The variation in the symptoms, I consider, must be regarded as due to variation in the size of the cyst, probably partly explained by attacks of inflammation in its wall. No history of spontaneous rupture could be obtained.

In the report of my colleague in January 1926, a swelling of the left half of the larynx was recorded. I have observed no lesion on the left side.

From the relation of the cyst, beneath the deep cervical fascia and extending into the larynx between the hyoid and the thyroid cartilages, it appears to be a closed extension of the laryngeal ventricle, analogous to the laryngeal air sacs so well described by Bland-Sutton in *Tumours Innocent and Malignant*, 4th Edition, p. 608.

SOCIETIES' PROCEEDINGS

SCOTTISH SOCIETY OF OTOLOGY AND LARYNGOLOGY

THIRTIETH MEETING, GLASGOW

November 30, 1929

President—Dr JOHN L. HOWIE

CASE 1. **Persistent Alveolar Fistula after Antral Operation**—R. P. MATHERS, M.B.—Tooth extracted December 1927. Three weeks later pain over left antrum. Pus expelled from nose on blowing through mouth. Seen April 1928. Caldwell-Luc. Mucosa polypoid. Fistula. Three attempts at closing: not successful.

Dr LOGAN TURNER said he had seen the patient, and suggested to Dr Mathers that he should enlarge the opening, remove some more bone from the alveolus, and refashion the flaps.

Dr DOUGLAS GUTHRIE showed a radiogram from a case under the care of Dr C. E. Scott, who was unable to attend the meeting. In this patient removal of an upper bicuspid tooth was followed by a gush of pus from the antrum and a fistula persisted until the radical operation was performed, which resulted in cure. Personally Dr Guthrie suggested to Dr Mathers that in his case the fistula should be freely opened through a vertical incision in the canine fossa, sufficient bone being removed to convert the tubular channel into a gutter. Should this fail, the plastic operation might be tried, but it was essential that the flap should be lined with mucous membrane or skin, and not raw on one surface. This could be accomplished

https://doi.org/10.1017/S0022215100034757 Published online by Cambridge University Press

by implanting a piece of stent covered by a graft of epithelium, with the raw surface outwards. In ten days the stent might be removed and three sides of the pocket incised, so as to produce a rectangular flap, which could then be turned outwards, so as to close the fistula, after curetting it thoroughly.

Dr JAMES ADAM advised Dr Mathers to try Dr Logan Turner's suggestion first before he tried Dr Guthrie's. The epithelium lining from the fistula should be removed; then if flaps are extensively undercut the fistula might close. Dr Adam thought this fistula would not have formed if Dr Mathers had not removed the lining of the antrum. Very often the antrum does not close up with fibrous tissue after removal of mucosa, and you get crusts for a life-time after that.

Dr LEITCH said that there was a plastic operation which he had seen described somewhere by a French writer. It consisted in making a semi-circular flap of mucous membrane from the lip opposite with its base downwards, and a smaller flap on the alveolar side of the fistula with its base upwards. The free edge of the first flap was stitched by one or two catgut stitches to the alveolar mucous membrane so that a double flap of mucous membrane was formed across the fistula. It was very efficient.

The PRESIDENT was sorry that he did not see the case but asked if any constitutional condition was present—any suggestion of a positive Wasserman or glycosuria or anything of that sort.

Dr MATHERS (in reply) said he had nothing to add to the notes but that he was obliged for the hints given and would try the simpler measure first if the patient would agree.

CASE 2. **Right Pansinusitis: Thrombosis of Ophthalmic Vein and of Cavernous Sinus**—JAMES ADAM, M.D.—Female, aged 23. Admitted to Fever Hospital on fourth day of illness, 8.1.29. Severe scarlet fever; toxic looking. 18.1.29—Sore throat. 22nd—Peritonsillar abscess (incised by Dr Ferguson); right upper eyelid swollen and painful. 23rd—Swelling of right lid worse; proptosis. Dr J. A. Mortimer incised through upper lid, no pus; repeated exploration of orbit to apex through both lids, no pus; vision hazy; finger counting difficult at 4 feet; retinal veins $3\frac{1}{2}$ times arteries; retinal œdema; no optic neuritis; pupil reacted; œdema and proptosis worse, temperature 100°.

