Considering the extremely septic mouths which we have to operate upon in hospital (and private) practice any measure which decreases the chance of septic absorption is useful.

Messrs. Wander have made for me a most excellent pastille under the name of "Formocal," which contains the above combination.

SOCIETIES' PROCEEDINGS.

ROYAL SOCIETY OF MEDICINE—LARYNGOLOGICAL SECTION.

February 1, 1918.

President: Dr. A. Brown Kelly.

Demonstration on Rhinoplasty.

(*Continued from p.* 408.)

The President: Besides the satisfaction of the surgical successes, it must be a source of gratification to those engaged in rhinoplastic work to reclaim for ordinary society men whose appallingly repulsive injuries would otherwise have condemned them to a life of isolation. When the war is over, and the cases requiring restorative treatment are rare, I hope that the experiences gained in this work will be utilised in forming a branch of our specialty which has been neglected by most of us. I refer to what has been termed "corrective rhinoplasty," which deals with noses that are healthy, but either by their abnormal size or shape cause disfigurement. At first this subject might seem too unimportant to be worth serious attention, but on glancing at the literature one cannot but be struck with the variety of conditions requiring treatment, and the excellent results obtainable.

Sir StClair Thomson: Are these instruments inside the nose for keeping it up successful, or have they, in some cases, proved failures? We might have to try them for accidents to the nose arising in the football field or at boxing matches. In reference to the lining of the nose, I think it was said that if one does not get epithelial lining the nose contracts. Apart from that, does much difficulty arise from the absence of ciliated epithelium? Do these noses which are lined with ordinary mucous membrane, *i. e.* grafts of mucous membrane, keep moist? Or do the patients get rhinitis sicca, or ozæna, or crusts inside the nose? In cases in which I have had to remove the turbinals entirely for malignant disease of the ethmoid region, as I have reported here before, I have been astonished that the patients have remained free from ozæna or atrophic rhinitis—a condition we used to anticipate in those cases. That experience has made me think that atrophic rhinitis is much more a pyogenic result than one of difficulty or defect of turbinal tissue and ciliated epithelium.

Mr. Herbert Tilley: In the case of a slight dent or depression following a submucous resection, do the exhibitors recommend the insertion of a portion of septal cartilage from another patient, or the removal of a small portion of rib cartilage from the same patient?

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Mr. H. D. Gillies (in reply): In reply to Sir StClair Thomson, I have not seen any case of atrophic rhinitis resulting from these injuries of turbinals or the measures taken for the repair of the nose. One point in connection with complete rhinoplasty is interesting from the voice-production point of view. One of the officers I showed lost a good part of his nose, as well as a portion of his superior maxilla, and it did not matter whether he had no nose, or whether Mr. Hett had moved his turbinals, or whether I had re-made his nose, he had the same nasal resonance, and his smell was normal from the beginning. I have not seen any case of atrophic rhinitis among these, and there is a possibility, if other methods are not available, that skin-grafting in the nose might be the means of curing atrophic rhinitis. Skin in the nose used as mucous membrane, as also in the mouth and in the eye-sockets, does admirably in my experience: it causes no trouble of any character. What it becomes histologically is not, I think, yet established, but from a practical point of view it is very satisfactory.

Mr. G. Seccombe Hett (in reply): With regard to Mr. Tilley's question as to autogenous *versus* heterogeneous grafts in the nose, I think he spoke entirely of the septal cartilage graft. Both have been tried, the septal cartilage in the autogenous and the heterogeneous manner, that is to say, grafting one person's septum into his own nose, and also into that of another patient, and that, so far, has proved satisfactory. With regard to heterogeneous costal cartilage grafts, Mr. Gillies knows about those better than I do. I have thought there was not so much vitality about the heterogeneous as about the autogenous grafts. With regard to Sir StClair Thomson's question, I do not know whether he includes unhealthy conditions, such as sinus disease or atrophic rhinitis, when speaking of the interior of the nose, but I appreciate the extreme necessity of making the cavity healthy before putting on a new nose; for instance, in one case, a man had a chronic antral condition; a new nose was brought down, and had to be lifted off again and the antra cleared out because the nasal cavities were full of putty-like material, and both antra had foul pus in them.

