into the (patient's) left frontal sinus, and, through the large hole it has made in the sinus septum, well into the opposite frontal sinus (the skiagram reverses the right and left sides).

useful he found strong solutions of nitrate of silver; strong solutions of argyrol were also very good. Also one might use scarlet-red ointment. In a recent frontal sinus case he thought it materially assisted epithelialisation on the surface of the opening. In some of the cases on which he had operated radically he found that even then the passage contracted, and he had been glad to resort to his frontal sinus bougies. In a recent case he used them for what he thought to be mucocele. There was distension in the upper and inner angle of the orbit, and it was feared that it might be a new growth. On opening externally, he found he could secure no passage into the nose. But he forced a passage and then

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introduced the rasp. Following the example of Dr. Watson-Williams, he used a backward-cutting punch, such as had long been used for the antrum, and found it acted extremely well in removing the crest on the posterior surface of the nasal bone, and with scarlet-red ointment the passage was kept smooth and free.

Mr. TILLEY said he would like to ask Dr. Watson-Williams to keep a very special record of the cases in which the inter-sinus septum had been perforated, in order to compare the results with those which had not thus been operated on. It was difficult to see how merely making a perforation between the two sinuses could expedite a rapid cure and a relief of symptoms. It was often one's experience to see pus return from one sinus when the other was irrigated. He had never been able to convince himself that the cases in which perforation had been caused by disease got better any quicker than did those in which the septum separated the two diseased sinuses. Only within the last two months he had had a patient in whom the sinuses communicated. There was a fronto-nasal canal into both frontal sinuses almost big enough to admit a cedar pencil, and on syringing up one the fluid flowed freely down the other. Nothing seemed to stop the suppuration, not even the employment of strong antiseptics. If one broke down the inter-sinus septum, one must chip off portions of bone, and he would like to know what happened to these. Did they get blown down, washed down, or did they slowly disintegrate within the sinus?

Dr. WATSON-WILLIAMS had used Dr. Grant's sounds, and they were useful up to a certain point. But the difficulty was that they merely dilated by stretching the parts, which consequently fell together almost as soon as the sound was withdrawn. In reply to Mr. Tilley, he did not think there would be any more difficulty with these small pieces of bone from the septum than with those from the rasped ethmoidal cells. Either they remained attached to muco-periosteum and would not necrose, or, if loose, they would become washed away. He agreed that if one got the frontal sinus so well open that a good flush could be procured by washing one sinus, there was no necessity for opening the septum. But both these cases had hung fire very much, although he had made a good opening into them; in each case they had very much improved since the free openings had been made in the frontal sinus septum, allowing, not only of a very free flush through, but also of better atmospheric ventilation.

Laryngeal Disease of Obscure Nature.—W. Jobson Horne.—A man, aged thirty-six, had had no throat affection until Christmas, 1913, when he had laryngitis; since then there had been hoarseness and almost loss of voice for five months. Three or four months ago there was dysphagia, when only slops could be taken. There is no history of lues or phthisis. The tongue is protruded to the left. An overhanging epiglottis, which is normal, makes it difficult to see the vocal cords, which are almost hidden by the ventricular bands. There appears to be impaired mobility of the left cord.

Dr. GRANT said there was paralysis of the left vocal cord, and loss of function of the left hypoglossal nerve, while the pharyngeal branch of the vagus seemed to have escaped. If there were assumed to be a growth in the medulla, a remarkable point was that with paralysis of the left half of the tongue there seemed to be no wasting of the muscle, such as would ensue if it were due to infra-nuclear disease.

Dr. D. R. PATERSON thought the loss of voice was largely due to

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approximation of the ventricular bands, and the question arose whether anything should be done for that, as it considerably interfered with the vibration of the true cords. He had had experience of such cases, and they seemed to be particularly unsatisfactory where the false cords were much thickened. Painting them with astringents failed to yield good results. It seemed to him that this aspect of the case was well worthy of discussion.

Dr. FITZGERALD POWELL thought that, in view of the paralysis of the tongue, central nervous trouble was to be feared.

Dr. JOBSON HORNE, in his reply, stated that the larynx had undergone considerable change since the one occasion upon which he had seen it. At that time, owing to the œdema of the ventricular bands, it was difficult to see the vocal cords. Rest of voice was enjoined, with the result that now it was possible, not only to see the vocal cords, but also to see that there was ulceration on the glottic aspect of the left arytænoid region, perhaps more extensive than the mirror showed. Although there was no history of lues obtainable, he would nevertheless advise that a Wassermann test be done and the future treatment of the case be based upon the result.

