SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

President—Dr W. JOBSON HORNE.

March 4, 1921.

Cystomata of the Larynx (Synopsis of an Epidiascopic Demonstration—Dr W. JOBSON HORNE.—Under the term "cystoma of the larynx" have been included conditions clinically alike but not pathologically akin. This explains the differences of opinion expressed as to relative frequency. Sir Morell Mackenzie regarded cystic tumours of the larynx as comparatively rare, whereas Moure, quoted by Bosworth, regarded cystomata as the most common of all the benign growths in the larynx with the exception of papillomata.

The number of cases I have seen, and have been able to collate from the Proceedings of the Laryngological Society of London and of this Section, would not support the views held by either of these observers. The question therefore arises, what may be regarded as *veritable cystomata* of the larynx and what conditions may simulate them.

True cysts of the larynx are *retention cysts* and *congenital cysts*. The former occur only in those parts of the larynx where epithelial glands are found. Hence retention cysts are more commonly found on the epiglottis. Congenital cysts are rarely seen, inasmuch as they occur within the ventricle of the larynx. Close to the anterior commissure, the roof of the ventricle, *i.e.*, the ventricular band, is thinned and through it a congenital cyst might herniate.

The conditions simulating cystomata, or *pseudo-cystomata*, are polypi and growths which have undergone cystic degeneration; eversion of the sacculus laryngis—commonly called prolapse of the ventricle—and circumscribed œdema on the glottic aspect of the arytenoid region.

An Account of Two Cases of Obstruction of the Œsophagus by a Foreign Body acting as Ball-valve—Mr SOMERVILLE HASTINGS, M.S. CASE I.—A woman, aged 30, after severe vomiting in September 1907, suddenly became unable to swallow anything either solid or fluid. A bismuth meal showed a constriction of the œsophagus, a little above the level of the heart, with marked dilatation above it. A diagnosis of malignant stricture was made. After two years her power of swallowing improved. Eight years ago she suffered from another similar attack, which improved after six weeks.

In September 1920, the trouble again recurred, and she presented

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herself at the Middlesex Hospital on 26th November 1920. The œsophagoscope was passed, and 11 ins. from the incisor teeth a large cherry stone was found, resting like a ball-valve on a smooth fibrous stricture of the œsophagus, with a lumen not quite large enough to allow the cherry stone to pass. The œsophagus above this was much dilated. After the cherry stone had been removed the swallowing once more became normal, and when last seen on 4th January 1921, the patient stated that she had put on weight and could eat anything.

CASE II.—Woman, aged 52. For several years she had had occasional difficulty in swallowing, which had always been relieved by manipulation of the neck. On the day of admission, she was eating some Scotch broth with some rather hard peas in it, when sudden obstruction occurred and she was unable to swallow fluids or solids of any kind. At 10 P.M. on the same day the œsophagoscope was passed, and 8 ins. from the upper incisor teeth a large hard pea was seen. The mucous membrane appeared sloughy, and a round constriction, not large enough to admit the pea, was seen. She has had no further trouble.

Case of New Growth in the Left Bronchus—Sir JAMES DUNDAS-GRANT, K.B.E., M.D.—A middle-aged man, with cough and shortness of breath of twelve months' duration. Tubercle bacilli were never found. The larynx was normal. Direct examination by bronchoscopy revealed in the left bronchus a pale flapping growth with indistinct fimbriation. The growth was removed by lower bronchoscopy after tracheotomy.

Two years later the stridor reappeared. On direct bronchoscopy a smooth rounded growth was seen in the left bronchus. The bronchus appeared to be narrowed. It is proposed to carry out removal again after reopening the trachea.

The X-rays show "shadows at the hila very heavy and woolly; lungs translucent; no evidence of deficiency of the air-entry seen."

No microscopic examination of the tissue could be made.

Case of Fixation of Vocal Cord following Healed Tuberculosis of the Larynx—Sir JAMES DUNDAS-GRANT, K.B.E.—A middle-aged man. There is almost complete fixation of the left vocal cord without any material infiltration of the aryepiglottic fold. The immobility is probably mechanical and caused by cicatricial changes following tuberculosis.