2.2.29.—Seen by Dr Adam—Left nostril normal, right congested; walls in contact, no pus seen; right antrum tapped, pus; infraturbinal wall removed. 3.2.29—Proptosis and œdema worse, temperature 100°; œdema of left upper eyelid; posterior part of nostril not visible owing to swelling; puncture of sphenoid, pus; middle turbinal and ethmoid removed; sphenoid wall broken, 4 c.c. pus removed; pneumococcus. 4.2.29—Œdema of left lid gone; right side still swollen; right frontal sinus opened (Howarth), slight pus; mucosa dark and swollen; infundibulum narrow; douched with saline and argyrol

https://doi.org/10.1017/S0022215100034757 Published online by Cambridge University Press

(10 per cent.). 12.2.29—Haziness gone; veins less in size; diplopia, temperature subnormal and remained so; œdema decreasing; proptosis and diplopia took two months to disappear; sinuses recovered. 10.8.29—Still thickening in orbit and above upper eyelids; vision normal. Was extension of œdema to left upper lid due to thrombosis of right ophthalmic vein extending to cavernous sinus?

Dr LOGAN TURNER said that all the orbital changes present were quite consistent with an acute inflammatory condition secondary to the accessory sinus affection. He would like to ask the exhibitor if he had excluded continuity of œdema from the right upper eyelid across the forehead to the left side. Œdema could spread very easily from one side to the other, and he thought the somewhat fleeting œdema of the left upper lid was simply associated with the acute œdema on the right side.

Dr ADAM said that when he sent forward the notes he did not think anyone could have said positively there was a cavernous sinus thrombosis—he merely wanted to raise the question. He also said (in reply to Dr Gardiner) that he punctured the sphenoid sinus with a spinal trocar and cannula and then used suction. It was impossible to see inside the nose—the walls were in absolute contact.

CASES 3, 4, 5.—**Analysis of 20 Cases of Bronchiectasis and Lung Abscess**—JAMES ADAM, M.D.—11 cases associated with sinusitis. 9 post pneumonia and no sinusitis. In sinusitis cases seven had right lung affected, two both, one left, one no record. Antrum affected in all. 9 cases post pneumonia—in six left lung affected, in two both, in one right lung. Two had had two attacks of pneumonia and two five. Tubercle bacilli in none. No reason to suspect tonsils and adenoid operation. No history or sign of foreign body. Bronchiectasis cases where treatment was carried out improved most by getting patient to cough hourly in inverted position together with occasional bronchoscopic suction—sputum could be reduced within fourteen days from 15 oz. to five or less. Fœtor diminished provided always sinusitis had surgical treatment. Bronchoscopic lavage abandoned as useless, if not harmful, except in lung abscess. In children stunted growth, clubbed fingers, rounded nails, rounded face (often well coloured) were prominent features.

Two Cases of Bronchiectasis with History of Pneumonia.—JAMES ADAM, M.D.—L. M., aged 19 (female). Tonsils and adenoids removed at 7. Pneumonia and whooping cough at 9, followed by bronchiectasis. First seen 1926. Undergrown, wretched-looking child; large fungatory glandular mass on left side of neck. Bronchiectasis—right lung, 18 oz. fœtid sputum. ? Left antrum by X-ray, twice tapped—negative. Treatment as indicated. Spit reduced to 40 oz. Gained 14 lb. weight. Clubbing of fingers and area of lung affected seemed diminished.

https://doi.org/10.1017/S0022215100034757 Published online by Cambridge University Press

S. P., aged 12 (female). Purulent spit since childhood—first treated as tubercle. Pneumonia 1925. Bronchiectasis—left lung. Condition typical. Sputum reduced greatly. Clubbing of fingers and area of lung affected seemed diminished.

Bronchiectasis, Sinusitis, Hernia of Stomach into Right Pleural Cavity.—JAMES ADAM, M.D.—May F., aged 10. Tonsils and adenoids at 4 and 7 years. Seen July 1929. First pulmonary symptoms 4 years ago. History nasal discharge—none seen. On inversion pus coughed up, no fœtor—no clubbing. Transillumination by X-ray indicate affection of left antrum; tap yielded turbid fluid; infraturbinal operation. 24 hours' sputum about 1 oz. Lipiodol injection showed cavity in right lower lobe. History indicated digestive symptoms and found that she frequently coughed on swallowing. X-ray—barium meal—showed cardiac end of stomach to right and seems to form a hernia through diaphragm into right pleural cavity; one film suggests possibility of fistula between lung or bronchus and lower end of œsophagus; barium swallowed and lipiodol injected into the bronchi reach same level; area occupied by lipiodol much less than that outlined by barium.

