in the peripheral than in the central portions of the growth. This is probably anatomically correct; still I have always found that the moment of the greatest hæmorrhage was when, having separated the tumour from its bony attachments, I proceeded to tear it away from its investing membrane.

More lately I adopted a method of controlling the hæmorrhage during the operation, which in difficult cases may be of service. I had a fibroma to operate on which elsewhere had been several times attempted. I knew that adhesions would make a rapid operation impossible. I had noticed my colleague, Sir Herbert Maitland's, practice in some of his jaw operations of applying a temporary clamp on one or both common carotids. He kindly assisted me in this case by applying a temporary clamp on the common carotid on the side where the fibroma had its principal attachments. The hæmorrhage was markedly less than usual, and I was able to proceed without hurry. This additional step in the operation is worthy of consideration. Maitland's clamp is a modification of Crile's forceps. By applying it on both carotids there would be practically no hæmorrhage. Maitland has used the clamp on both common carotids with safety in a large number of jaw operations. Maitland's clamp is encased in soft rubber to avoid injury to the coats of the vessel.

SOCIETIES' PROCEEDINGS.

ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

February 4, 1915.

President: Dr. J. W. Bond.

Tumour in Region of Right Tonsil and Soft Palate.—J. W. Bond.—Patient, a woman, aged fifty-two. A painless swelling in region of right tonsil was noticed about six months ago, and it has since increased in size. The fauces are almost completely obstructed by a smooth, round swelling, covered by mucous membrane, and with a definite border all round. The mass is attached on the right side, and extends from the hard palate above to below and behind angle of jaw, where it can be felt externally. Posteriorly it extends to back of lateral pharyngeal wall. It is slightly movable. No tonsil proper can be seen.

I think it would be well if we could have more statistics as to the

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results of operation in this region. We know that the prognosis of epithelioma seems bad, but we do not know the prognosis of adenomata, endotheliomata, and the varieties of sarcoma. I think the tumour can be enucleated.

Extensive Scarring of the Face.—J. Edmond.—This patient, a man, aged twenty-seven, suffered from ulceration in the region of the nostrils, which began twenty years ago. During the next fifteen years the lesions were twice curetted, and he had several prolonged courses of treatment by Finsen light and X rays. Five years ago the ulcers rapidly healed after medicinal treatment (presumably by potassium iodide and mercury). Can anything better be done to conceal the deformity?

The PRESIDENT: This seems to be a case of ancient syphilis, with bad damage to the nose. I had a case very much like it some years ago; several operations which I performed did not do much good. Finally, a nose was made from the forehead. It is not necessary to attempt that in this case; I think some plastic operation is possible.

Dr. KENT HUGHES: I think a good deal can be done for him by lifting up a central portion from the upper lip, and putting an epithelial graft on the other side of that. It makes a very good columella, as pointed out by the late Sir Henry Butlin.

Fish-bone in Œsophagus, followed by Abscess in Neck.—Norman Patterson.—Patient, a woman, aged forty-four, came to the London Hospital on August 12, 1915, complaining of a pricking sensation on the left side of the throat. She said that two days previously a fish-bone had stuck in her throat. She was examined with mirror and œsophagoscope—no bone discovered. Next day a fish-bone about 1 in. in length (specimen shown) was brought up. Two days later (August 15) a swelling was noticed in the neck, occupying the position of the left lobe and isthmus of the thyroid. The swelling increased in size, and extended upwards till, by August 20, the whole of the left side of the neck was swollen. On the afternoon of that date, as the patient had some dyspnœa, the house surgeon made an opening in front of the sterno-mastoid, but failed to find pus. The patient was seen by the exhibitor the same evening, and examination of the larynx showed swelling behind the left arytænoid, some swelling of the arytænoid itself, and impaired movement of the left vocal cord. Under a general anæsthetic a free incision was made behind the sterno-mastoid, and a large abscess evacuated. A tube was left in for two days. Recovery was rapid and uneventful. The pus contained a variety of organisms.

The PRESIDENT: I wonder where the bone could be when not found by œsophagoscopy or other examination. In recent cases a bone can generally be found, but I always doubt about cases which have gone on for several weeks: in my experience we do not find them.