Abnormal Overgrowth of Nose (Bulbous) in a Child, aged two. —J. L. Irwin Moore.—This case was sent to me at the London Throat



Abnormal overgrowth of nose (side view).

Hospital. The child was born in this condition. Dr. Worthington, of Exeter, who was consulted, writes me as follows:

"This case was brought to me about a year and a half ago with a tumour at the end of its nose much the same in appearance as it is now. I thought the swelling was cystic, and that it might be a dermoid in an unusual situation. I found on cutting on to it, however, that it consisted of fine fibrous tissue, closely adherent to the skin and also to the perichondrium of the cartilage of the alæ. There was no capsule and no definite limitation whatever. I removed as much as I could in an

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attempt to at any rate make a more shapely nose. But it was a very difficult and unsatisfactory job, for the whole face was on a much smaller scale than it is now. The wound healed well, and the appearance was certainly improved, but the tumour again slowly recurred until in proportion it was just the same as before. I have seen the case again off and on since last February, and I am sure that it has not grown any larger since then. After carefully considering all the possibilities, I have declined to operate again, as, short of cutting off the end of the nose, I do not think removal is practicable, and partial removal my experience has shown to be of no avail. You will notice that the substance of the growth comes well on to the columella in front."

The PRESIDENT said he would have thought the case might well have been operated upon again, and the tip of the nose considerably reduced. Mr. Graham had operated upon a similar case with success.

Dr. JOBSON HORNE advocated waiting to see if the abnormal portion of the nose kept pace in growth with the rest of the nose. If it did not, in time the nose might outgrow the abnormality, and operative interference for cosmetic or æsthetic purposes would be unnecessary.

Mr. HARMER said the case was an admirable one for diathermy, which could be performed without shock to the child, and without causing much scarring.

Hill's Feeding-tube in Epithelioma of the Œsophagus.—J. L. Irwin Moore.—Radiograms showed the stricture and dilatation of the œsophagus above it. Patient had dysphagia for two months, and when first seen on September 18 he had lost 37 lb. in weight. Solid or semi-solid food if swallowed was soon vomited. He could only take liquid food. There was a large secretion of mucus day and night, of which he vomited a breakfast-cupful at a time. The tube has remained *in situ* for seven weeks, and food is retained. He can now swallow liquids by the mouth without discomfort. He is relieved of the mucous secretion. He is gaining in weight, is comfortable and in good spirits, and able to do his daily work.

Dr. D. R. PATERSON asked whether these tubes had been found useful in malignant disease at the entrance of the œsophagus, where the difficulty caused by inability to swallow the saliva was very annoying.

Mr. ROSE asked whether these tubes had been used for cases of non-malignant stricture, and whether there was a tendency for such strictures to dilate whilst the tubes were being worn.

The PRESIDENT said that in his experience these styleted tubes were not well tolerated in all post-cricoidal cases. Symonds's soft rubber tubes should always be tried first in those cases—the long tube, not the funnel; but they were liable to be coughed up or vomited. That occurred in a case of his that very day, and a styleted tube had to be substituted. He used these tubes for their bougie effect in cases of non-malignant stricture, and they usually acted very well. If not, they could be dilated more drastically afterwards with a Brüning's dilator.

Dr. IRWIN MOORE replied that the case showed the great advantage of feeding such cases by means of Dr. William Hill's oro-œsophageal tube, especially from the patient's point of view. When he first saw the patient on September 18 he had lost 37 lb., was very miserable from starvation, and practically ready for gastrostomy. He had had no food for four days; liquids, which he had previously been able to swallow, being vomited almost as soon as swallowed. He could now take nine pints of food in twenty-four hours, consisting of beef-tea, milk, custards

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Benger's food, and light boiled eggs—a considerable portion of which (during the past two weeks) he had been able to swallow by the mouth, and alongside of the tube. He had put on 6 lb. in weight in seven weeks.

