SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

President: VICTOR LAMBERT, F.R.C.S. (Edin.)

(March 4th, 1955)

Discussion on "Treatment of Bilateral Abductor Palsy"

(Opening papers by MR. H. P. LAWSON and MR. NEVILLE YOUNG, on pp. 374, 390)

MR. R. G. MACBETH reported a case in which he had performed a tracheostomy and twelve years later had performed a Woodman-type operation because of increasing coughs in the winters. He showed a slide illustrating a minor modification of the technique.

MR. J. C. MCFARLAND reported seven cases treated successfully by the Woodman operation. Though it was stated that the operation was difficult he did not think it too difficult to get a reasonable result in regard to both speech and breathing.

DR. A. LASKIEWICZ related a case of bilateral vocal cord paralysis after thyroidectomy in a man of 45. The operation performed was devised by Lorre and was the first method of surgical relief of this condition to be recorded. The operation consists of arytenoidectomy and submucous resection of the vocal fold by the modified curvilinear incision through the subchordal and arytenoideal region. He used to perform thyrotomy with a sharp stomatological disc attached to the dental driller. It gave a satisfactory result.

MR. G. E. ARCHER said that, although it might sound self-complacent, he had found a modification of the King operation very successful and not particularly difficult, and had been satisfied that it relieved the roaring and dyspnœa and at the same time preserved a good voice. There were certain technical points which must be remembered, for example it was most important for the arytenoid cartilage to be fixed at the right level so that the vocal cord was not elevated or fixed too low down. He asked Mr. Lawson how long he had been doing the operation of submucous resection of the cord, as it seemed possible that the scar tissue would eventually stenose the larynx.

MR. R. D. OWEN recalled that when a similar discussion was held at the 1952 Summer Meeting of the Section in Manchester he had mentioned the thyrofissure approach (*Proc. R. Soc. Med.*, **45**, 824). It involved removing the arytenoid cartilage under complete hæmostasis and an easy access. A diathermy coagulation point was applied to the arytenoid bed before the mucosal margins of the bed were brought together. This later promoted further abduction.

In his experience of seven cases carried out by this method he had come to

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the conclusion that all that was necessary was the simple removal of the arytenoid itself. The outward traction of the vocal process was unnecessary.

These patients afterwards had a good voice, and the stridulous noise during speech and sleep disappeared.

MR. LAWSON, answering Mr. Archer, said that in one case he had carried out the operation five years previously and had since seen the patient fairly regularly. He had never yet found any signs of a stenosis resulting from the operation. On the whole the patients breathed well after it and, following speech therapy, their voices were quite good.

The PRESIDENT expressed the thanks of the Section to the openers and said he was sorry there had not been a longer discussion. That must not be taken as indicating lack of appreciation of the papers, it was due to shortage of time.

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