Mr. TILLEY: Recently I missed a portion of a pheasant's bone in the gullet. When one gets below the cricoid region, where the œsophagus enlarges, it is easy for a bone to lie in the folds of mucous membrane and to be missed by the œsophagoscope. I withdrew the instrument carefully while watching the posterior wall, and I did not think the bone was there. A pledget of wool was inserted to remove some secretion, when it caught in something, and on removal the bone was adherent to the wool. It is easy to pass the œsophagoscope over a coin in the same region of the gullet without seeing the foreign body.

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Sarcoma of Naso-pharynx and Cervical Glands; Result of Treatment.—Norman Patterson.—The patient, a woman, aged thirty-nine, came to the Hospital for Diseases of the Throat, Golden Square, in July, 1913, complaining of discharge of mucus and blood from the nose and throat, and inability to breathe through the nose. The whole of the naso-pharynx was filled by a mass of new growth which projected nearly down to the free edge of the soft palate. It was soft to the touch and bled profusely after digital examination. There was some enlargement of the glands in both anterior triangles.

September, 1913: The patient was referred to Dr. Sequeira for X-ray treatment. After six applications through the mouth the growth had entirely disappeared. At a later date a tube of radium was inserted into the post-nasal space, although by this time the tumour had completely vanished. In spite of eight applications of X rays to the neck, the glands continued to enlarge. Operations on the neck were carried out on the following dates: June 26, 1914: Dissection of right anterior triangle. July 29, 1914: Same procedure carried out on the left side. On this side there were enlarged glands deep to the sterno-mastoid, which were removed after section of the muscle.

February, 1915: An enlarged gland had appeared on the right side above the clavicle. A thorough dissection was made in this neighbourhood after turning outwards a triangular flap of skin; one incision was made along the line of the clavicle and the other down the anterior border of the sterno-mastoid. Microscopic examination of one of the glands showed mixed-celled sarcoma. Since the last operation the patient has had several applications of X rays. There is now no sign of recurrence. The patient is somewhat deaf on the right side. There is a history of discharge from the right ear in 1912, which lasted a week.

The PRESIDENT: The result in this case seems to be a very happy one, owing to the utilisation of the various forces which we now have at command. At one time such cases would have been left alone.

Partial Excision of the Thyroid Cartilage as an Alternative to Thyrotomy in Malignant Disease of the Vocal Cords.—H. Lambert Lack.—The patient, a man, aged fifty-five, had an epithelioma involving the greater part of the right vocal cord, only the extreme ends being free. The specimen and microscopical section are shown; also a larynx dissected to illustrate the method of operating.[1]

I performed this operation in my earliest thyrotomies, but subsequently adopted the usual method. Latterly I have reverted to it. In my opinion it has many advantages. Better access means an easier, more rapid, and more thorough operation. The removal of the underlying cartilage certainly aids in thoroughness. The easy control of bleeding means less trouble with the anæsthetic and less danger of blood entering the lungs. Should packing of the wound be considered necessary, it is much easier to introduce it and later to remove it. It does away with the necessity of splitting the thyro-hyoid membrane and the violent pulling apart of the two halves of the thyroid, which often leads to much subsequent discomfort and difficulty in swallowing. In my next case I intend to go further. I shall try not to split the thyroid cartilage in its whole extent, but to leave a small piece in the middle line quite at the top (see specimen shown). In this way the operation, although more thorough than thyrotomy, will be as simple

[1] See JOURN. OF LARYNGOL., RHINOL., AND OTOL., April, 1916, p. 121.

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and as free from danger as tracheotomy. Moreover, if the growth crosses the middle line in front, it can still be removed in one piece without cutting into it, this advantage being emphasized in my original account of the operation.[1] In this paper the risk of cell transplantation from cutting into a growth, and the advantages of avoiding it, were especially considered. Also, occasionally, the bared piece of cartilage necroses and leads to considerable delay in healing. After this operation healing seems to take place more quickly.

With regard to the voice, I think the results may be even better than after thyrotomy. If the soft parts are removed right down to the cartilage one cannot expect much granulation tissue to spring up, and in some of my cases a large gap has resulted, with a very poor voice. After removal of portions of the cartilage and, in one case, of half the larynx, a better voice has been obtained than is usual in thyrotomy, and in much less time. Members may remember the historical case of Montagu Williams, whose voice after hemi-laryngectomy was so good that there was thought of his returning to the Bar, and he did fulfil his duties as a police magistrate for several years subsequently. I expect, therefore, this method to yield better ultimate results than thyrotomy.