Case of Chronic Suppuration of the Antrum of Highmore treated by the Canfield Operation—Sir JAMES DUNDAS-GRANT, K.B.E.—Female, aged 18, had suffered from discharge from left antral cavity for three years. Treatment by irrigation had been without effect. By opening the antrum through the anterior angle, that area of the cavity could be better dealt with than was possible either

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through the canine fossa or through the inferior meatus of the nose. He thought the canine fossa route involved more laceration.

Bilateral Paralysis of the Internal Tensors of the Larynx—Mr PHILIP FRANKLIN, F.R.C.S.—Girl, aged 12. Loss of voice for six months; sudden onset since the age of 4. Several attacks of aphonia lasting a few days.

Notes of a Case of Pharyngeal Pouch removed from a Male, aged 72—Dr W. H. KELSON.—Patient, a man aged 78, had a large pharyngeal pouch removed by exhibitor seven years ago. Complete relief of all symptoms followed until February of the present year when he came complaining of slight difficulty in swallowing, but there was no regurgitation of food. Œsophagoscopy showed marked dilatation at the site of the former pouch, and at the bottom of this there was annular constriction.

The skiagram indicates the presence of malignant disease.

Carcinoma was found post-mortem at the seat of the former pouch.

Case of Left-sided Glosso-palato-vagal Paresis—Mr W. M. MOLLISON.—A female, aged 35, with aching of the throat and loss of voice for two days. The tongue was protruded towards the left side, and the left side was less resistant. The soft palate was drawn up to the left side on phonation. The left vocal cord was stationary. The trapezius and sterno-mastoid on the left side were weak.

The Wassermann reaction is negative.

Case of Lingual Thyroid—Mr GEORGE BADGEROW, C.M.G.—A female, aged 25. A tumour is seen at the base of the tongue, which causes no difficulty in swallowing or breathing, nor does it interfere with speech.

Bilateral Abductor Paresis of Cords with Simple Enlargement of Thyroid—Mr C. F. BEEVOR, M.B.—A male, aged 16. There is a soft regular enlargement of thyroid, both lobes and isthmus being affected. Examination of larynx shows partial bilateral abductor paresis of cords. Patient can lie down in bed comfortably; stridor can always be heard, but is much more marked on exertion.

SECTION OF OTOLOGY

February 18, 1921.

President—Sir CHARLES BALLANCE, K.C.M.G., C.B., M.V.O., M.S.

ABRIDGED REPORT.

Zinc Ionization and Electrolysis in the Treatment of Chronic Otorrhœa—Dr A. R. FRIEL.—(Published in *Medical Press and Circular*, 9th March 1921.)

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Mr GAY FRENCH.—The cases which I have so far treated with zinc ionization are sixty-three. Complete cessation of discharge after one treatment, eighteen—(six of these were treated over a year ago). Twenty-four cases required two to six treatments (most of these were old-standing cases with granulations). Twenty-one cases proved failures; of these, eight are definitely better, but the ear still remains moist; six were subsequently operated on—two were found to have cholesteatoma, and four had old-standing involvement of the mastoid. Personally, I consider this method of treatment is far better than any other. I also consider it useful from the diagnostic point of view, inasmuch as failure generally denotes some involvement of the mastoid.

Paralysis of Eye Muscles in connection with Mastoiditis; Recovery—Mr W. M. MOLLISON.—In two cases paralysis came on in the course of mastoiditis. (1) After operation for acute symptoms arising in the course of a chronic suppuration; (2) in the course of simple acute mastoiditis. In the latter, there was no rise of pressure in the cerebro-spinal fluid. In the first case, the fluid was under increased pressure and slightly cloudy. In neither was extension of disease found towards the tip of the petrous. The eye paralyses were probably due to metastatic infection, almost certainly meningeal and not nuclear or central. In both, recovery was complete. Both cases had certain features in common; pain about the affected eye, nausea (or vomiting), slow pulse, combined with paralysis of the levator palpebrae superioris; but in the first case paralysis of the third cranial nerve, in the second of the sixth cranial, was present.