Dr LOGAN TURNER said there was a point which he thought Dr Adam himself referred to at a previous meeting of the Society, and that was the question of frontal lobe abscess in cases of bronchiectasis being etiologically associated with frontal sinus suppuration. The frontal lobe abscess instead of being metastatic might possibly be due to direct extension from the frontal sinus suppuration. It was a point which could not be proved without careful autopsy and microscopic examination, but it was an interesting point.

Dr FRASER asked if there was supposed to be any particular connection between bronchiectasis and accessory sinus suppuration. It was a common thing to have acute maxillary antrum suppuration associated with acute middle-ear disease on the same side. Chronic sinusitis and bronchiectasis were of course both chronic suppurations in the respiratory tract, one in the upper and one in the lower part, but unless the association of the two conditions was of frequent occurrence he doubted if the connection was a close one.

Dr HARPER said he had never seen a case of bronchiectasis following the removal of tonsils and adenoids. Professor Leonard Findlay had done considerable research work on the question of bronchiectasis in children, and his conclusions were that most of these cases followed pneumonia and had no relationship to any operation.

Dr GUTHRIE asked why bronchiectasis was the sequel of sinusitis without any infection of the intervening part of the respiratory tract with the pharynx, larynx or trachea. In a descending infection in the course of an ordinary cold, those intervening parts are always affected as the process extends downwards.

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Dr BROWN KELLY thought it was a recognised fact that inspiration of pus during sleep could cause infection of the lungs. The last number of the *Archives of Oto-Laryngology* contained an article describing a method of putting into the nose of a sleeping child, at intervals, a few drops of iodised oil which on X-ray examination was seen in the lungs. The authors were able to introduce a surprisingly large quantity in this way. Dr Brown Kelly said that a case of lung abscess was supposed to be due to an operation he had done, although there was no sign of it until about two months later. The patient was taken to the country for several months and recovered entirely. The American literature gave a very unfavourable prognosis in such cases. He would like to know if any one present had worked in America and could explain why the Americans had so many cases and there were so few here.

Dr FRASER said he thought Dr Brown Kelly's last question might be answered—because American specialists do so many tonsillectomies. He understood that in America at least one adult out of four has had tonsils and adenoids removed, so that as there are 120,000,000 people in the United States a good many tonsils operations must be performed. Apart from that, Dr Fraser understood that lung abscess following tonsils and adenoid operation was not due to inspiration of bits of tonsil or adenoids growth, but to blood infection through the pharyngeal veins to the right heart, and so to the lungs. This fact was not in favour of bronchiectasis being due to infection spreading down from the sinuses.

The PRESIDENT said that the Society was very much indebted to Dr Adam for bringing these cases of bronchiectasis before them, and for giving them an opportunity of meeting in the hospital.

Dr ADAM (in reply) said that with regard to cerebral abscesses associated with bronchiectasis, the frontal lobe rather than the cerebellum was likely to be affected. It struck him some years ago that sinusitis might be directly connected with the situation of the abscess, but the difficulty about this idea was that, as Gowers pointed out many years ago, a frontal lobe abscess was in a majority of cases on the left side. He once saw a surgeon operate for a frontal lobe abscess in a case of bronchiectasis. Uncertain of which side it was on and ignorant of Gower's statement, he went in first on the right and found no pus, then went in on the left side and found it. The patient died. Dr Adam thought the frequency of left-sided frontal lobe abscess was possibly due to the same cause as the frequency of right-sided hemiplegia due to left-sided embolism; and therefore one could not help thinking that the frontal lobe infection in bronchiectasis was due to septic embolism from the lung and was not directly connected with the sinusitis. That was the only way in which he could explain the frequency of frontal lobe abscess on the left side. As to the connection between sinusitis and bronchiectasis, Dr Adam said there was no doubt whatever, and the proof was that the bronchiectasis in these cases was almost always on the right side. The pus naturally came down the right bronchus just as foreign bodies also go down the right bronchus rather than the left, and was apt to go down there in sleep.

That bronchiectasis occurs much more in connection with sinusitis than is realised was shown by a case which Dr Adam published in the *Journal*

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when the idea first struck him. In one case a sinusitis had been missed by one specialist after another, and it was not until he had washed out the sinus for a minute or two (the fluid at first returned clear) that he washed out a thick pultaceous mass, dried in pus, which must have been there for years. Dr Adam found that Mullin of Colorado Springs had hit on the same idea as himself about a year before—that bronchiectasis was connected with nasal sinusitis, and the fact that it was most frequently on the right side.