New Laryngotomy and Tracheotomy Tube.—A. L. Abel.—This is a modification of Fuller's bivalve tracheotomy tube. The difference is that one limb of the valve has been lengthened $\frac{3}{16}$ to $\frac{4}{16}$ in., and the concave border of that prolongation has a scalpel edge. The object is to render the time-interval between the tracheal incision and the insertion of the tube *nil*. The method of use has been to make a small skin incision first, transversely or vertically, and, without anything further being done, the instrument is held between the thumb and finger, and by a slight rotatory movement the tube is carried into the trachea or larynx. After the tip of the smaller valve has passed the obstruction, which it does easily, the patient is at once heard to breathe, and the inner tube is then inserted. With this guarding the point, the instrument is driven home. The instrument fits its incision exactly, and there is no escape of blood or air. There is no need to drive it home, neither does it need tying. So far it has been used in fifteen or twenty cases of laryngotomy; for tracheotomy, only on the dead body. It has been employed in connection with operations on the jaw, throat, and tongue. It has been said that it might cause sepsis by healing up so rapidly; but the wound heals by first intention and is closed almost at once, and leaves no scar. No sepsis has been produced inside the trachea, and it has given gratifying results.

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Epithelioma of Soft Palate and Uvula.—Andrew Wylie.—Male, aged thirty-eight, complained in October, 1917, of pain in the throat, and later of difficulty in swallowing, with slight cough and spit. Dr. Rothwell (Maidstone), saw him in November, and administered potassium iodide and mercury, after tuberculosis had been excluded.

Patient attended Hospital in December and there was marked symmetrical ulceration of the soft palate, extending to the tonsils. The uvula was also affected. The Wassermann reaction was *positive* and the appearance was similar to specific disease, but even large doses of anti-specific remedies had no effect. Chest normal; no tubercle bacilli found. Enlarged gland has appeared recently on the right side. A piece was removed, which Dr. Wingrave reports as typical epithelioma. I intend to treat the case by diathermy.

Frontal Sinus Suppuration; Suppurative Meningitis for Fourteen Days; Operation; Recovery. — W. M. Mollison. — B. S——, aged twenty-nine, was admitted to Guy's Hospital in July, 1917, on account of acute frontal sinus suppuration in the site of a previous operation. The man had previously had over thirty operations of the nose and both frontal sinuses, all in a provincial hospital except the last, which was in Guy's in December, 1916, when a thorough operation was performed on the left sinus; during his recovery from this, pain along the course of the left supra-orbital nerve was a prominent symptom. On admission in July, 1917, there was a red, tender swelling in the left supra-orbital region and considerable discharge of pus from the nose; operation was performed and pus found in the sinus; drainage into the nose was established and a rubber tube inserted; at the same time, as the nose was narrow, a submucous resection of the septum was performed. The man made a good recovery except that he complained still of pain along the supra-orbital nerve; he was discharged in August.

On September 27 he was readmitted on account of continued pain and nasal discharge. On October 1 the left sinus was again opened and more bone removed from the limits of the sinus and granulations gently curetted; a very thin fronto-ethmoidal cell was found far back over the orbital roof containing granulations; again a tube was inserted along the passage from the operation cavity to the nose and kept in place for ten days. After operation the patient's temperature at once rose to 100° F., and remained between 100° and 102° F. all through the illness. He was ill, complaining of slight headache, his mouth and tongue were dry and he was somewhat delirious at times. On the twelfth day after operation (October 12) he had a rigor and his headache became severe. Lumbar puncture showed cloudy cerebro-spinal fluid under increased pressure; the puncture was repeated daily for the next fourteen days, the needle being left in place each day for about two hours; it was impossible to keep it in longer as the man had so much pain in the back and legs.

Six days later (October 18) further operation was undertaken, as the meningitis did not appear to be getting worse and no organisms were found in the fluid, though it was crowded with leucocytes. The previous supra-orbital incisions were re-opened and joined by an incision across the bridge of the nose, and from the inner end of the left supra-orbital incision one was carried up on to the forehead for 2 or 3 in. Bone was removed to expose the dura mater over a considerable area; the bone showed small spaces containing granulations towards the root of the nose and the intersinus region; these granulations led the operation as

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it were to the right side, which was found to contain beads of pus. When the bone had been removed between the sinuses just above the root of the nose, a small vessel was seen standing out as a strand between the dura mater and the nose; this vessel was taken to be the most anterior part of the superior longitudinal sinus, and as it had been surrounded by septic bone it was considered to be a possible source of the meningitis; it was therefore ligatured in two places and the intermediate piece removed for section; microscopical examination showed it to be a vessel with an organising thrombus (this is shown). The dura mater over the whole area was normal in appearance, and the superior longitudinal sinus showed no sign of thrombosis higher up.