The PRESIDENT: Twenty-two years ago Mr. Lambert Lack helped me with a laryngeal case, when I removed a large part of both thyroid plates, leaving the posterior and superior borders. I also removed the cricoid. I am glad there has been a development of this operation of laryngo-fissure or thyrotomy. At a late meeting I stated there was difficulty in obtaining a proper view of the diseased part in these cases. The operation now described by Mr. Lack will give one a better view of the region from which the growths spring, and especially of the posterior part. Mr. Lack also mentions the risk of cell transplantation due to cutting into the growth, and I sure that is a decided risk. Of late years in these cases I have always used the actual cautery, because one gets the knife and the wound tainted, and cauterizing the wound lessens the risk of recurrence.

Sir STCLAIR THOMSON: I think Mr. Lack's object is a very worthy one, because, as we said in a debate here not long ago, one difficulty of laryngo-fissure is getting to the posterior end of the cord, both for seeing and for dissecting it off, as well as for dealing with possible hæmorrhage. And, as I mentioned at the time, I sometimes get a better opening than some of my colleagues, by semi-dislocating the larynx on to the spinal column in order to be able to look at it sideways and lift one of the alæ. By so doing, I have not had such great difficulties as one would imagine. Mr. Lack's suggestion is only suitable in certain cases. Anyhow, it is not suitable for cases which go across the middle line, unless one is prepared to take a bit of the thyroid cartilage on the opposite side. And it is difficult to know, before you have split the larynx and opened it as widely as possible, what is the extent of the growth you may have to deal with. So I do not regard this as an "alternative" to laryngo-fissure; it can only be an "addition." I think it wise to split the larynx first, because no method of laryngoscopy ever tells one exactly the extent of the growth. In some of these cases I have had to pare off the growth into the subglottic region, and although these cases generally show that the growth is too far gone, still, I have had two cases in which I have had to split the cricoid cartilage in order to get into the subglottic region, and the patients have lived for years afterwards. The simpler

[1] See *Lancet*, 1896, i, p. 1638.

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an operation is, the more perfect it is likely to be; and it is only when new that operations are complicated. At the beginning laryngo-fissure was complicated by many things which we have now got beyond. There is the Hahn's tube, which Mr. Lack still uses. I have used it, but I am glad I said "Good-bye" to it ten years ago, because it was a very unsatisfactory method of cutting off the blood from the lower air passages. It had to be carefully prepared with a sponge, which was very difficult to keep aseptic; moreover, one had to wait for it to dilate and so block the trachea. The only case of pneumonia I ever had was after one of these tubes had been used. By the simpler method of packing with gauze or a sponge from above, one can be absolutely certain that no blood goes into the lung. During the last ten years I have had no trouble with these cases, excepting in one in which there was difficulty of swallowing; all the other patients could swallow in twenty-four hours. The exception was the case of a man, aged sixty-eight, who had sclerosed arteries and was alcoholic, and he had to be fed through the nose for ten days. This method of Mr. Lack's, though very elegant and giving a view far back, would still entail the splitting of the thyroid cartilage at the top if one wished to go as far above and below as might be necessary. Therefore, though it might be suitable for some of the more limited cases, those are just the cases in which one would not require it.

Mr. TILLEY: I have not practised the operation now under discussion; but one gathers from the demonstration that there are advantages in connection with it when the growth is small and limited. It would be possible to remove a small nodule on the cord in this way. But in each case upon which I operate I feel more and more strongly that we cannot take away too much of apparently healthy tissues around the cancer. In my last patient I cleared out all the tissues, from the top of the thyroid to the cricoid ring, though the growth was only a small nodule. I am quite prepared to hear someone say that was unnecessary, but the proof will depend on the after-history of a series of such cases. At the last meeting I showed a case of recurrence, seven years after the primary operation; the nodule was situated in the lower part of the remains of the ventricular band, which had been left at the operation seven years previously. Now if I had taken the precaution to remove the apparently healthy tissue from the whole inner surface of the thyroid, probably there would not have been a recurrence. Mr. Lack's procedure seems to me to be well conceived, and it might be applicable to a small growth; but if I adopted the method I should take out the whole side of the thyroid cartilage, and should not limit it to a small window. I hold this opinion as the result of some experiences in recurrence after the lapse of a long period of time—*e. g.* thirteen and fifteen years after the primary operations. I do not think you can make too wide a removal of tissue in these laryngeal cases or in cancer in any other region. With regard to Hahn's cannula, I use it merely as a convenient form of tracheotomy tube, but it has no sponge coating, and when I insert it I pack a long strip of gauze above it and proceed at once with further steps in the operation.