As to tonsils and adenoid operation, pulmonary accidents are unlikely as long as you practise suction. Dr Adam thought he had seen one case, but there was no proof whatever that any tissue had fallen from the tonsils operation into the lung. There was a post-mortem and no trace of such was found. That was in line with what Dr Fraser had said. Dr Adam carried out Dr Jackson's method, but he gave it up as spreading infection. On watching the bronchiectatic patient cough, one found it an imperfect cough—the pus simply slipped down again and putrefied; and what happened on washing out the lung was that the pus, made more fluid, simply scattered into the bronchi and the measure was therefore not only not helpful, but harmful. If inversion was persistently practised once an hour, it was extraordinary what nature would do. Dr Adam thought the films showed that, especially in the case of the last girl he showed. Nothing had been done to the lung except inversion. The patient lay on her stomach across a stool, put her hands on the floor and her head well down and coughed. Diminution of pus from 15 ounces to 5 ounces within a week is proof positive of the value of the method. Dr Fraser referred to inspiration of material into the lung. Dr Adam said he had a case which he had recorded of a man with a subglottic tumour. He did a tracheotomy, split the cricoid and took out the tumour. It did very well for four days and then the patient took septic pneumonia and died, which Dr Adam thought was due to a small piece of the tumour dropping down and infecting the lung.

Case 6. **Teratoid Tumour of External Auditory Meatus**—James Adam, M.D.—Mrs H., aged 65. Growth in right ear for 18 years. Very deaf—hears shouting only with either ear. Weber to right. Left tympanic membrane much retracted. First seen 16.8.28. What was taken to be a large osteoma with unusually thick fibrous and cutaneous coat was found to fill external meatus, dilating it enormously. Patient advised to let it alone. 16.10.29—Attack of pain with giddiness and discharge of pus. 23.10.29—Through usual post-auricular incision tumour was delivered and its pedicle severed with a gauge. The pedicle was attached behind joint of jaw.

Pathologist's report (Dr Margt. Gilmour)—A simple form of mixed tumour, probably congenital. It resembles tumour derived from branchial cleft or thyroglossal duct in having ciliated epithelium. Several varieties of epithelium are present, including glandular acini resembling respiratory tract epithelium, trabeculæ and acini composed of cubical epithelium, recalling tubules of solid glandular organs.

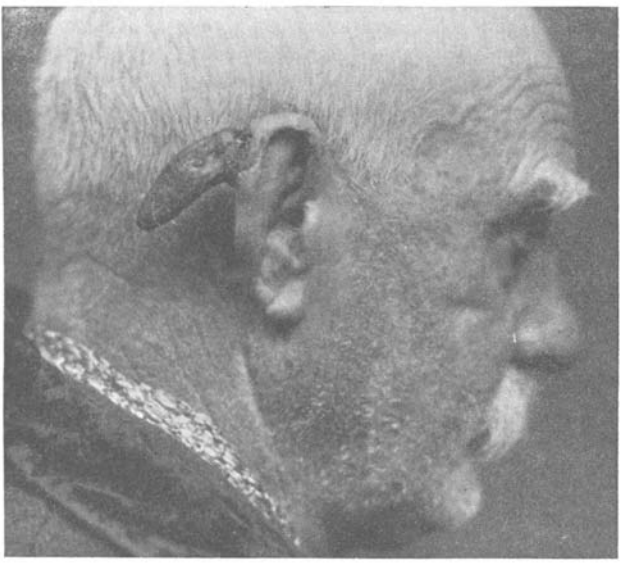
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There are areas which show appearances commonly described in mixed tumour of parotid. Stroma includes myxomatous fibrillar and hyaline areas.

CASE 7. **Carcinoma of Gullet: Rupture into Aorta**—JAMES ADAM, M.D.—Male, aged 55. Dysphagia since October 1928. Occasional pain. Admitted 28.9.29. 2.10.29—Œsophagoscopy. Tumour mainly posterior wall about 12 inches from incisors. 28.10.29—Death from sudden hæmorrhage. Pathological report—Carcinoma of gullet with extension into lung and rupture into thoracic aorta. Specimen shown.

Dr ADAM said there had been two cases in Stobhill where radium was put in for malignant tumour and there was rupture of the carotid afterwards.

CASE 8. **Horn growing from Right Auricle**—E. A. M. CONNAL, M.B.—Male, aged 69. History of one year's duration. Also scaly



deposit of epidermis in a similar situation on left ear (in region of Darwin's tubercle), suggesting commencing horn there. Commencing separation at base of horn had developed during time patient awaited admission to hospital for removal.