After operation the patient at once improved, the headaches ceased and the temperature came down, and the cerebro-spinal fluid soon became normal. Finally on November 20 the skin-flaps were adjusted.

Dr. DAN MCKENZIE: The case is interesting because of the question which arises as to how the meningitis was produced, presumably by this thrombosis. I think it is the first case in which a thrombus has been discovered in the operation for frontal sinus trouble. I would like to enter a caution against the use of the term "suppurative meningitis," which is conventionally limited to cases in which bacteria are found in the cerebro-spinal fluid. In this case I do not think they were found; consequently it belongs, strictly speaking, to what is called "serous meningitis." The difference in the prognosis between these forms is very great, and that is where the nomenclature is important. This case may come into the category of milder meningitis cases, but all the same the result of the treatment is certainly a matter for congratulation.

Mr. MOLLISON (in reply): The little vein in the section shows thrombosis in the lumen, and outside shows chronic inflammation. I think the inflammation may have been going on in this vein since the submucous resection was performed, three months before the man developed the meningitis.

Calculus of Tonsil.—C. H. Hayton.—D. C——, aged thirty-five, an Italian patient, was sent to hospital with suspicion of a calculus in the tonsil. The patient complained of irritation at the back of the tongue, with a constant desire to swallow. An examination of the mouth revealed an enlarged red bulging left tonsil quite in contrast to its fellow on the opposite side. At first sight it simulated a peritonsillar abscess, but the readiness with which the patient opened his mouth and the absence of pain precluded the possibility of a quinsy. A small white spot was noticed on the tonsil. A probe elicited the stony hardness of a calculus. With local anæsthesia the stone was readily removed. It is a pyramidal-shaped stone, the base measuring 2·7 cm., altitude 2·2 cm. and thickness 1·8 cm., and the weight 7·9 grm. No examination was made for the *Leptothrix buccalis*. From appearances it is composed of phosphate and calcium carbonate.

The PRESIDENT: I suppose that Mr. Hayton, in mentioning leptothrix, has in mind the view that these calculi may develop around leptothrix filaments in crypts, but I think such an occurrence extremely unlikely. Leptothrix is abundantly present int he mouth, and the caseous masses in lacunar tonsillitis swarm with them, yet calculi of the tonsils are very rare. Many years ago, when trying to show that what was then termed *Mycosis leptothricia* was a keratosis, I planted an excrescence of keratosis from a patient in one of my tonsillar crypts to see if a mycosis would develop, but with negative result. Long afterwards pus began to

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come from my tonsil, and one day while squeezing this out a tiny calculus came away. There is little doubt as to its having formed around the excrescence. A foreign body probably in most cases forms the nucleus of a tonsillolith.

Tumour of the Epiglottis.—W. Jobson Horne.—The patient was present at the meeting of the Section on December 7, 1917. The tumour was then described as a cyst of the epiglottis. Subsequently it was further examined and found to be a solid tumour. A portion was removed for microscopic examination and reported to be a round-cell sarcoma. The use of radium has produced a most satisfactory result.

Dr. Jobson Horne (in reply to a remark by the President): I would like to show the microscope specimen at a future meeting, with a view of obtaining opinions upon the nature of the growth. The term "sarcoma" appears to me to be too comprehensive.

Laryngo-fissure.—A. L. Macleod.—W. B——, aged fifty-five, engineer. First seen on May 16, 1917. Complained of hoarseness, *lasting eighteen months; no cough; no difficulty in swallowing;* abstainer, moderate smoker. On examination a nodular growth was found on the anterior third of the right cord, which was fixed. Patient was seen on May 21 by Sir StClair Thomson, who advised operation, with reservation on account of (*a*) length of case, (*b*) fixation of cord, and (*c*) possible invasion of cartilage. On May 25 a Wassermann test proved negative. On June 6 a laryngo-fissure was performed, Dr. Irwin Moore kindly assisting. Recovery was rapid and uneventful. *Pathologist's Report:* "Section shows a typical extensive epithelioma."