Perithelioma of the Pharynx.—J. Coubro Potter.—Dr. POTTER said that the case was referred from the May meeting for a report.[1] The diagnosis had been confirmed by Mr. Shattock, as follows:

Report upon a Nasopharyngeal Tumour referred for opinion from the Section.—The neoplasm consists of groups of tortuous, closely-packed, well-defined columns of cells. Many of these exhibit a lumen, which is in some cases empty, and in others holds a finely granular or homogeneous coagulum, which has slightly shrunken from the containing space. Some of the channels are wide and complex. The lumen of the different spaces is lined with a flat-celled endothelium, the cells on the outer aspect of which are cuboidal or columnar. Channels with similar structureless contents occur in certain areas of the connective-tissue, but furnished only with a flat endothelium; this indicates that the flattened lining elsewhere is not the result of pressure arising from the central formation of a degeneration product, but represents a proper endothelium. The new growth falls into the class of perithelioma, the channels being, presumably, of lymphatic origin.

Brain Abscess secondary to Frontal Sinus Suppuration; Drainage; Recovery.—Dan McKenzie.—The patient, a young man, aged twenty-seven, was brought to hospital with a fistula in the right eyebrow leading into the frontal sinus of that side. The history was as follows: Six weeks before, the patient, who had for long been the subject of a purulent discharge from the nose, suddenly developed an abscess in the right upper orbital region with high fever and some delirium. After the abscess had been freely opened, however, these constitutional symptoms rapidly disappeared and the patient got well enough to go to business, to frequent football matches, and to lead an altogether normal life. As the fistula did not close, however, he was brought to hospital. An X-ray examination having been made, the patient was admitted for operation. The X-ray plate on this occasion showed a "normal," that is an air-filled sinus. After he had been put under chloroform I inserted a probe into the frontal sinus through the fistulous opening and was surprised to find that it passed an unusually long way into the cavity o the skull, so that it seemed as if it were an enormous frontal sinus w had to deal with. But on opening up the sinus we found it to be quite a small one, with a second fistulous opening in its posterior wall leading to a large abscess, seemingly within the frontal lobe. About 6 dr. of fœtid pus was evacuated. The fistula having been slightly enlarged, a drainage-tube was placed in the abscess cavity with its outer end projecting from the supra-orbital wound. The *débris* removed from the abscess was reported by Dr. Wyatt Wingrave to contain cerebral cortical tissue.

The patient did very well. No untoward symptoms made their appearance, and, a month later, being undecided as to how long the drainage-tube, which I had meanwhile shortened a little, should be retained, I re-opened the sinus to find the brain abscess cavity apparently obliterated and the tube lying amid granulations. It was therefore removed, and, after another tube had been inserted through the infundibulum and out at the anterior nares so as to drain the sinus, the forehead wound was entirely sutured. Six weeks later the maxillary antrum, which

[1] JOURN. OF LARYNGOL., RHINOL., AND OTOL., January, 1915, p. 48.

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was also the seat of suppuration, was opened and drained. The patient now seems to be quite well.

The only symptom which might have been due to the brain abscess was a rather low pulse-rate, about 60. There was no appreciable interference with the intellectual powers; no change in the optic disc; no emotional disturbances, and no paretic or paralytic phenomena.

X-ray plates (by Dr. Ironside Bruce), showing a probe in the abscess cavity, were on exhibition (Figs. 1 and 2).