CASE 9. **Melanomatous Sarcoma**—W. S. SYME, M.B.—Male, 30 years. Large swelling of left auricle showing many large venous spaces. Pathology report—Melanomatous sarcoma; diathermy twice. Attending Western Infirmary, Glasgow, for two years for treatment with CO_2 snow.

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Dr SYME said that one of his ideas in showing this case was to ask what future treatment one should give; and with regard to the question of doing a plastic on the ear, whether it would not be better to give the man eventually a false auricle.

Dr ADAM said that the late Dr Dawson and Col. Stevenson published very interesting papers about the development of melanoma after an injury to the foot. It is not an uncommon thing in the East. Dr Adam asked if this case had been abroad.

Dr SYME reported there was no history of the man having been abroad.

Dr SOUPER asked if there was any history as to how long the swelling of the auricle had been present before it had been seen. He asked whether the case, as seen at present, was regarded as cured.

Dr SYME (in reply) said that as far as he could make out from the patient, he attended the Skin Department of the Western Infirmary with a swelling about the size of a shilling originally, and that this was treated with CO_2 snow at various intervals. Eventually the man himself gave up the treatment as unsatisfactory, as he did not seem to be making progress. He had not been to the Western Infirmary for six or eight months until he (Dr Syme) saw him. When seen by Dr Syme first of all it was about the size of a small pear. Dr Syme said he was not satisfied in his own mind that the thing is at present entirely cured. There are one or two coloured patches which are not entirely satisfactory.

The PRESIDENT asked if there was any suggestion of using radium instead of CO_2 snow in this case.

CASE 10. **Lupus of Palate**—W. S. SYME, M.B.—Female, 49 years. Healed lupus of palate. Treatment by Finsen, and in Western Infirmary, Glasgow, 22 years ago. Warty growth easily made to bleed on edge of healed area. Pathological report—The epithelium is hyperplastic and exhibits irregular downgrowths. No actual invasion of underlying tissues. Cutis vera is seat of marked infiltration by lymphocytes and plasma cells. No evidence of any lupoid process seen. Lesion should be regarded as potentially malignant. Diathermy. Dismissed well.

Dr HARPER said it was most uncommon to have tuberculous and malignant disease present in the throat at the same time. Malignant disease was frequently seen in conjunction with syphilis.

Dr SOUPER said he thought it was known that one got malignant disease on top of chronic lupus. He had seen cases in the Skin Department in Aberdeen Infirmary—not necessarily in an elderly patient, but even in a young patient—where the lupus had been present for a long time.

Dr HARPER asked—Not in the throat?

Dr SOUPER said he thought it arose many years afterwards in lupus of the face that had been treated by X-ray, but he would not like to say it was the same in lupus of a mucous membrane.

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CASE 12. **Epithelioma of Fauces**—W. S. SYME, M.B.—Male, aged 45 or 46. Epithelioma of right fauces and side of tongue. 20.2.28—The late W. S. Syme ligated external carotid and removed growth by surgical diathermy. 22.11.28—Shows very large clean cavity.

Dr LOGAN TURNER remarked that this was a very good result; one could feel no glands.

Dr GARDINER asked how old the patient was.

Dr SYME replied 45 or 46 years.

The PRESIDENT said that there was a tendency in these days to neglect diathermy. He had a feeling that diathermy was much more effective than radium in selected cases of malignant diseases.

CASE 13. **Perforation of Nasal Septum**—W. S. SYME, M.B.—Male. To show large septal perforation. History of syphilis in South Africa thirty years ago. Wassermann reaction negative.

Dr SYME said he showed this case really to be taken with Case 11 (which did not appear), as much with regard to the etiology of the condition as anything else. In Case 13 there was a great amount of bony destruction, but in Case 11, as far as he could make out, there was no destruction of bone. In both cases the Wassermann was now negative. In No. 13 there was a history of syphilis thirty years ago, but in the other there was no such history. In a case where there was no destruction of bone but where it was a cartilaginous condition, might it be due to his having worked with acids?

CASE 14. **Epithelioma of Hard Palate**—W. S. SYME, M.B.—Male, aged 60. Epithelioma of hard palate. 23.7.29.—Five needles of 1.5 mgrms. radium each inserted peripherally. Two needles came out after two days. The remaining three stayed for five days.