Middle-Ear Suppuration with Paralysis of the External Rectus Muscle of the same side—Mr ARTHUR J. HUTCHISON.—Boy, aged 7; measles, 5th June 1918. Complained of pain in left ear, 12th June 1918. After paracentesis, pain ceased and temperature dropped to normal; 17th June 1918, temperature 102° F., accompanied by shivering; 6th July 1918, paralysis of the left external rectus. Hutchison found only red inflamed bone but no pus, except in the antrum and attic. Normal dura mater in middle fossa. Five days later, temperature 103.8° F., vomiting and stiffness of the neck. Lumbar puncture gave turbid fluid (streptococci). Antistreptococcus serum injected daily, both into the flank and into the spinal canal. Death on 16th July. No post-mortem.

Complete Bilateral Abolition of Acoustic and Vestibular Reactions following Cerebro-spinal Fever—Mr ARCHER RYLAND.—Male, aged 22, hearing normal when he joined the army. Cerebro-spinal fever in November 1917. On recovery, complete deafness in both ears. Tympanic membranes appeared normal; audition abolished; cochleo-palpebral test negative; Lombard voice-

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raising test negative; vestibular systems, no response. He still has tinnitus. Romberg's sign negative. No vertigo. Pointing test, and Babinski-Weil test, show no deviation. The patient himself stated that his illness had commenced with headache and vomiting, pain in back and giddiness. "The medical officer was talking to me until suddenly I could not hear what he said, although I knew he was talking, as I could see his lips moving. . . . For a month I was delirious, and during this time I had eighteen lumbar punctures. . . . In February 1918, I could not move my back. . . . About April I started to walk, holding the back of a chair. . . . They found I had got a curvature of the spine, and made me do physical exercises."

Epithelioma of Auricle — Mr NORMAN PATTERSON. — Man, aged 67. Nine years ago was operated on for epithelioma of the right auricle. He had a very large mass of glands in the neck. The auricle was removed and an extensive operation carried out in the neck, which entailed removal of a large portion of the sternomastoid and internal jugular. (*Lancet*, 1913, i., p. 962.)

Cirsoid Aneurysm involving the Temporal Bone and Neck—Mr NORMAN PATTERSON.—Female, aged 46. Discharge from and deafness in left ear since childhood; pain occasionally; facial paralysis, six weeks; giddiness for three months. No nausea, vomiting or tinnitus. Weber to right; bone conduction shortened; aural polypus filling meatus. Rotation—right to left, no nystagmus; left to right, nystagmus four seconds.

First operation (16th August 1920)—Post-meatal wall eroded, severe venous hæmorrhage from origin of polypus. Second operation (20th September 1920)—Again severe hæmorrhage. (Pathological report—Inflammatory polypus, no sign of malignancy.) 11th January 1921—Pulsating expansile swelling in left anterior triangle with systolic thrill. Left tonsillar region visibly pulsates. Left facial paralysis still present along with paralysis of left vocal cord and left hypoglossal. Left pupil slightly dilated. Pressure on common carotid causes pulsation to cease.

March 18, 1921.

President—Sir CHARLES BALLANCE, K.C.M.G., C.B., M.V.O., M.S.

ABRIDGED REPORT.

Dr ALBERT GRAY gave a lantern-slide demonstration illustrating the pathological conditions found in two cases of septic meningitis.

Injuries to the Ear in Modern Warfare—Mr T. JEFFERSON FAULDER and Mr LIONEL COLLEDGE.—Published *in extenso* in the *Journal of Laryngology and Otology*, June 1921, pp. 277-283.

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Societies' Proceedings

A Device for Tuning-Fork Testing—E. A. PETERS, M.D., F.R.C.S., and R. LAKE, F.R.C.S.—The device is for attachment to tuning-forks when testing bone-conduction. The greater the pressure on the bone the longer are the vibrations heard by the patient. When the pressure is 8 oz. the fork is heard by the normal person for twenty-nine seconds; when the pressure is 16 oz. the sound is heard eight to ten seconds longer.