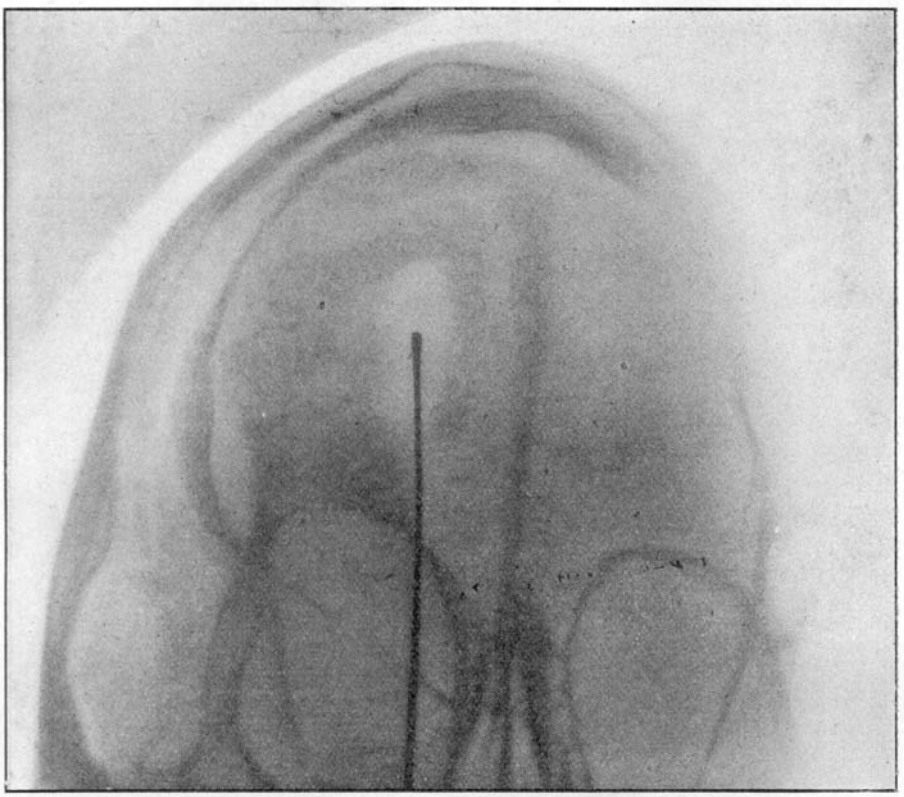


FIG. 1.—Abscess of frontal lobe. Probe in abscess cavity inserted through the frontal sinus. (Antero-posterior view.)

Mr. HORSFORD had operated upon a case a year ago for extensive nasal suppuration, double antral and ethmoidal. About three weeks ago he was asked to see the patient again. Recently he had had frontal and occipital headache, disturbance of gait, and a tendency to fall forward. He had found that the left sphenoidal sinus was diseased, and he opened it freely. There was relief of the posterior headache, but the other symptoms persisted. The right sphenoidal sinus was also diseased. He had slow cerebration, a tendency to fall forward and latterly to fall backward, indefinite headache, a pulse-rate of only 50 to 66, a subnormal temperature, and, in fact, most of the symptoms pointing to cerebral disease. Dr. Risien Russell thought there were definite, though slight, signs pointing to frontal abscess. Mr. Donald Armour explored the skull in that region,

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and opened the frontal sinus on that side, but found but little disease of the frontal sinus and no frontal abscess. Nothing further was done, and the patient died next day. *Post mortem* there was found an extradural effusion of clear fluid in two places in the anterior fossa on the right side, and nothing else abnormal. This case showed the difficulty in the diagnosis of cerebral complications of nasal disease.

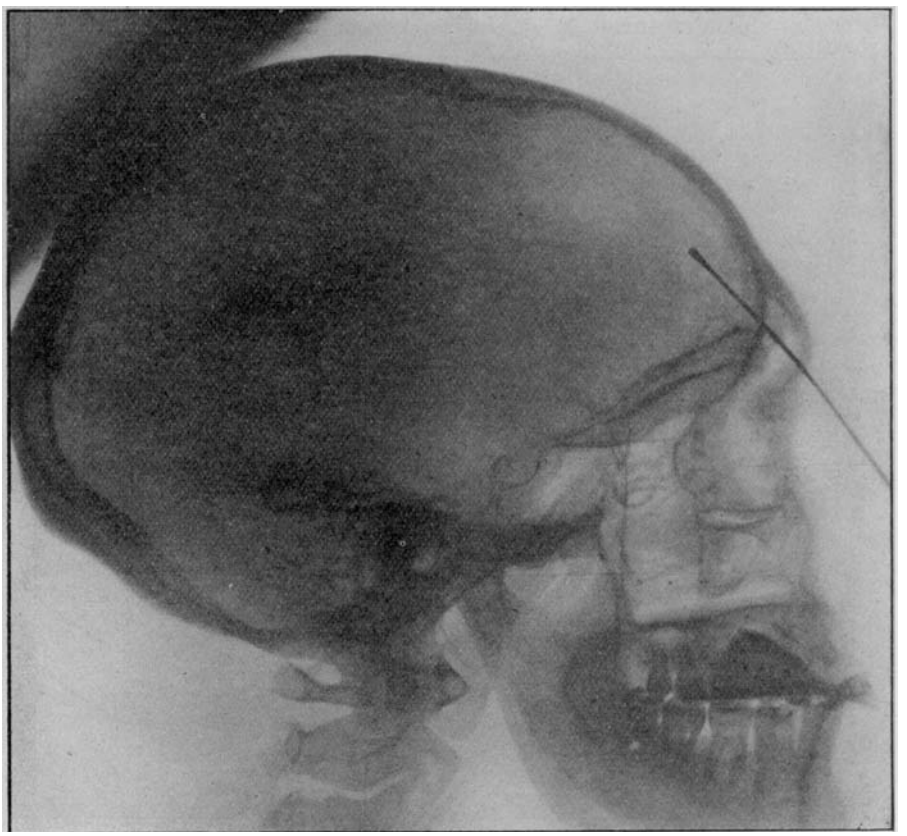


FIG. 2.—Abscess of frontal lobe. Probe in abscess cavity, inserted through the frontal sinus. (Lateral view.)