Dr LOGAN TURNER asked if the diagnosis in this case was microscopic.

Dr E. CONNAL said he thought he made out enlarged glands on both sides in the submaxillary region. He asked if there was any proposal to investigate these.

Dr SYME said that it was a microscopic diagnosis. This man is continuing under observation and the suggestion at present is that we give him external deep X-ray therapy. He certainly has an enlargement of the glands, particularly on the left side. One of the interesting points about the case was that we put in the five needles of 1.5 mgrm. radium with the idea of leaving them in for five days. The figures in this billet are really wrong. The needles did not all remain in for five days, thus giving a smaller dosage than was intended; not a dosage of 1596 mgrm. hours but only 612 mgrm. hours. The radium expert gave the correct figures afterwards.

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The PRESIDENT said he had a case about six years ago which he treated with diathermy, and a surgeon removed the submaxillary glands and applied some radium to the cavity before closing the wound. The patient is still alive and well. The President thought it a satisfactory arrangement to combine the two, but that could be better arranged when there were more supplies of radium available.

Dr STEWART said that in one recent case of squamous epithelioma of the hypopharynx he used diathermy, and four to five days later, inserted 40 mgrms. of radium into the growth for 1920 mgrm. radium hours. The local result was very nice, but about a month later the patient returned with secondary deposits in the spine.

CASE 16. **Double Mastoid Disease**—D. QUIGLEY, M.B.—Male, 21 years. First attended Ear Hospital July 1929. Complained of severe pain in left ear, no discharge, no previous ear trouble. Diagnosed and treated as furuncle. September 1929: returned; ear apparently had discharged off and on since first visit. Pain behind ear and definite tenderness on pressure. Admitted for observation. Furuncle present in meatus rendering satisfactory otoscopy impossible. Patient looked and felt well, hearing unimpaired. Temperature normal, pulse averaging 85. No œdema over mastoid. Condition remained unaltered, the moderate pain and definite mastoid tenderness persisting. X-ray examination made—report positive. Cortical mastoid operation performed. One large compartment of pus extending to tip of mastoid; bone soft and carious; sinus exposed. Wound cleansed—B.I.P. applied; incision closed except for gauze drain. Five days after operation temperature rose; complaint of pain in right ear; case taken over by Dr R. J. Watson. Second X-ray was taken of right ear; similar condition was revealed. Cortical mastoid operation performed.

Dr FRASER said that this case brought up the old question of the diagnosis of furunculosis from mastoiditis. In many cases it was extremely difficult to make the correct diagnosis and he had often made mistakes. He suggested that if there was difficulty in diagnosis, the case should be treated as one of mastoiditis. One should not persist in regarding the case as due to furunculosis. If a so-called "furuncle" did not clear up in three or four days it was far better to cut down.

Dr ADAM said he would like to ask Dr Fraser, as a matter of differential diagnosis, whether the hearing was not a great help, as in furuncle the hearing was not nearly so degraded as in mastoiditis.

Dr QUIGLEY reported that in this case the hearing was unimpaired.

Dr HARPER said he did not think the hearing was a guide in such cases. He had a case under his care at present where there was no middle-ear suppuration, the drums were practically normal and the hearing unimpaired. On opening the mastoid extensive destruction was found.

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Dr SOUPER asked if the exhibitor was able to give any fuller report on the X-ray examination—as to what the exact report was. If extensive disease was found, there was not much description of it on X-ray examination of the first mastoid.

Dr QUIGLEY said there was very definite dullness of one mastoid as compared with the other. He had not seen this case until it was admitted. He had not seen it as a furuncle.

Dr FRASER said he doubted whether radiograms were of great value in the diagnosis because when there was cellulitis behind the ear in a case of furuncle, you got practically the same picture as when mastoiditis was present. We all knew we had to operate on many mastoids before there was actual breaking down of the bony partitions between the cells.

Dr SOUPER said that this was what he wanted to know. If the X-rays simply showed blurring of the cells, there was no differentiation between furuncle and mastoiditis.

CASE 17. **Dental Cyst**—R. J. WATSON, M.B.—J. S., 53 years. Dental cyst rupturing through hard palate and into floor of nose. Swelling on roof of mouth and left upper alveolus—several years' duration. Wassermann reaction negative. Transillumination clear; X-ray "dental cyst." Probe passes through palate from mouth to floor of nose. Pathological report: Tissue from granulation round palatal sinus. Histologically there is marked irregular hyperplasia of covering epithelium which is growing down into deeper tissues. Specimen does not go deep enough to admit of definite diagnosis of malignancy. Appearances in the section might well be due to simple chronic inflammatory lesion.