Two Cases of Lateral Sinus Thrombosis without Otorrhœa—W. M. MOLLISON.—CASE I.—Miss H., aged 20. Four weeks ago influenza? For fourteen days deaf in the left ear and earache; for ten days pain over left mastoid and occipital region. Temperature 104° F. on several occasions. No rigors. Left membrane dull; whisper at 2 ins. Operation: granulations in antrum leading to the lateral sinus; on the sinus small collection of pus; wall resistant. Sinus opened backward till bleeding met with at the junction with the superior petrosal sinus; internal jugular ligatured. Two days later re-operation, as temperature high; sinus thrombosed $1\frac{1}{2}$ in. farther back. Recovery. The bleeding from the superior petrosal sinus at the first operation was sufficient to suggest that the limit of thrombosis had been reached, whereas clot really extended $1\frac{1}{2}$ in. beyond.

CASE II.—Mr Y., aged 17. Ten days' earache (left); temperature rose steadily till six days ago, when it was 104° F. Mastoid tender but no otorrhœa. Mr Sheaf operated and found pus in the mastoid; exposed a small area of sinus and thought it normal. Temperature remained at 102°. Patient looked ill and felt cold; tongue dirty. Second operation: in the angle between the posterior and middle fossæ, an extradural abscess was found; the sinus clot was not complete. It was turned out, and the internal jugular vein ligatured. Recovery.

DISCUSSION.

Mr SYDNEY SCOTT said he had published, eleven years ago, two cases of extradural abscess in which the tympanic membrane was never perforated; the drum was absolutely normal and hearing perfect. Brain abscesses, traceable to non-perforative otitis media, had been met with in which post-mortem examination showed adhesions with a direct track between the abscess and some cells of the middle-ear.

Sir WILLIAM MILLIGAN considered it unlikely that such cases occurred without infection of the middle-ear, though such infection might be of a transient nature, so that at the time of examination no actual evidence of it remained. Infection might occur through the petro-squamosal sinus of a vestigial vein, which opened directly into the sinus after running across the tympanic roof. He had seen only

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one case of sinus thrombosis in which there was no clinical evidence of middle-ear disease. The responsible organism was the pneumococcus.

Dr H. J. BANKS-DAVIS recalled a case in which Sir Charles Ballance opened a cerebellar abscess in a baby. At the time of operation there was no rupture of the tympanic membrane.

Mr MUSGRAVE WOODMAN mentioned the case of a girl, aged 9, with acute pain over the left mastoid, and some swelling in the neck. The drum was injected but not bulging (no otorrhœa). The lateral sinus was thrombosed. The jugular vein was tied. Recovery. Mr Woodman had operated upon the opposite ear four years previously, and the lateral sinus was also thrombosed; otorrhœa however was present. In this case there was a curious anatomical condition present on both sides, the sinus took a sharp bend forward at an acute angle, and was separated from the mastoid only by a thin plate of bone.

Mr FAULDER had had a case of bilateral inflammation of the mastoid, which cleared up on one side but had to be operated upon on the other. There was no evidence of middle-ear disease on either side. The mastoid was diseased, and this was associated with abscess of neck glands on the same side.

The PRESIDENT had seen one case of acute osteomyelitis of the mastoid which had nothing to do with ear disease. He had seen three or four unusual cases following influenza, in which there had been a slight discharge from the ear, then the tympanum had healed, and the suppuration had extended backwards to the mastoid, the lateral sinus or to the brain. He remembered the case of a healthy boy, aged 6, with a hare-lip. He cured the hare-lip. At the end of three weeks the sister said the boy was not well and the wound, which had healed perfectly, was beginning to break down. The boy would not take his food. Occasional temperature of 99° F. Many petechial spots were noted about the body. The ears and every part were examined. The boy died. At post-mortem extensive disease of the petro-mastoid was found. There was suppuration in the lateral sinus. The internal organs were covered with petechial hæmorrhages.

Mr. F. J. CLEMINSON had treated a boy, aged 10, with a red fluctuating swelling over the right mastoid; he had a perfect tympanic membrane and normal hearing. At operation he found a fistula leading from the abscess cavity to the lateral sinus. The sinus was healthy. The case might have been one of acute tuberculous osteomyelitis in the bone over the lateral sinus.

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