Sir StClair Thomson: I have a drawing which will show the extent of the growth in this case before it was operated upon. It should be one of our objects to show how these epitheliomata can be treated, for unfortunately, in the provinces and elsewhere, they have hitherto been left in the hands of the general surgeon, with disastrous results. To-day I received a letter from America, showing that they suffer over there in the same way.

Orbital Tumour.—J. Gay French.—The patient, a widow, aged fifty-eight, by occupation a dressmaker, stated that about nine years ago she first noticed a bulging of the left eye. This condition continued until about eighteen months ago, when the eye began to water, and she then felt some pain in the eyeball.

She first came under my care on November 1, 1917, when it was noticed that the left eye was displaced, and that there was a definite bulge above the inner canthus. There was no diplopia, and an examination of that eye with an ophthalmoscope revealed nothing abnormal. The swelling was soft and fluctuating, but on deep pressure a definite bony mass could be felt. An examination of the nose revealed nothing abnormal beyond the fact that the left middle turbinal was slightly enlarged.

An X-ray plate was taken, and it shows definite thickening on the upper and inner side of the orbit. This extends also into the ethmoidal region. Transillumination showed the left frontal sinus dark.

Within the last month the growth has definitely increased in size.

Mr. Howarth: This is a mucocele of the ethmoid and left frontal sinus. I have seen about eight cases. In some the ethmoid alone is involved; in some the frontal sinus alone; in one both frontal sinuses were affected and one ethmoid, so that one could get fluctuation from the right frontal sinus to the left ethmoid. The duration of this case—nine

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years—is not unusual. One of mine was of seventeen years' duration. I think if Mr. French were to cut down on that, he would find the bony tumour was involving the ethmoid and possibly the left frontal sinus, and that if he drained it into the nose the eye would go back, and the patient would be cured. The contents in these cases vary a good deal: sometimes there is thick mucus, sometimes inspissated pus. Usually the contents are sterile, but sometimes they contain bacteria.

Mr. O'Malley: I think this a mucocele, but it is difficult to say whether it is connected with the ethmoid or with the frontal sinus. If I were called upon to deal with it surgically, I should not think of attacking it merely from the front aspect where it is presenting above the inner canthus, because, as has been pointed out, sometimes these mucoceles are connected with the frontal sinus back wall, the sinus may be absorbed, and thus one gets sepsis and meningitis. I think this should be opened over the point where it is presenting, and then be connected freely with the ethmoidal region, after taking away the middle turbinal, so that there is a safe way into the nose for free drainage.

Sir StClair Thomson: In my text-book there is a photograph of a case very like this, but more exaggerated. That patient was a medical man, and the frontal sinus was full of the gelatinous sort of material which Mr. Howarth described. Dr. Logan Turner has pointed out the non-necessity, indeed the danger, of being too operative in these cases. As Mr. O'Malley says, you may only stir up sepsis, and sufficient has been done so long as you secure good drainage into the nose.

Mr. Gay French (in reply): I am going to operate on the case next week, and shall try to effect drainage into the nose. I hope to report the result to the next meeting.

Three Cases of Symmetrical Nodules of the Vocal Cords.—E. D. D. Davis.—Case 1: A doctor's widow, aged thirty-eight, of no occupation, complained of hoarseness of six weeks' duration. She was neither a singer nor voice-user, and had neither cough nor any other symptom apart from hoarseness. The larynx shows typical, symmetrical, pale, small "singer's nodules" on the anterior third of both vocal cords. No adequate cause for the condition can be found.

Case 2: A female munition worker, aged twenty-six, attended the hospital for hoarseness of twelve months' duration. Symmetrical reddish nodules, about the size of a small peppercorn, can be seen on the anterior third of both cords. The patient has a dry cough, but is not a voice-user. The nose is normal. When she was first seen there was slight pharyngitis.

Case 3: A stage-hand, aged thirty-two, first seen in December, 1916, suffering from left frontal headache, with nasal catarrh and chronic laryngitis. There was considerable oral sepsis, and after dental care the œdematous left middle turbinal was removed, and the septal deformity corrected by a submucous resection. There was no sinus suppuration. The nose improved, but the chronic laryngitis remained. The patient had frequent mild attacks of bronchitis with persistent cough, but repeated examination of the sputum and chest did not reveal pulmonary tubercle. Alchohol was forbidden. In April, 1917, symmetrical œdematous projections, resembling singers' nodules, developed on the anterior third of both vocal cords, and have not disappeared in spite of treatment.

