SOCIETIES' PROCEEDINGS

THE NORTH OF ENGLAND OTO-LARYNGOLOGICAL SOCIETY

A MEETING was held on January 21st, 1950, at the Royal Eye and Ear Hospital, Bradford. Cases were demonstrated by MR. DONALD WATSON, MR. J. H. OTTY and MR. KAVANAGH.

CASE I, MR. WATSON.

Mr. H. W. Aged 48. Huskiness of voice 4 years. Right cord fixed, false cords thickened and overlapping. Chest X-ray negative. W.R. and sputum negative.

MR. TUMARKIN had noticed the dramatic history of " something going " in a man's throat when stumbling. Could this have caused a hæmatoma? Probably it would remain unchanged.

MR. FINLAY BROWN saw a similar case 4 months ago following a severe bout of coughing. He is gradually recovering his voice.

MR. SIMPSON had had a case of fixed cord after influenza. It came on after severe bouts of coughing, of the explosive type. He had another case of fixed cord as the result of direct trauma to the larynx in a Rugby player. The thyroid cartilage had been injured causing a hæmatoma.

CASE II, MR. OTTY.

R. H. Aged 45. Seen June, 1948. Hoarseness 3 months after swallowing a fish bone. No pain or dysphagia. Right arytenoid œdematous and fixed. Excess secretion in pyriform fossa. Endoscopy showed ulcer on posterior surface of right arytenoid. Biopsy—no new growth found. Seen at intervals. *2.4.49*, granulomatous mass in anterior commissure, removed *10.6.49*. Biopsy—no new growth found. W.R. and Kahn negative. *3.10.49*, larynx clear. Swelling and fixation of arytenoid persist.

MR. OTTY regarded this case as an arthritis of crico-arytenoid joint, because of the persistence of the ulcer for 3 months after swallowing the fish bone. He had removed simple granuloma from the anterior commissure.

MR. GRAY thought the patient's story true and that the bone was still present. She had some granulations still in the anterior commissure, which probably marked the anterior end of the bone, the ulcer on the post-cricoid surface being the site of entrance. He had a similar case of a woman who swallowed a needle which passed through the length of a false cord.

MR. JOWETT had had a similar case after removal of a boot protector, in a child of 18 months, with the road surface on the posterior pharyngeal wall. One of the spikes was in the crico-arytenoid joint. He was able to get it out

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with a certain amount of difficulty. It resulted in a fixed cord. At age of 4½ the child had whooping cough and died in a paroxysm.

MR. OTTY would have had him X-rayed to see if there was a foreign body but it probably would not have shown. When last seen in December no granulations were present.

CASE III, MR. OTTY.

Mr. J. R. Aged 35. Congenital occlusion of posterior nares. Mr. Otty showed this case as he thought the younger men might not have seen a case before.

MR. TUMARKIN asked if it would be worthwhile excising the septum as he would then be able to blow his nose.

CASE IV, MR. WATSON.

Mr. E. H. W. Aged 39. Keratosis laryngis after glossitis.

MR. WATSON. Routine examination revealed curious formation, and on a second examination of the larynx he saw one cord, the right, " plastered with white paint ". Since then the condition has varied, got more granular, but is a very fine example of keratosis laryngis.

PROFESSOR LAMBERT had had three cases, and watched them all as a pre-malignant condition, which he would treat by radium. The point to remember is that when these cases go over the border-line they go like an acute inflammation. He would treat them all as malignant.

MR. THOMAS asked if Members knew of an hereditary factor in keratosis laryngis. He and his predecessor, Dr. Acomb, had had a man under observation for 15 years. His son had now developed the disease and had been observed for 3 years. Another sibling was known to have it.

MR. SIMPSON had had a case passed on by Mr. Ritchie Rodger, which was watched all through the war years. Two biopsies had been done, and his first opinion on clinical grounds was that the condition was malignant. The patient was lost sight of for a year, but reported again at Out-patients with a huge inoperable carcinoma.