Major P. G. GOLDSMITH (Canadian Army Medical Corps) said the result drew one's attention to the fact that suppuration might exist in the frontal sinus with but few symptoms, especially if there were no meningitis. He saw a case in which the patient died of acute osteo-myelitis of the frontal bone with orbital phlegmon following a radical frontal sinus operation. There was found *post mortem* an abscess larger than a walnut, with thick walls. There had been only slight headache, no nausea, nor optic neuritis, nor was there any apparent communication between the suppurating sinus and the dura or abscess.

Sir STCLAIR THOMSON pointed out that the condition was not due to operation, and for their own sakes members should bear these things in

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mind. He had a case in hospital in which he operated upon a frontal sinus, and it appeared to be doing well. But the patient then developed symptoms pointing to an abscess in the frontal lobe on the opposite side. A *post mortem* revealed a lateral abscess in the brain on the untouched side. In private practice it was possible that the surgeon might be blamed for what was in no sense due to operative traumatism.

Aspergillosis on the Maxillary Antrum.—Herbert Tilley.—This communication will appear as an original article in a later number of the JOURNAL OF LARYNGOLOGY, RHINOLOGY, AND OTOLOGY.

Intrinsic Epithelioma of the Larynx, suitable for Laryngo-fissure.—Sir StClair Thomson.—The patient, aged sixty-nine, complained of absolutely nothing except hoarseness, which has been coming on for six months. The whole of the left vocal cord is replaced by a red, knobby, ulcerating infiltration; the cords move well; the rest of the larynx is quite normal; there are no enlarged glands. The Wassermann reaction is negative. Patient weighs 13 st. 6 lb. There are no indications of tubercle. He is a non-smoker. The case is shown to illustrate the difficulty of diagnosing certain cases of epithelioma of the vocal cord. The infiltration is not suitable for removing a portion for microscopical examination, and the diagnosis therefore depends entirely on the naked-eye appearances and on exclusion of other possibilities. It is proposed to treat the case by laryngo-fissure, for which it seems eminently suitable.

Mr. HERBERT TILLEY said he did not think there was any doubt about the diagnosis. It was one of the clearest cases showing freedom of the cord in malignant disease which he had seen.

Sir FELIX SEMON said that he regretted he had not seen the case himself, but as it was stated that the whole of the left vocal cord was replaced by a red knobby ulceration, he thought that operation should not be delayed longer, as this could only increase the gravity of the operation. At the same time, hearing that the mobility of the cord, in spite of the extent of the disease, was quite unimpaired, he wondered whether *senile tuberculosis* was altogether excluded. He also was reminded of certain odd cases which Mr. Shattock and he had seen together, in which, clinically, there could apparently be no doubt as to the malignancy of the condition, whilst microscopically the affection was found to be an obscure infective inflammation, which even Mr. Shattock did not know how to describe exactly. Thus this case, too, after all might not be malignant. All the same, he agreed with Sir StClair Thomson's operative proposals.

Dr. DUNDAS GRANT advised Sir StClair Thomson not to remove a large portion of it by means of Jurasz's forceps. He once did so in a similar case which he believed to be malignant, and he pulled away nearly the whole of the vocal cord, and it proved to be non-malignant. The patient's anxiety was removed, but the voice was not recovered. He did not regard the present case as certainly malignant. Mobility of the cord did not exclude a diagnosis of malignancy, but mobility would be most unusual with a growth of this extent if malignant. He would be much interested in the result of the microscopical examination of a small fragment.

Dr. DAN MCKENZIE asked if the exhibitor had thought it an unsuitable case for the removal of a portion for microscopical examination. In supposed laryngeal cancer, the absence of any support of the diagnosis from the microscope would lead the speaker to hesitate to perform thyrotomy.

Dr. JOBSON HORNE agreed that the case was not very obviously a case

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of epithelioma of the vocal cord; the cord was so remarkably free in movement in spite of the extent of the ulceration. He had seen similar cases which subsequently were proved to be senile tuberculosis of the larynx.

Dr. Fitzgerald Powell entirely agreed with Sir StClair Thomson as to the nature of the cases and as to the procedure he proposed to adopt. He could not agree to the suggestion of punching out a portion of the diseased cord for diagnosis. If the disease was tubercular it was better away, and if malignant, as he thought it was, it would only hasten the spread of the growth from the cord to the deeper structures.