Symmetrical Ulceration of the Vocal Cords.—E. D. D. Davis.—A woman, aged forty-seven, was first seen in April, 1916, and complained

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of gradual loss of voice of three months' duration. An examination showed symmetrical ulceration, with formation of granulation-tissue on the anterior third of both vocal cords. Repeated examinations of the sputum and chest were negative. Weight constant; Wassermann reaction negative, and there is no history of syphilis. The condition has remained unaltered in spite of varied treatment.

Mr. HERBERT TILLEY: Some of these patients do not make any particular use of their cords, and it is just possible we may have to give up the idea that these vocal cord nodules are all caused by excessive use of the voice. I have seen cases in young children who have not been particularly vociferous either indoors or in the playground, and I have seen them in adults who, even in reply to leading questions, could not admit there had been undue use of voice. I presume Mr. Davis will treat them in the usual way—that is, if they do not get well after prolonged rest, that he will apply the point of the galvano-cautery, and by the indirect method.

Sir STCLAIR THOMSON: These are very interesting cases, because I have been puzzled by singers' nodules occurring in people who are neither singers, nor orators, nor shouters. Some I have found had a deaf mother or other relative, and the shouting needed may have been the cause of it. With regard to the case of symmetrical ulceration of the vocal cords, I have watched such a case three or four years and tried to get at the cause—whether syphilis, tubercle, nose trouble, tobacco, alcohol—but found nothing to account for it.

Dr. JOBSON HORNE: During the past year I have seen several similar cases. With regard to treatment, I am not in favour of an application of the galvano-cautery to the vocal cords straight away; they seem to get all right with rest of voice and a general improvement in health. Hospital patients more slowly recover robust health and find it more difficult to rest the voice; this probably accounts for the persistence of the condition in some cases. In the last case I could not see ulceration of the vocal cords; the condition seemed to be similar to that in Cases 2 and 3, but in a more acute stage. It would be instructive to receive a further report upon this group of cases.

Mr. FRANK A. ROSE: One feature common to the first two cases of symmetrical nodules of the vocal cords is the high degree of laryngitis which is present; there is swelling and redness of the mucous membrane and of most of the interior of the larynx. That is much more intense and conspicuous than is usual in cases which one calls singers' nodules. I do not recall a case of the latter, in a schoolmistress, for example, in whom there was this degree of laryngitis.

The PRESIDENT: The interesting question about nodules is their ætiology. I agree with Mr. Tilley that while they usually occur in those over-using or abusing the voice, such as school teachers, freak singers, etc., they are also found in young children. The cause probably lies in the manner in which the cords are pressed together, possibly owing to the action of the external thyro-arytænoids. These nodules develop where maximum contact takes place, in the middle of the ligamentous part of the cord. They are usually epithelial hypertrophies, sometimes granular. I think there is no better way of treating the very small nodules than by lightly touching them with the cautery and then drawing it away. Some members of the Section are very averse to this method.

Mr. E. D. D. DAVIS (in reply): I am much indebted to members for their suggestions as to the pathology and treatment of these conditions. I am sorry the first case did not come, but it was a typical case of

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symmetrical nodules on the vocal cords, known as singers' nodules, but which I have called "symmetrical nodules." The patient in the second case has a recent cold, and the laryngitis now present has developed since I saw her last. When I first saw her the larynx showed singers' nodules, but the nodules were red and inflamed. The last case has altered recently too, but there was no doubt about the presence of ulceration. I have treated it by removing the granulation-tissue and applying tincture of iodine, and the ulceration is now healing. One occasionally sees such a case as this where there is no evidence of either tuberculosis or syphilis, and which does not respond to treatment. She has been attending since 1916, and is only just beginning to improve.

Tumour of the Nasopharynx.—W. Stuart-Low.—A man who for two years has suffered from nasopharyngeal obstruction. In the nasopharynx there is a large, red, firm and pendulous swelling which has a broad base and is attached to the roof of the cavity. It is very firm to the touch, and has occasionally given rise to hæmorrhagic discharge, although not profusely. It is proposed to remove this tumour, and I shall be obliged if members will give their opinion of their experience of the best method of doing so.

Mr. Tilley: My impression of this case, after a cursory examination, is that it is a choanal polypus, with a congested lower border seen below the edge of the soft palate. By watching the tumour while the patient moves his palate one sees the growth move very freely, and I do not think it would do this if it were a fibroma attached to the base of the skull. On looking into the right nasal cavity one sees what appears to be a polypus. Furthermore, by digital examination I found there was a smooth mass passing into the posterior choana.