Dr. BROECKAERT, of Ghent (speaking in French): Two years ago for the first time I demonstrated in Paris a method which is somewhat between a thyrotomy and a hemi-laryngectomy. One striking thing about the two cases was the ease of the post-operative treatment. I bring the skin over, and close the wound at once. I introduced it to Dr. Moure, of Bordeaux, who was satisfied with it and carried it out. I

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also introduced it to a Dutch colleague, Dr. Quix, who modified it slightly by turning in a flap of skin from the side, so as to line it with a graft. I call it a window excision of part of the larynx. It is very important to leave the upper and posterior borders of the thyroid wing, a point which makes the great difference between this operation and hemi-laryngectomy, which I, like others, have found to be an even more fatal operation than complete excision of the larynx.

Dr. KELSON: I would like to ask Mr. Lack one question. He says in his notes: "I performed this operation in my earliest 'thyrotomies,' but subsequently adopted the usual method." I ask why he abandoned that method.

Mr. LACK (in reply): I am sorry I mentioned Hahn's cannula. I pointed out in the *Lancet* twenty years ago that it was impossible to rely on it, and that it was necessary to pack the trachea above it. This has invariably been my practice, although I still generally use a Hahn's cannula, as it is convenient for the anæsthetic. The criticism of Sir StClair Thomson and Mr. Tilley is based upon a misapprehension, perhaps because in the specimen I dissected only a very small window is cut. In my description, I state that all the cartilage which in the usual operation of thyrotomy is laid bare by removing the mucous membrane inside the larynx should be cut away. The amount of cartilage removed corresponds with the amount of soft parts removed, and this may be as extensive as the operator desires. As Prof. Broeckaert showed, the whole thyroid cartilage, with the exception of the upper edge and the posterior edge, may be removed as well as half the cricoid. The removal of the cartilage, by giving better access, allows a more thorough operation and the removal of a more extensive growth than a simple thyrotomy. Whether or not it is advisable to split the thyroid as a preliminary does not affect the principle of the operation, which is the removal of the cartilage as well as the soft parts.

Total Laryngectomy for Cancer, Three Years after Operation.—Dan McKenzie.—The patient was shown before the Section on March 7, 1913. The operation took place on January 12, 1913, having been preceded by tracheotomy fourteen days before. Novelties in the technique consisted, first in the treatment of the trachea, the upper end of which, after division, was closed with catgut sutures while the tracheotomy tube was left in the tracheotomy opening. Three weeks after operation the upper end of the trachea began to gape, and the tracheotomy tube was removed from the tracheotomy opening and inserted into the upper end of the trachea, allowing the tracheotomy wound to close.

The interval during which the upper end of the trachea remained closed was that during which wound discharges are most liable to cause pulmonary complications. It is to this precaution that the rapid apyrexial recovery of the patient is attributed. There is now, three years since the operation, no sign of any recurrence. The cervical glands, none of which could be felt on palpation, were not removed.

The PRESIDENT: Would it not be practicable to insert a tube upwards, and so improve the voice?

Leukoplakia of Vocal Cords.—Herbert Tilley.—The patient is a stout, healthy-looking male, aged fifty-two. He complained solely of hoarseness, but in reality it was a gruffness of his normal voice. No

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history of syphilis. Wassermann reaction negative. On the right side of the tongue there was a small smooth patch suggestive of chronic superficial glossitis. No other stigmata of syphilis in the throat or elsewhere. The vocal cords were slightly congested but freely movable. From the middle of the upper surface of each cord, and extending to within ¼ in. of the anterior commissure, a dead white patch could be seen, in appearance identical with the plaques seen in a leukoplakic tongue. The surfaces of the plaques are flat, and there is no suggestion of ulceration, thickening, or infiltration of the cords in the neighbourhood of the white patches.