MR. THORBURN had seen a simple keratosis which became malignant, and he was interested to know why Professor Lambert had changed his mind regarding treatment, as he had originally been against it.

PROFESSOR LAMBERT said that he had changed his mind as the result of seeing a case starting after influenza. It began to grow up, then ran over the border-line. He is now emphatic that treatment should be as a pre-malignant condition, and would treat it by irradiation. He would use the Finzi-Harmer operation if indicated, but prefers irradiation.

MR. TUMARKIN wondered if there was a single form or more than one variety. Pathology seemed varied.

MR. FINLAY BROWN had had a case and done biopsies that were inconclusive. He subsequently got another biopsy that was malignant and the new pathologist went back over the old sections, examined them carefully, and would originally have reported carcinoma, the exact pathological significance of which he could not express an opinion about.

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CASE V, MR. OTTY.

R. M. Aged 14. Nasopharyngeal fibroma shown at first meeting of the Society.

MR. OTTY. It had been proposed to treat this case with injections of sodium morrhuate. This had been done, and he now showed the result.

MR. ARCHER had followed Mr. Otty's original suggestion in a case of a large nasopharyngeal fibroma which was about the size of a tangerine orange. It was injected with sodium morrhuate at weekly intervals at first, later the length of time between the injections was increased. The growth disappeared completely in about 6 to 8 months. There was atrophic crusting in the right side of the nose, the septum having been pushed so far over to the opposite side by the growth. He proposed later to do the septum operation to remedy this. The disappearance of the growth was quite dramatic, some of it coming away in large sloughs. As far as one could tell, its point of origin was above and posterior to the inferior turbinal, but it was very difficult to determine as it seemed to have a wide base, and when first seen it filled the nasopharynx and came half-way forward in the right nasal fossa.

MR. BLACK had had one case recently, affecting the posterior part of the septum and roof of the nasopharynx, and was seen lying along the left nostril. It was pulsatile on palpation. At biopsy it bled profusely. The histological report showed something like granulomatous tissue—a soft fibroma. He injected it with sodium morrhuate and tried diathermy needling. When he stuck the needle into it there was a pulsatile stream of blood from the needle hole. It disappeared completely in 2 months.

Since then he has seen an adult with one mainly posterior ethmoid behind the eye, causing proptosis. It was like a hæmangioma on biopsy. It had not done so well with injection of sodium morrhuate.

MR. OTTY queried the advisability of radical or conservative treatment. He thinks they will probably disappear, going with the approach of puberty.

MR. TUMARKIN asked where we were getting to with sclerosants.

MR. OTTY had had a tumour in Aberdeen similar to Mr. Black's which bled furiously every time it was touched. From the first injection no further bleeding occurred and afterwards O.P. treatment ensured adequate airway. Two more cases disappeared after watching.

PROFESSOR LAMBERT queried that they were nasopharyngeal fibromata on account of age. He thought we were getting tied up with terminology. Simple tumours of basisphenoid tend to go, not at puberty, but a good deal later on.

MR. OTTY said first boy started off when 14 years, and continued to 23, and the other case was about 17.

CASE VI, MR. WATSON.

Mr. M. Nasopharyngeal fibroma.

MR. WATSON. This tumour commenced growth in the nasopharynx, and instead of growing forwards, grew downwards. The tumour shelled out easily enough, but he encountered very troublesome bleeding, which was very difficult to stop. In evening further severe hæmorrhage.

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MR. THORBURN did not agree that this could be called a nasopharyngeal fibroma because of his age and because it was not restricted to the naso-pharynx. He thought it was an ordinary fibroma which happened to be growing in the pharynx.

MR. BLACK suggested that this case could be called a fibroma and may be similar to a mixed salivary type of tumour. There are quite a lot about.

CASE VII, MR. KAVANAGH.

A boy aged 8. Swelling in nasopharynx, appearing below soft palate. For diagnosis.

MR. BLACK suggested a biopsy.

MR. OTTY was reminded of a series of cases of lipomata reported by Norman Paterson. The pathology cannot be established until after a biopsy or the removal of the tumour, and this is an eminently removable tumour.