Dr LEITCH said, Was this really a dental cyst? It was not a usual position, and it seemed to him more of the nature of one of those rare cases of naso-palatine duct cysts. There was a very good description of such cysts, and also of dental cysts, given in a recent number of *The Laryngoscope*.—("Unusual Cysts of the Maxilla," by Dr Joseph Schroff, *The Laryngoscope*, March 1929, Vol. xxxix, No. 3, p. 173.)

Dr HARPER asked Dr Leitch if there was any definite situation for a dental cyst. Personally he had seen them all over the hard palate and canine fossa.

Dr LEITCH said that he did not mean to say that it was *not* a dental cyst, but it seemed to him that it suggested a naso-palatine duct cyst as described in that paper, and he thought further investigation should be made and the case brought forward on a future occasion.

Dr WATSON (in reply) said that with regard to the question of the dental cyst, unfortunately the plate, which was taken while he was on holiday, had gone amissing and he had not seen it. He merely got the report. He himself thought it was malignant and that was the reason why he took away the specimen. The pathologist reported that it had not gone deep enough for a definite diagnosis of malignancy. He proposed next week to open it.

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CASE 18. **Case for Diagnosis**—R. J. WATSON, M.B.—B. S., aged 36. Complaint: hoarseness and loss of voice at intervals for eight years. Dyspnœa becoming more severe in four weeks up to date of admission—1.10.28. Wassermann negative; no paralysis of tongue, lips, face or palate; pupil reacting normally. Suspension laryngoscopy—cords fixed in adduction position. Admitted with severe dyspnœa; tracheotomy performed several hours later. Treated with mercury and iodides; no change in larynx since. The tracheotomy tube is the patient's own invention.

Dr FRASER said he had ascertained that this patient was a Russian, and he wondered whether the question of scleroma had received attention. The case seemed to him to be rather of that nature than one of paralysis of the vocal cords.

Dr BROWN KELLY said that he had also asked the patient as to his residence in Poland, Russia, etc., but that the patient stated he had been thirteen years in this country. There was no sign of scleroma in the nose. The larynx showed no definite infiltration, but this might be present in the subglottic region where often chronic hypertrophies were the first and only changes in laryngeal scleroma. He (Dr Kelly) asked if it would not be worth while to open up and examine from the tracheotomy wound.

Dr HARPER asked if extensive scleroma of the larynx could be present without some involvement of the nose to some degree.

Dr LOGAN TURNER asked if the Society could have a report of this case next year.

CASE 19. **Multiple Plasmocytomata**—C. MACARTNEY, M.B.—Male, aged 62. Admitted 20.6.29. Complaint: sensation of lump in throat for one year, and dysphagia. Examination—Multiple fleshy polypoid growths with the following distribution: *Soft palate*, three on right anterior pillar, one on left and one on left side of uvula. *Epiglottis*, one to right of base. *Larynx*, one on right side, growing from the false cord; true cords not involved. Pathological report, 19.5.29: (*a*) Growth from naso-pharynx; polypus showing well-marked chronic inflammation; no definite evidence of malignancy and (*b*): 2.7.29—Growths from soft palate and larynx. Report as above. Marked cellular infiltration, chiefly of plasma cells arranged in alveolar fashion, suggestive of (*a*) simple polypi showing marked chronic inflammatory changes and marked infiltration with plasma cells. (*b*) Multiple plasmocytomata. The latter diagnosis is possibly the correct one. Wassermann negative. Operation: the growths all removed by direct method. *Result:* later, two small growths appeared on upper wall of soft palate. They have not been removed.

Dr MACARTNEY said that the case would be published. The majority of the members here had not heard of the condition before. The interesting point to him was that the growths which he did remove had not recurred. They came away quite simply. He had not found much in the literature about the subject.

https://doi.org/10.1017/S0022215100034757 Published online by Cambridge University Press

CASE 20.—**Malignant Disease of Left Pyriform Sinus. Follow-up Case**—(Case No. 11 at 28th Meeting)—G. B. BRAND, M.B.—Mrs M., aged 53. At meeting in 1928. Suspicion of recurrence; piece of tissue removed; endoscopy; found to be simple granulation tissue. Patient still well, with no sign of recurrence; tendency for food particles to collect in pyriform space of affected side.