Sir StClair Thomson replied that the patient's blood-pressure was 200 and his age sixty-nine, so that it was not such a very simple case to operate on. He showed the case because in some instances one had to wait for some indication of malignancy. This was a case in which the "penny-in-the-slot" method of diagnosis did not work; it depended entirely on a trained eye. He did not regard it as an absolutely clear case, but he brought it to show how one must sometimes act on a probability. With regard to tubercle, the patient had been overhauled by a physician. With regard to removing a portion for examination, this was not a growth "on" the cord. Sir Felix Semon would agree that there were cases in which the cord was infiltrated and there was no differentiation between the cord and the growth. If a portion were removed and reported to be non-malignant, he would still not like to leave that patient alone. If it were his own larynx, he would not have it touched for removal of a piece, because of the danger of rapid spread afterwards. Senile tuberculosis of the larynx was very difficult to diagnose, and it would often occur in the absence of pulmonary or other symptoms. One thing he did as a routine, which was helpful when doing laryngo-fissure: When the larynx was split, instead of having a pathologist to examine the growth on the spot, he felt it with the finger; there was a peculiar cartilaginous feel which he regarded as almost pathognomonic.

Pulsating Elongated Swelling on Lateral Wall of Pharynx.—W. Stuart-Low.—*Case* 1.—A boy, aged seven, who has a pulsating elongated swelling on the lateral wall of the pharynx on the left side just behind the tonsil. He was sent to the hospital for removal of tonsils, no complaint being made of any inconvenience in the throat. The interesting points with reference to this case are: The youth of the patient, the danger of injury to the vessel in operating on the tonsils, and whether it is likely to develop into the same troublesome, and sometimes painful, condition—that of the second case.

Case 2.—A man, aged sixty, with a similar pulsating swelling also on the left side of the pharynx; the pulsation can be felt up the side of the neck towards the ear. He complains of a throbbing in the neck, and sometimes of pain, and that the beating keeps him awake at night. This is most likely an aberrant branch of the carotid or the ascending pharyngeal artery; pulsations can be both seen and felt in the pharynx and neck. If the boy shows an early stage of what the man illustrates, can anything be suggested to prevent him developing what is an incapacitating condition?

Dr. Peters thought Mr. Stuart-Low might safely perform tonsillectomy, and might use the new guillotine exhibited that afternoon. The second case he regarded as one of arteriosclerosis; that the symptoms were due to degenerated arteries, rather than to one particularly enlarged vessel.

Mr. Herbert Tilley said he had had a case identical with the first

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of these, and because of the marked degree of pulsation he postponed operation on a large septic tonsil, but in six months the symptoms increased so much that the operation was decided on, and all preparations were made for severe hæmorrhage, but he did not think he had ever seen a case in which tonsillectomy was accompanied by less hæmorrhage.

Dr. GRANT said that perhaps if this condition were more frequently sought for it would be oftener found. He did not think there was any reason for anxiety that it would develop into a troublesome painful condition. With regard to the request for suggestions to prevent the case developing into an incapacitating condition, there were some enlarged and infiltrating glands which seemed to push the vessel a little farther into the pharynx than would be the case in their absence. In the second case he thought there was a slight drooping of the left eyelid, suggesting interference with the sympathetic, producing weakness of the non-striated muscle in the orbit.

Dr. D. R. PATERSON said that in the second case there was deafness and tinnitus aurium present which added to the discomfort, and thought the pharyngeal condition might have but little to do with his symptoms. He had certainly seen just as prominent vessels with no complaint whatever on the part of the patient.

Sir FELIX SEMON said that a perusal of the *Transactions* of the old Laryngological Society would show the records of several such cases of pulsating vessels on the posterior wall of the pharynx.

Mr. STUART-LOW replied that the discovery was due to his assistant, Dr. MacKeith, who saw the condition when about to operate. The man was incapacitated, as this kept him from sleeping, and was costing the State money every week.