MR. THORBURN advised that a biopsy be taken to exclude malignant disease. The appearances, however, were not wholly inconsistent with lymphoid hyperplasia following a bad removal of adenoids.

MR. SIMPSON suggested more radiological investigation desirable.

MR. KAVANAGH said X-rays had been taken and showed a soft tissue swelling with what might possibly be a denser swelling lying above or behind. He will have more films taken.

CASE VIII, MR. OTTY.

Mrs. F. C. Aged 42. Result of Woodman operation for bilateral abductor paralysis of vocal cords.

MR. OTTY explained that the operation was from behind thyroid cartilage and not through the window.

MR. LAWSON, after discussing the operation with Mr. Otty, realized that he had done it himself, but had thought it King's operation. He would be interested to know if Mr. Otty had found it difficult to do. He had found it a difficult procedure to work behind the pharynx.

MR. OTTY confirmed this difficulty in operating. He would find it easier next time, however, because he didn't realize how high up the body of the cricoid comes. Arytenoid cartilage a good deal higher up. Preferred that approach to doing it through a window.

CASE IX, MR. WATSON.

B. W. Meningitis. Lateral sinus thrombosis. Recovered.

MR. WATSON said that this was a child aged 5. The case was interesting because he had removed the bone right back to the torcula, and now hair was growing in the scar. Also, because every time it was dressed she flicked her nose, which was a reflex through the middle meningeal branch of the 5th. He had kept her on sulphathiazole for a day or so, when she progressed, and took her off for a few days and she went back, and he had discussed the case with Mr. Ewart Martin (with whom all members would feel sympathy in his illness). Mr. Martin had advised keeping the child on sulphathiazole, as he had had a case of osteomyelitis of the upper jaw which had been on sulphathiazole continuously for 7 weeks. Mr. Watson did so, and she thrived on it.

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MR. SIMPSON thought the case was interesting in that he wondered if many younger men had seen the long, swinging temperatures that were frequently met with in his younger days.

CASE X, MR. WATSON.

Mrs. W. Leontiasis ossium. Result of four operations.

MR. WATSON said that before operation this case was a very ugly woman. Mr. Basil Hughes had removed a bit of bone from under the left eye. Mr. Watson had lifted the whole of the face and carved away excess bone with a gouge. In those days one used the Newcastle bipp, and the woman healed up without any bother. Two years later she had two little bony growths under her eyes removed by local excisions. She now has a well-fitting dental plate. If it were to grow again he would not have the slightest hesitation in removing the bony growth.

CASE XI, MR. OTTY.

Mrs. D. P. Aged 35. Case of mixed parotid tumour upper end of trachea.

MR. OTTY had regarded the patient as a bronchial adenoma, and considered the possibility of irradiation, dismissed it, and then excised the larynx.

GROUPS A AND B. MR. WATSON. *Results of Finzi-Harmer fenestration and interstitial irradiation for extrinsic carcinoma of larynx.*

MR. WATSON said that this had been discussed at other meetings, but he wished to show the results. Up to 1927 or so he had cut the larynx about a good deal, and removed part of the upper jaws. The results were not satisfactory so he decided to send his next two laryngeal cases to London, where he had heard of excellent surgical results. They both died. In 1928, Dr. Chester-Williams, the radiotherapist, arrived in Bradford, and it was a very fortunate day for Bradford when he did. They decided to collaborate, and now if Mr. Watson has a case they always see it together. They may or may not decide it needs a biopsy for diagnosis. In some cases they did not do biopsies. He expressed his great appreciation of Dr. Chester-Williams as a colleague. He knew a lot about cancer and a great deal about radium. They had done 39 cases, some not intrinsic carcinomas. The last series were all intrinsic. There had been a lot of argument as regards biopsy. He was of the opinion that when two people agree a case is malignant there is no need to take a section. The " proof of the pudding was in the eating " and when a tumour is treated with radium and it disappears, the inference is that it is a carcinoma.