The fact that both cords are affected, and that they are normal in the immediate region of the anterior commissure—*i. e.* that the plaques are not continuous—would seem to negative the idea of their being an early stage of epithelioma, and the term "leukoplakia" has been given because the appearances are so like that condition when seen on the tongue.

The PRESIDENT: There is more growth on the left cord than on the right, and an interval between without growth; there is some flagging of the left cord, and there the growth goes down some distance. The diagnosis seems to rest between malignant disease and tubercle. At present no one can say what it is with certainty, and the case must be watched.

Sir STCLAIR THOMSON: I should not like to make a diagnosis. The cords are abraded, and one may be ulcerated; and there is on both of them this white sloughy membranous secretion, which Mr. Tilley says he has brushed off and it has returned. It may be some infection from the nose or some local suppurative infection. As it is on both cords, tubercle seems more probable than malignant disease.

Mr. STUART-LOW: I had a case like this sent to me from South Africa; the patient had the same condition on one vocal cord. The late Sir Henry Butlin once sent round some statistics relating to the spread of infection from one cord to the other, and asked us to give him details of our experience of the process.

Mr. TILLEY (in reply): I show the case here because I think I have not seen one exactly like it before. The man is strong, stout, and perfectly healthy. He has no physical signs of tubercle, and there is no history of syphilis; the Wassermann test is negative. Beyond the slight gruffness of his voice, which he has had for eighteen months, there is no other symptom. On the right side of the tongue we found a smooth patch which suggested chronic glossitis, and he has therefore been having, since December 4, 10 gr. iodide of potassium three times a day and $\frac{1}{16}$ gr. of perchloride of mercury in solution. He says he is better, and that his throat and voice seem better; but I cannot detect any difference in the laryngeal appearances. I show him because of the possibility of early malignant disease. While he has been under my care I have had under my notice a medical man whose somewhat similar laryngeal appearances have puzzled me very much; but they were limited to the right vocal cord. Some fifteen years ago he suffered from a digital chancre, and two years later I saw him with a gumma under his right Eustachian tube. Six years after that, in spite of different courses of treatment, he comes with this patch on the right vocal cord, which I took to be a recrudescence of his old trouble. But injections of grey oil and iodide of potassium internally did not result in its disappearance. I wondered whether it was early epithelioma. The condition disappeared after a week's vocal rest. The patient shown to-day cannot take

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a week's vocal rest. I could not convince myself that there was any deficiency in the movement of the left vocal cord. I think I shall let the case run a little longer, keeping an eye on him; and if I find any sudden increase in size of the patch, or evidences of infiltration, I shall operate at once. In answer to Sir StClair Thomson, I have rubbed that patch twice with nitrate of silver, and it is adherent. I do not think it could be wiped off or that the epithelium could be removed with forceps.

Case of Hypopharyngeal Carcinoma; Removal; Restoration of the Wall by Turning in a Piece of Skin.[1]**—W. M. Mollison.**—

The PRESIDENT: We are glad to see cases of this rare operation, and hope this case will be more successful than the original series reported by Mr. Trotter. No cure was recorded in his five cases. I should like to see this patient again at the end of a year, if she is then alive.

Dr. DUNDAS GRANT: Mr. Waggett showed a similar case here one or two years ago, and I do not think he reported any recurrence in it. I do not think he turned in a flap of skin, a very admirable part of the operation in this case. I am particularly interested in this condition, because it was I who suggested it should be made a subject of discussion at the last International Congress—*i. e.* post-cricoid carcinoma. It had been forced upon my attention by the fact that I had seen several cases in remarkably young women, a surprising fact considering that we had been brought up, as it were, on the idea that carcinoma of the larynx in women was very rare. It has now become a very important chapter in laryngeal surgery. Such cases as this encourage us.

Mr. CYRIL HORSFORD: I have a similar case of pharyngeal cancer, in the lateral wall, very early and limited, except that it is now beginning to encroach on the larynx. There is no palpable gland, and I thought it would be suitable for Mr. Trotter's method of lateral pharyngotomy. But the prognosis in this class of case is so bad that one hesitates before advising such a severe operation. I ask whether, after his experience, Mr. Mollison can say my case is likely to be capable of being dealt with satisfactorily by his method.