Hæmostatic Guillotine.—G. J. F. Elphick.—The instrument was designed for the complete enucleation of tonsils, which are removed from their beds, with their capsules, without loss of blood. The method used is approximately that of Sluder, but, in addition to the one cutting blade, there is a crushing blade, which enters between the anterior faucial pillar and the tonsil, and effectively crushes all vessels between the capsule of the tonsil and its bed. When the crushing blade has been pushed home, it remains locked in this position by the Hagedorn catch at the base of the handle of the instrument. A light pair of fixation forceps is now applied to the protruding tonsil (*i. e.*, on the uvula side of the blade), and the cutting blade, which enters between the crushing blade and the tonsil, pushed home. The tonsil is now lifted out on the fixation forceps. The crushing blade, being still applied to the vessels which have been cut through, may be left on for a few moments, and then gradually released by pressing down the catch with the little finger.

The method is a simple one; there is no bruising of the faucial pillars or surrounding tissues, no muscle-tissue is removed, and in vigorous adults, where the risk of hæmorrhage may be great, it offers the safest possible way of preventing bleeding, in that all vessels that have been cut through can be held just as long as the operator pleases, and when released the proximal ends have been thoroughly crushed by the serrated edge of the crushing blade. The blades of the instrument are made in three sizes, and the one chosen should be of such a size that the tonsil can be most comfortably pushed through the ring. The fixation forceps are only necessary to prevent the tonsil from falling down when isolated.

The PRESIDENT, referring to the statement on the agenda paper that Sluder's method was used, said that the technique carried out in this

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country was really that of Whillis (of Newcastle). It was a development of an older method, which was illustrated in Sir StClair Thomson's book, in which enucleation was performed with the shaft of the guillotine lying across the buccal cavity. That Dr. Elphick's hæmostatic guillotine was an excellent enucleating instrument he could testify from personal experience.

Dr. DUNDAS GRANT asked how the cutting blade was to be driven, seeing that both hands were supposed to be already occupied.

Dr. ELPHICK replied that after pushing the tonsil through the ring with the left index finger the crushing blade was pushed home with the right hand and automatically held in position by a Hagedorn catch, and both hands could be then released, if necessary, for pushing home the cutting blade.

Deficient Tension of Vocal Cords.—H. Lambert Lack.—The patient, a man, aged twenty-five, has suffered from weakness of the voice three years or more. He cannot tell when it commenced, but says he had a good voice when he was eighteen. There was no definite history of onset or cause. He has had a good deal of treatment without effect. On phonation there is an elliptical opening between the cords. The cords themselves are somewhat congested. There does not appear to be much functional element in the case. Suggestions as to the pathology of the condition and treatment would be welcomed.

Mr. HERBERT TILLEY said he thought it was a case of weakness of the internal tensors. He had never seen treatment do good in chronic cases, and he did not think this patient would get any better.

Dr. DUNDAS GRANT said it was interesting that this man practised the alto voice and sang in that voice in a choir. This meant some unnatural action of the muscles of the larynx; at any rate it put a great strain on the fibres of the internal thyro-arytænoid muscles required for thinning of the cords and damping of certain portions of the cord. He saw this condition often, in minor degrees, as the result of laryngitis.

Extensive Papilloma of the Trachea.—H. Lambert Lack.—This patient was first seen in 1906. She had consulted various physicians and specialists, complaining of difficulty in breathing, which by some was considered to be asthma. A correct diagnosis had never been made until one day the patient expectorated a small piece of papilloma. When I first saw the patient she had considerable dyspnœa and pink granulations could just be seen in the lowest part of the trachea. The bronchoscope was not then in use. As the patient's condition was desperate I decided to give her chloroform, open the trachea as widely as possible and get the growths out quickly. This was done. The patient became more and more cyanosed as the operation proceeded, but directly I pushed my finger down the trachea, breaking down large masses of papillomatous growths, which completely obstructed the tube, the patient was able to cough up blood and growth and at once breathed more freely. A large amount of growth was then removed by forceps and curetting. The masses seemed to grow from all round the trachea for a distance of an inch and a half and more, extending nearly to the bifurcation. The patient made a good recovery, but the trachea was kept open for a subsequent examination. Two or three weeks later some small growths were removed under cocaine and then the tracheal opening was allowed to close. The patient has remained perfectly well ever since. Lately, some

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small papillomatous growths have appeared on the skin of the neck. The case, as far as I know, is unique.

Dr. GRANT said he had described a similar case.[1]

Epithelioma of Right Tonsil.—Hunter Tod.—The patient, a man, aged forty-two, has noticed, for two or three months, slight pain on swallowing and shooting pains up to the ear on the affected side. On examination the right tonsil is found to be superficially ulcerated. The edge of the ulcer extends into the anterior and posterior pillars of the fauces and on to the base of the tongue. The margin is raised, everted, and indurated. No glands can be felt in the neck. It is a comparatively early case, and suitable for operation with the knife or diathermy treatment.