PROFESSOR LAMBERT disagreed about biopsies, but agreed to this extent, that if he thought that a cord was malignant, even although the section was negative, he would treat it as malignant. Bigger centres, in which you would include Manchester and Bradford, should set a pattern in treatment, and if treated cases were not proved malignant by biopsy, then statistics were unreliable and the value of a method difficult to assess. He thought that young surgeons should be brought up to do biopsies. In a whole series of cases in Manchester, it was found that a biopsy did not prejudice the end result, in fact, cases in which a biopsy had been performed had done better than those in

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which a biopsy had not been carried out. Manchester was much more conservative in its application of the Finzi-Harmer operation than other centres, and it was not used where the posterior part of the cord was involved.

MR. LAWSON asked if the cords were ever known to be deformed permanently as a result of taking a biopsy ?

MR. WATSON said they were always deformed and hoarse. The parson in the series wasn't, because he may have used his voice freely in the beginning. His oldest case, done 19 years ago, had always been a bit hoarse. Patients who are dependent upon their voices for their livelihoods should not have any investigation by biopsy that will prejudice their voices after treatment.

DR. CHESTER-WILLIAMS then addressed the meeting on the treatment of carcinoma of the larynx by radium. He said he had not realized he was to be asked to speak and so had brought no notes with him. The treatment by Harmer's fenestration method was comparatively simple and in a large measure depended on using needles of the right size and the right strength. The main point in the surgical procedure was that the window should be neatly cut out of the cartilage leaving no ragged edges and not damaging the muco-perichondrium. The clergyman who is shown in one of the cases was a most satisfactory case. He had taken Holy Orders late in life and after 2 years' service in the Church had developed carcinoma of the larynx which was treated by Harmer's fenestration method. Within 3 months of treatment he was again able to intone the responses.

There is no point in taking a biopsy though the diagnosis was reasonably certain. In carcinoma of the cervix one could take a biopsy without affecting a patient's economy, but in the larynx such biopsies might damage the cord and affect the functional result. With regard to the radiological details in Bradford, we used a variety of needles of varying overall length so as to ensure satisfactory implant into the window, the active length of the needles being cut.

In association with Mr. Donald Watson he had had only one case of perichondritis which made an uninterrupted recovery. The usual procedure was to leave 9 to 10 mgms. of radium *in situ* for a week, giving approximately 6,000 r to the cord.

MR. WATSON didn't agree with Professor Lambert about the statistical results. He thought result to the patient was more important. The young men could do biopsies to be sure of their diagnosis, but when one has seen a lot of cases there is no need to do one. Mr. Watson had a confession, however. He did do one which was a carcinoma to look at, which disappeared. The man now had an ulcerated larynx and his W.R. is positive. Fifteen years ago at Colne, he saw a case with a typical carcinoma ulcer on the posterior pharyngeal wall. She had a laryngo-fissure by Mr. Milligan in Manchester previously. She was not treated with radium, but with diathermy. She went home quite happy, and he saw her once more. There was no difference in the look of the ulcer. She reported again some time after complaining about her ears, and during the course of the examination he asked her about her throat. She told him she had gone to the doctor and he had given her the same bottle of medicine as before, and her throat was quite better.

MR. OTTY did not think that the Finzi-Harmer operation gave comparabel results with laryngo-fissure.

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MR. WATSON described the method used by Souttar. Plaques were placed in two vertical incisions either side of the larynx. It was a very simple operation to do. They always did a biopsy to make sure of the extent of the growth. The woman shown had returned after Souttar's operation with what they thought to be a recurrence, but it turned out to be fibrosis. The man in the series had the side opposite the tumour start to suppurate a little where dressing on the right side, but he is much more comfortable to-day than he was.

PROFESSOR LAMBERT hoped that if Mr. Watson did any more of this Souttar's technique of interstitial irradiation, he would publish his results, and not maintain a discreet silence about them.