Dr BRAND said that this was the case shown at the Victoria last winter, and there was a suspicion then that there was some recurrence. He removed a piece of the tissue by endoscopy and it was found to be ordinary granulation tissue. Since then she has been under continuous observation, and little bits of granulation tissue seem to form from time to time and particles of food stick to it. These can be wiped away. There is no glandular recurrence and the patient is perfectly well. She swallows without discomfort. Dr Brand wondered if the paralysis of the hypoglossal nerve had anything to do with the hold-up of the food particles.

CASE 21.—**Laryngeal Case.**—G. B. BRAND, M.B.—Mrs R., aged 42, had simple growth, histologically fibroma, removed from anterior commissure of larynx thirteen months ago. Since then speaking and singing voice has been quite good until two weeks ago, when she developed a cold, and the hoarseness was severe. Small growth showing on anterior part of left cord and some thickening in corresponding region of right cord.

Dr BRAND (in reply to Dr Logan Turner) said that the appearances were quite different from the original. It was an anterior commissure growth.

Dr FRASER said he understood that Dr Brand intended to remove this swelling and have it microscopically examined, and he suggested that the case be reported at the next meeting.

CASE 22.—**Laryngeal Case.**—G. B. BRAND, M.B.—Male, aged 34 (grain miller). First seen 25th November 1929. Hoarseness three months; had previous attack two years ago, which lasted one month. No pain, slight cough, voice getting worse in spite of treatment. There is slight septal deflection to left side with some crusting on right middle turbinate; some dry purulent secretion on the posterior pharyngeal wall; no pus in the choanæ; right antrum is dull on transillumination; right vocal cord thickened; some limitation of movement; small flabby-looking growth in interarytenoid region just in front of right arytenoid.

Dr BRAND said he only saw this case for the first time last Monday and there had been no investigation. He thought it was an interesting case and brought it up. His own impression was that there was a tubercular element in the case. He had not got the result of the Wassermann reaction.

Dr BROWN KELLY said that ulceration extended around the glottis, both vocal cords were affected, and there was thickening in the interarytenoid region.

https://doi.org/10.1017/S0022215100034757 Published online by Cambridge University Press

CASE 23.—**Case of Deafness for Diagnosis.**—G. B. BRAND, M.B.—Female, aged 19. Since diphtheria six years ago gradually increasing deafness. No history of suppuration. Noises in the head. Paracusis not marked. Responses to various tests of hearing are variable from time to time. Wassermann reaction negative. Upper air-passages healthy except for some bad teeth. Hearing tests on 29th November 1929: Bone-conduction, watch heard on both mastoids and frontal; does not hear whisper or conversational voice; loud voice heard at about 1 foot on both sides; Schwabach normal; Weber lateralised to right side; tuning-forks C 32-2048 heard by air-conduction in both; monochord to 18,000 d.v. Eustachian tubes patent; no improvement on catheterisation. Caloric test: Syringing with cold water produced well-marked nystagmus to the opposite sides in both ears—right side, 50 seconds, left side, 40 seconds. Past-pointing and falling reactions normal.

Dr FRASER said he thought this patient was hysterical. The patient was able to hear a watch on her forehead and on both mastoids, and yet one required to shout in her ear to enable her to repeat the words. It seemed to Dr Fraser to be practically impossible that anybody should be able to hear a watch on the forehead and mastoids and yet should require to be shouted at before she would repeat. The vestibular reactions were quite normal. According to Dr Hurst, this would at once place her in the category of hysterical deafness.

Dr J. P. STEWART asked if there was any treatment for a case of hysterical deafness.

Dr LOGAN TURNER suggested isolation or starvation.

Dr BRAND said he had watched the girl very carefully and had been convinced that there was a functional disturbance. The question of malingering could be ruled out.

AUSTRIAN OTOLOGICAL SOCIETY.

MEETING OF 28TH OCTOBER 1929.

(*Abstract of Proceedings, Monatsschrift für Ohrenheilkunde*, December, 1929.)

By A. R. TWEEDIE, F.R.C.S.

Labyrinthitis, Chronic, Purulent or Tuberculous. Sterile Meningitis. Labyrinth Operation. Recovery—E. RUTTIN.—Girl, aged 21. First applied for treatment in March 1929, complaining of right otorrhœa of some days' duration. On examination, the meatus was found occupied with pale granulation tissue, the appearance of which strongly suggested tubercle. The histological report of the specimen, however, did not support the suspicions.

https://doi.org/10.1017/S0022215100034757 Published online by Cambridge University Press