The President: If I had seen only the growth in the nasopharynx I should have hesitated to offer an opinion, having been deceived several times with such. But the polypoid condition in the right nostril indicated the nature of the growth. There seems to be no doubt about its being a naso-antral polypus. A good specimen can be obtained by using a bent snare, passing the loop up behind the soft palate, gripping the growth and tearing it out, when the naso-pharyngeal and nasal portions together with a cyst from the antrum will come away *en masse*. Smaller naso-antral polypi are easiest removed by Lange's hook.

Mr. W. Stuart-Low (in reply): I have not seen the case for two months, and when I last saw it it seemed to have the characters which I have described here. It is a very unusual case. The whole thing is a mass of redness, and it is different from any choanal polypus I have seen or felt.

Shrapnel Embedded in the Neck.—W. Stuart-Low.—A soldier wounded in France four months ago. Subsequent treatment by partial closure of the glottis and trachea, which necessitated tracheotomy and a re-insertion of this tube some weeks after its removal and still demands its retention. There are still small pieces of shrapnel lying in the tissues, embedded deeply beside and behind the larynx and trachea, as seen in the skiagram shown, and I am anxious for an expression of opinion from those having practical experience of such cases as to whether or not I should cut down and remove these fragments. The man complains of occasional pains in the neck.

Case of Double Lacrymal Stenosis; Right Side successfully treated by Internal Dacryocystotomy (West's Operation).—James

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Donelan.—The patient, a boy, aged eleven, had suffered from epiphora for several years owing to lacrymal stenosis. For this two external operations, of which the history is unknown, had been tried over two years ago. The result was apparently not good, as the skin over the lacrymal sac on both sides was in approximately the same condition as may still be seen on the left, when he was sent to my department at the Italian Hospital by our oculist, Mr. Stanford Morton, with the suggestion that I should attempt the internal operation. This was done on November 8, 1917, the details of West's operation being carried out as nearly as possible according to the description in Sir StClair Thomson's book. The result appears to be so satisfactory that it is now intended to attempt the other side in the hope that if a lacrymal sac is still present, which there is some reason to doubt, a similar result may be obtained. The great difficulty of the procedure in so small a space was in making sure that one had got hold of the lacrymal sac before using the scissors.

Thyrofissure and Removal of Right Cord six years after Operation.[1]**—G. C. Cathcart.**—W. L——, male, was sent to me in September, 1911, with the following history. He was aged sixty-three, and complained of fatigue and hoarseness of the voice. He had had this for three years on and off and said it first came on after a long and tiring motor drive; for the last six weeks it had been continuous. On examination there was a small pedunculated tumour growing from the junction of the anterior and middle two-thirds of the right vocal cord. I removed this with Mackenzie's forceps and sent it for microscopic examination; the report was as follows: "This small pedunculated tumour is a papilloma composed of thickened masses of squamous epithelium in a stroma of areolar tissue. The surface of the tumour is necrotic, and there is some inflammatory reaction at the base. There is no evidence of any tendency to infiltrate the pedicle, which is quite free from growth. We see no reason to regard it as malignant, but the case should be carefully watched."

His voice got much better for a week or two, but in November he complained of more difficulty in speaking. On examination the papilloma seemed to be growing again, and there was a little depression on the cord, as if it were being infiltrated. Dr. Greville MacDonald and Mr. Charters Symonds saw it with me in consultation, and we came to the conclusion that it was malignant. On December 25 I performed a thyrofissure, after doing a low tracheotomy. On opening the larynx, the growth, as generally happens, was found to be much more extensive than when examined by the laryngoscope. The whole of the cord and arytænoid cartilage was removed, the wound was closed up and the tracheotomy tube removed after a week. The patient did very well and left the home in three weeks.

The report on the growth removed was as follows: "The tumour is a squamous-celled carcinoma; the section shows the tumour mass invading the submucous structures, but there is no erosion of cartilage; the limits of the specimen are free from growth."

The peculiarity about the case was that six months before he came to me he had seen two other throat specialists who said he was only suffering from laryngitis, so that the papilloma must have grown very quickly. The patient has had lessons in voice production, and his voice is now very fair. Two years ago he felt so well that he married again.

[1] Reported at a meeting of the Section held December 7, 1917 (patient not present).

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