Mr. MOLLISON (in reply): I brought the patient forward so soon after operation because of the interest of such cases, and to emphasise the comparative ease of the operation under intra-tracheal insufflation of ether; this does away with the necessity of tracheotomy beforehand, and the tube in the larynx does not get in the way after opening the pharyngeal wall. I dissociate these hypopharyngeal cases from pharyngeal cases; they are usually women between thirty-five and forty years of age. I undertook the operation in this case because the history was comparatively short—only four months—though doubtless the ulcer had been there some time previously; also she had a long thin neck, which made the operation comparatively simple. I followed Mr. Trotter's method, as described in his Hunterian Lectures, but found I had to remove the lateral lobe of the thyroid gland to get low enough to reach the lower edge of the ulcer. Then one could remove the whole wall of the hypopharynx and strip it off the back of the cricoid, leaving only a narrow strip of mucous membrane to make continuity of the upper with the lower parts. The turning in of the skin was comparatively easy; when it was fixed in position a tube was passed from the mouth through the œsophagus to the stomach; on its removal at the end of three days

[1] See JOURN. OF LARYNGOL., RHINOL., AND OTOL., April, 1916, p. 129.

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the junction was quite water-tight, and at no time since the operation has any food come through.

Plastic Operation for Nasal Stenosis.—W. Stuart-Low.—Patient, a soldier, wounded at the battle of Ypres four months ago, received a very severe injury to the nose, which was quite flattened, the bones of the septum being crushed and the alæ forced down flat. He underwent repeated operations in the military hospitals in order that a nasal passage might be re-formed, and when he was sent to the Central London Throat, Nose, and Ear Hospital, the anterior nares were quite obliterated by cicatricial compression. Moure's operation was performed. The right ala having been freed and the soft structures towards the inner canthus turned up, passages were then bored out in the flattened tissues, and a long inner tracheotomy tube placed in them. This was found very useful indeed in maintaining the opening, as its flange prevented it passing in too far. Soft catheters were then passed twice daily into the passages and naso-pharynx and out at the mouth, and these were pulled see-saw fashion for five or ten minutes at a time. The catheters were greatly enlarged, and now No. 12 is used. This was found very effectual in maintaining and enlarging the passages, which are now good. He can breathe quite freely, even at night.

Naso-pharyngeal Fibroma.—F. A. Rose.—A boy, aged twelve and a half. A swelling has been noticed in the left cheek for seven months. There has been bleeding from the nose upon about twenty different occasions. A smooth, firm, rounded tumour fills the left side of the naso-pharynx and the posterior part of the left nasal fossa. A portion of the growth projects below the malar bone. The left eye is proptosed.

The PRESIDENT: I suppose the question here is as to the best method of approach. I am not now so inclined to use the mouth operation as I used to be. In this case I would do something like Moure's operation as a beginning, and then go further down if necessary, from the upper part of the maxilla and through the alveolar process, so as to get a good exposure of the growth through the front of the face. It may be possible for Mr. Rose to operate through the mouth and secure a good result, though I doubt it. We could not very well palpate the growth to define its limits posteriorly.

Dr. KELSON: It is doubtful whether it is a simple naso-pharyngeal fibroma. It seems more like certain malignant cases which one sometimes sees.

Dr. JOBSON HORNE: I attach importance to the site of origin of the growth being determined before its removal. So far as I have been able to examine the case the growth appears to me to be antral and not naso-pharyngeal in origin.

Dr. KENT HUGHES: I palpated this case in the hospital and I do not think it is naso-pharyngeal; I think it arises from the antrum. It is prominent in the nose and adherent to the septum and turbinate; there is proptosis and a fulness above the zygoma. I doubt whether it is simple fibroma.

Plumbism and Pyorrhœa associated with Passive Œdema and Thickening of the Uvula, Epiglottis, and Arytænoids, with Enlargement of the Glands in the Parotid and Submaxillary Regions.—Jobson Horne.—The patient, a man, aged fifty-seven, is a sanitary fitter. For thirty-one years in this occupation he has been

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working with red and white lead and paint. On September 1, 1915, he came to the Metropolitan Ear, Nose, and Throat Hospital on account of deafness, and mentioned that there had been some "swellings in the neck." Eighteen months previously he had attended on account of "closing of the throat." At that time it was noted that the uvula was enlarged and the arytænoids were œdematous, but no enlargement of the glands was recorded. Upon further inquiry it was ascertained that he had had similar throat symptoms at intervals before his first attendance at the hospital.