GROUP C. *Operative treatment of intrinsic carcinoma of larynx. This was not given any particular discussion.*

GROUP D. MR. OTTY. *Four cases of pharyngeal diverticulum.*

MR. OTTY apologized for the lack of X-rays in these cases. He had done 15 cases now, and the first 4 had been done by the two-stage method, dividing and separating the sac, and anchoring it. Every one of these recurred. Since then with the advent of penicillin and sulphonamides, all had been done with the one-stage method, and so far there had been no trouble. The majority had healed by first intention. He thought that sulphonamides had revolutionized the work here.

MR. LODGE congratulated Mr. Otty on the success of his cases. The few cases that had come Mr. Lodge's way had been in elderly patients who would not consent to any operation attended by much risk. He had therefore freed and inverted the sac, which was not at all difficult, and drawn it up into a little pocket made for it, by blunt dissection, between the upper pole of the thyroid gland and the larynx, where it was secured by stitching to the fundus of the sac, the upper end of the superior belly of the omohyoid muscles, cut across for this purpose. He understood that the objection to such methods is the possibility of development of malignant disease in the sac, of which instances have been known. In these cases, however, the patients were so old that remote malignancy was less to be feared than immediate mortality. Antibiotics had certainly altered the position, and Mr. Otty's operations were clearly on the right lines.

MR. BLACK asked what means of identifying the sac was used ? The last one he had done, he put an œsophagoscope into the sac first, packed it with gauze, then it was easily liberated by blunt finger dissection.

MR. OTTY said the sac had often been easily identified, by putting the œsophagoscope into the sac.

MR. THOMAS had experience of six cases of pharyngeal diverticulum. One had had the diverticulum removed 10 years previously, and had developed a carcinoma in a recurrence. This supported Mr. Lodge's statement. Three patients had been operated on successfully, and two more who were very old, were treated by simple dilatation of the upper œsophageal sphincter. With regard to the identification of the sac, he had found inflation of a rubber balloon within, a great help.

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MR. SIMPSON said the simplest way to dissect the sac is with the œsophagoscope still inside it. The sac should always be excised. Before excision of the sac, the cricopharyngeus sphincter should be widely dilated.

MR. OTTY confessed that when he got down to the neck of the sac he had been inclined to risk a certain amount of stenosis to get rid of it later than stress dilatation. One case had had sac excised previously by one of the general surgeons, and he had the utmost difficulty in identifying the neck of the sac. There was a risk of chest complications.

GROUP E. MR. OTTY. *Two cases of laryngeal papillomata. A boy and a girl.*

MR. OTTY said the little girl had had some form of radiation (untraceable) and he thinks hers will disappear spontaneously. The boy has had removal on numerous occasions, and has also been painted with œstrogen oil, but there had been no appreciable difference. He removed them by using a gum elastic catheter and when catheter was in place, removed the papillomata round about. This was a satisfactory method because he had a sucker and an air-way. Beyond repeated removal what is the answer?

MRS. CAVANAGH said she was interested in the problem of multiple papillomata. She, too, had used Dimenform to paint with, but had had no improvement. Speaking to the dispenser, however, had revealed that there were two units. She had previously used the weaker solution, but apparently the new type has ten times the strength of the other, and she now intends to try the new strength.

MR. SIMPSON had also had a series of papillomata. He had removed some 7 or 8 times, and now the case was clearing up. A girl is clearing on œstrin in the strong solution. In a third case he had tried simple removal and œstrin, but with no result. The papillomata could be seen growing like waving seaweed on the posterior pharyngeal wall. In desperation he gave radiotherapy, and although he thought he would lose the boy from the reaction, the papillomata have now disappeared completely. He is the only success with radiotherapy.

PROFESSOR LAMBERT had had two cases which he had been able to watch beyond the age of puberty. One of these, a female, had been irradiated at about the age of 10, and the papillomata were still present at the age of 26, and it made him think that irradiation had done harm. He said that he had discussed the problem with Colledge, and he was very strongly opposed to irradiation of any kind in the papillomata of childhood.

MRS. CAVANAGH said that in her case, the mother produced something which might have been a red herring, but was of interest. Just before this child was born she had been treated for vulval warts. Mrs. Cavanagh wondered if the child could possibly have inhaled any infection whilst passing through the birth canal?