Mr. HARMER thought it was an early epithelioma and suitable for treatment by diathermy. The important question which was brought up at Aberdeen by Dr. Lack, as to whether diathermy was superior to the knife in the treatment of all accessible growths of mucous membrane of pharynx and mouth, was raised by this case. He (the speaker) thought the results of diathermy were so admirable that it was preferable to a cutting operation in such a case. After diathermy the patient would be able to leave his bed on the second, or at worst the third day, and that could not be said after an even trifling operation with the knife.

The PRESIDENT thought the pronouncement made independently by Dr. Lack, Mr. Harmer and himself, was a very important one—viz., that it was permissible, in the first instance, to try a non-cutting operation such as diathermy in throat cancer; with it there was less bleeding and less risk of implantation and dissemination, as the lymphatics were sealed. The results of surgical diathermy were very extraordinary, especially in a condition like advanced throat cancer, which it robbed of many of its terrors in the direction of obstruction of the upper respiratory and food passages.

Mr. TOD replied that he favoured diathermy.

Carcinoma of Palate.—Hunter Tod.—This case had been treated for lupus for over a year without success. A portion of the tissue was then examined by microscope and found to be carcinomatous. Treatment by diathermy, two sittings: (1) August, 1914, and (2) early in October. Growth now eradicated, except over small area on left side. Further diathermy treatment was proposed.

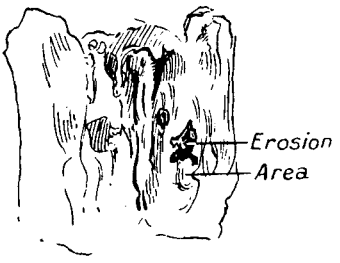
Ulceration of Soft Palate and Tonsil.—Walter Howarth.—Patient, a male, aged twelve. The condition has lasted three months, and is said to have been progressive during that time, but is stationary at present. Section shows general hyperplasia, but no evidence of tuberculosis.

Rhinogenic Meningitis.—P. Watson-Williams.—A. S——, admitted on September 22, 1914, had been complaining of discharge from the nose and headaches for some months. The left and right antra were explored, and the left contained pus. Right antrum opened some months previously. September 30, 1914: The left maxillary antrum opened intranasally. Frontal sinus not operated on. October 1: Restless, complaining of pain behind nose.

[1] JOURN. OF LARYNGOL., RHINOL., AND OTOL., 1904 xix, p. 649.

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Two days later developed symptoms of meningitis. F. O.: Right blurred and left same; optic neuritis. October 4: Died with symptoms of general meningitis. *Post-mortem* examination: Acute purulent meningitis originating from an area of erosion in the middle ethmoidal cells roof—*i. e.* opposite side to operation.[1] N.B.—(1) There was a normal left frontal sinus, but no right frontal sinus could be found; (2) if a right pre-nasal frontal sinus operation had been attempted (as had been the case some months previously by another operator) it must have failed and the rapidly following death with the *post-mortem* finding would have



Sketch showing the crista galli (in median line) and, on either side of it, the cribriform plate and other parts of anterior fossa forming roof of nasal passages. On the right side the erosion area is indicated.

suggested the operation as the cause of meningitis; (3) if the right antrum had been operated on at the same time as the left, instead of months previously, it would also have caused suspicion of traumatism or thrombo-phlebitis due to operation as the cause of death. This case has therefore a medico-legal interest.

Abstracts.

PHARYNX.

Rolleston, J. D., and Macleod, C.—Intramuscular Injections of Antitoxin in the Treatment of Diphtheria. "British Journal of Children's Diseases," vol. xi, No. 289.

The authors conclude that intramuscular injection, preferably in the vastus externus, deserves to supersede all other methods of administration of antitoxin in the treatment of diphtheria for the following reasons: (1) It is quite as simple as the subcutaneous method, ensures much more rapid absorption, is less painful, and less liable to give rise to abscesses at the infection site. (2) It is superior to the intravenous method, not only in the greater simplicity of its technique, but also in the less rapid excretion of antitoxin after injection. (3) The more rapid absorption of antitoxin by the intramuscular route is shown, not by the effect on the faucial or laryngeal process, but by the lesser incidence of paralysis, especially of a severe kind. *Macleod Yearsley.*

[1] For a similar case see JOURN. OF LARYNGOL., RHINOL., AND OTOL., vol. xxvii, p. 538.

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