Towards the latter part of November, 1915, there was a recurrence of the "swellings" about the neck, and in January of this year he attended again at the hospital. There were then, on the left side, three obvious swellings, one over the parotid and two at the angle of the jaw, of the size of damsons, discrete and free from pain or tenderness; another and similar swelling, but less obvious, was symmetrically situate over the right parotid region. The teeth and gums were in a very unhealthy condition—tartar, pyorrhœa, gingivitis, together with a faint blue line. The uvula was enlarged almost to the size of the tip of a little finger, the epiglottis was considerably thickened, obscuring a complete view of the larynx, but the arytænoids were seen to be enlarged. The voice was natural, but there was some difficulty in swallowing. Twenty-one years ago the patient was laid up for thirteen weeks with pneumonia. Examination of the lungs and heart yielded nothing abnormal. There was no sputum and no cough. There was no history of any specific disease nor of tuberculosis. There were no enlarged glands palpable other than those mentioned. The glandular enlargement was probably due to local causes. The treatment given was quinine (1 gr.) and iodide of potassium (5 gr.) thrice daily, and a mouthwash of peroxide of hydrogen. Within ten days there was instantaneous and marked improvement, the "swellings" rapidly subsided, and the patient expressed himself as feeling decidedly better.

Mr. Clayton Fox: I think it is probably primary tuberculosis in the upper deep cervical and parotid lymphatic glands. The condition of the uvula is certainly not tuberculous, but there is some infiltration of the epiglottis without œdema. I regard the œdema of the uvula and arytænoids as secondary to lymphatic obstruction.

Dr. Donelan: I noticed that the œdema of the epiglottis has almost disappeared, doubtless as the result of treatment. The œdema of the uvula and the glandular enlargement are still present. I was unable to detect any evidence of tuberculosis in the larynx.

Dr. Jobson Horne (in reply): The possibility of the lesions being due to tuberculosis has been kept in mind, but so far no clinical evidence has been obtained to support the suggestion. Moreover, as there has been such a remarkable subsidence in the glands and reduction in size of uvula and epiglottis after ten days of treatment with iodide of potassium (5 gr.) internally and peroxide of hydrogen as a mouthwash, I am all the more inclined to associate the condition with plumbism.

Intense Dryness of the Mouth, associated with Ulceration of the Pharynx.—Cecil Graham.—Female, aged forty-six, noticed loss of voice, suddenly, towards the end of November, 1915. She had pneumonia four months previously, but was well during the interval preceding the loss of voice. She has no moisture in the buccal cavity, the mucous membrane being perfectly dry; and superficial furrows are seen on the tongue which are formed by the papillæ and which do not

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extend into the substance of the tongue. The pharyngeal wall is coated by sticky mucus, and shows superficial ulceration from the naso-pharynx to the arytænoids. The vocal cords are pink and fleshy, and their close apposition is prevented by inter-arytænoid thickening. The left nasal fossa is clear, and the maxillary sinuses are translucent, but there is some inspissation secretion, small in amount, in the right middle meatus.

Dr. DUNDAS GRANT: I think the condition of the larynx was secondary to the nasal suppuration, the swelling in the inter-arytænoid space being due to infection by the inhaled pus. The vocal cords are red rather than infiltrated; that may be secondary to the dry mouth and to the crusts in the nose. I do not know what is the cause of the dryness of the mouth.

Dr. KELSON: I think this patient's urine should be examined; the case reminds me of appearances seen in diabetes.

Sir STCLAIR THOMSON: The appearance suggests that something has been going on for some time, because in the inter-arytænoid region there is that chronic hypertrophy which is generally associated with the descent of pus from the nose or with a late syphilitic manifestation.

The PRESIDENT: This afternoon Mr. Graham has received an intimation that the Wassermann reaction is positive. There has doubtless been purulent rhinitis for years and a secondary atrophic rhinitis with descending atrophic trouble.