GROUP F. MR. WATSON. *Five cases of acute frontal sinusitis.*

MR. WATSON had reported on the first case in the Journal, but there was nothing to see now. He was cured purely and simply with penicillin. He had pan-sinusitis and 10 days after his temperature had dropped. Mr. Watson

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put a needle into both antra. There was no pus at all, killed by the penicillin. It is one method that is well worth trying. The next boy had just an ordinary swelling over his eye, and Mr. Watson tried him first of all with pure penicillin. The swelling did not go down, and he did a local drainage there. The next boy had a local drainage but he failed, and Mr. Watson had to do a Howarth's operation. The woman in the series had been a very difficult case, and had had several operations, but nothing that Mr. Watson could do was any good. At the last operation he noticed a small sequestrum, as he thought, in the frontal sinus. It must have been the whole of the posterior wall of the frontal sinus. After removal of that and penicillin she cleared up. This is the danger, there may be some dead bone somewhere. The next case had also been tried with an original incision. He didn't do well, and so the Howarth's operation was repeated, and at the last operation skin-grafting was also done. Possibly the best procedure would be to skin-graft these cases originally if a Howarth's is to be done.

MR. MCGUCKIN thought the cases fell in two groups, genuinely acute and chronic or relapsing. In new acute lesions having an efficient blood-supply, blood-borne therapy might be expected to produce a good result, and this was a common experience. In chronic lesions the result from such therapy was seldom useful, except that a particular exacerbation might thereby be alleviated.

MR. OTTY agreed with Mr. McGuckin. Many cases are going to respond to sulphonamides and penicillin. He had seen Woods operating in Dublin on a frontal sinus—the Hajek frontal sinus operation. There was not much success in keeping open the fronto-nasal duct post-operatively, and he was not convinced that skin-grafting would do it. The Hajek operation is to expose the frontal sinus and remove the anterior wall, not completely but sufficiently widely so that one can see all the recesses of the sinus, and cut out all the diseased mucosa. The ethmoid is cleared out and then the cavity is a duct, as was done with the old Schwartze's operation, so that it heals with granulations, in the hope of obliterating the frontal sinus by fibrous tissue. Woods removes mucosa and then, strips of mucosa right down to the middle meatus. If the stripping has been done efficiently, the fronto-nasal duct will close, and once this is closed, there is no recurrence. Occasionally, immediately after operation the skin breaks down, and discharges for a week or so. Many heal by first intention.

MR. LODGE thought that as much depended on the pneumatization of the frontal sinus as on that of the mastoid. He had operated that morning upon a case of frontal sinusitis, and there were little round cavities in the frontal bone, reminiscent of pot-holes in limestone rock, or the holes in Gruyère cheese. In such a case the response to penicillin would not be so good. One had to consider the virulence of infection, but the soil was as important as the seed.

GROUP G. MR. OTTY. *Four cases of failure in radical mastoid operations.*

MR. MCGUCKIN said that it was nice to see an exhibition of failures, and *en route* to the meeting he had been considering the various reasons why his own radicals failed. Applying these to the cases shown, the first case seemed to show two factors: a granulating stenosis of the entry and an irreversible

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pathology in the lining of the cavity. There was probably also some osteitis. The boy of 3 had a perfectly good cavity, but was likely to have continuous or repeated discharge through childhood, something similar to the tubo-tympanic contamination in the permanent perforation syndrome. This trouble might well cease at or about adolescence. The patient J.I. had suffered from otorrhœa all his life, but his operative cavity seemed absolutely safe, even though there was the slight nuisance of tubal contamination. The reddening of the promontory hardly suggested an osteitis of the labyrinthine capsule. He was rather sceptical as to what relation there might be between the otitic factor and the patient's cardinal complaint of his eyes.

MR. THORBURN thought that these old mastoid cavities which tend to granulate in a troublesome way, would often respond to zinc ionization.

MR. WATSON suggested Thomas Guthrie's 8 per cent. silver nitrate.

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