Chronic Syphilitic Laryngitis with Marked Stenosis.—William Hill.—Man, aged thirty. Primary syphilis contracted ten years previously. Severe tertiary ulceration and deformity of larynx one year ago, necessitating tracheotomy. Portions of hyperplastic tissue have been freely removed through an endoscope, but stenosis has speedily recurred. Patient cannot breathe well through an ordinary intubation tube, showing that the upper end of the trachea is also stenosed. It has been found impracticable to use a Schimmelbusch apparatus through the present ordinary tracheotomic orifice, and in view of the syphilitic nature of the lesion, with the tendency to contraction, the exhibitor has hesitated to resort to any further cutting operation. Suggestions are invited as to any other treatment.

Dr. DUNDAS GRANT: I suggest he should try Thost's dilators, which are passed from below upwards. The horizontal limb of the plug goes underneath the tracheotomy tube; they are graduated and can be used one after the other. Possibly after reopening the larynx one could again do the laryngostomy.

Lupus of the Mouth and Throat.—W. Kent Hughes.—Patient, a female. There is a large nodule on the side and under surface of the tongue, divided into two by pressure upon the second bicuspid (left lower). The under surface and extremity of the tip have now a granular surface, but until recently were occupied by a large flat nodule. The left side of the lower jaw is extensively involved in the region of molars and second bicuspid. The epiglottis has almost disappeared, but the disease in this region is quiescent.

I am not responsible for the diagnosis of lupus; the case was sent to me by Mr. Harmer. This is about the only pest which does not luxuriate in Australia; I have not seen an instance there. Five years ago the woman had occasional loss of voice, and four and a half years ago she noticed that her epiglottis was affected, next the lower part of the base

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of the tongue, then the tip of the tongue, lastly the jaw. Three years ago she came under Mr. Harmer's care, and he gave her tuberculin, and that improved the larynx and base of the tongue, but had no effect on the anterior side of the tongue or the jaw. Then 60 gr. sodium iodide by ionisation was tried, twenty applications, and she has had forty applications of the Simpson lamp. That was last November, and I did not see her again until a fortnight ago, when she was steadily becoming worse; therefore I decided to try the effect of Spengler's I.K. therapy. I have had only a small experience of that treatment, but it has been so striking in the person of my wife that it seemed worth trying in this case. Spengler advised it in lupus and tubercle, and the result has been most surprising in a fortnight, the tongue condition having half cleared up in that time, and the girl eats better and feels improved in every way. On testing by Spengler's precipitation test, which he admits is only a rough-and-ready method, an enormous improvement in the patient's resistance is seen. My wife's case was a most striking one: she had been "going down hill" for seven years, and at one time had twenty bacilli per field (that was last October); now she has only one bacillus in five fields, she is putting on weight, and in the last ten weeks her temperature has only once been above the normal.

The PRESIDENT: With regard to lupus of the throat, nose, larynx, etc., in my experience one falls into the pit now and then if one fails to have a Wassermann test carried out and carefully done. I have seen many cases diagnosed as lupus when the condition was syphilis, and *vice versâ*.

Mr. HUGHES: Wassermann's reaction was negative.

Abstracts.

PHARYNX.

Roy, Dunbar.—Partial Paralysis of the Soft Palate following Removal of Tonsil and Adenoids. "Laryngoscope," 1915, p. 361.

The writer has apparently had his nerve somewhat badly shaken by an unfortunate result of removal of adenoids and tonsils. The patient was a male, aged four, who was operated on on May 20, 1913. Complete enucleation was accomplished without trouble, and "with less traumatism than usual." Two days later there was no pain in the throat, but a week after that the child was brought back with a history of fever (101° F.), malaise and inability to articulate distinctly. On swallowing, liquids returned through the nose. Examination showed the pharynx to be in good condition—both pillars appearing normal. The tongue was coated. The child was given small doses of strychnine, and later the naso-pharynx was irrigated with alkaline lotion and touched with argyrol. Within ten days the temperature subsided and the patient was able to swallow better, but the soft palate still had a leathery look. Within the next month the voice was practically normal.

Roy gives it as his opinion that operations for the removal of tonsils and adenoids should not be looked upon as a simple procedure, but should have the same thought and care "as any other major surgical operation." Within the last few years Roy has seen various mutilations of the pharynx caused by the so-called tonsillectomies. The anterior and posterior pillars are often united into one flat cicatrix, and in many

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